Highlights from MACPAC January Public meeting

Overview: On January 26 and 27, 2023 the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public meeting. Presentation slides and the agenda for this meeting can be found on MACPAC's website.

Session 1: Improving Medicaid race and ethnicity data collection and reporting: Review of recommendations and draft chapter for March report

Presenters:

- *Jerry Mi, Research Assistant*
- *Linn Jennings, Analyst*

Background

- MACPAC has been exploring ways to improve Medicaid race and ethnicity data collection and reporting, recognizing the importance of quality data to health equity.
- As a part of their focus on health equity, improving the usability of this data is also a key priority of the Biden administration. In particular, the Biden administration wants to increase the usability of federally collected race and ethnicity data by identifying data inadequacies and supporting agency efforts to improve data quality.
- States have broad flexibility to determine which race and ethnicity categories to collect on their applications, and submission of such information on an enrollment form is not a requirement for Medicaid eligibility. Every state currently collects race and ethnicity data during enrollment. However, state collected data on self-identification may be more granular than the federal categories and not easily reportable to the Transformed Medicaid Statistical Information System (T-MSIS). Also, many stakeholders identified beneficiary reluctance to report their race/ethnicity due to concerns about how the information may be used as a barrier. The Center for Medicare & Medicaid Services (CMS) currently has a "model application", however states can create their own more comprehensive applications.
- MACPAC conducted interviews with stakeholders, including managed care organizations (MCOs), state officials, the Center for Medicare and Medicaid Services (CMS), and application assisters to gauge race and ethnicity data collection in Medicaid. This has led to draft recommendations for Commissioner review.

Recommendation #1

- The Secretary of the U.S. Department of Health and Human Services (HHS) should update the model single, streamlined application to include updated questions to gather race and ethnicity data. These questions should be developed using evidence-based approaches for collecting complete and accurate data. The updated application should include information about the purpose of the questions so that the applicant understands how this information may be used. HHS should also direct CMS to update guidance on how to implement these changes on a Secretary-approved application.
- *Rationale:* Implementing modern, evidence-based approaches to gathering race and ethnicity data can improve applicant trust and result in better quality data. Self-reported data from applicants is considered the "gold standard." However, states need guidance to these suggested changes since most states utilize alternative applications that differ from the HHS model.

- *Implications:* According to the Congressional Budget Office (CBO), there may be a small, short-term increase in federal spending as the new model application is developed and systems are updated. Enrollees will gain a greater understanding of and trust in the new system, making them more likely to self-disclose data about themselves. Plans and providers are unlikely to be impacted by these changes. States may need to make minor changes to systems.

Recommendation #2

- The HHS Secretary should direct CMS to develop model training materials to be shared with state and county eligibility workers, application assisters, and navigators to ensure applicants receive consistent information about the purpose of the race and ethnicity questions. The training materials should be developed with the input of states, beneficiaries, advocates, and application assisters and navigators, user tested prior to implementation, and adaptable to state and assister needs.
- *Rationale:* Many beneficiaries enroll in Medicaid with the help of application assisters, navigators and eligibility workers. These on-the-ground workers are critical to convincing beneficiaries about the importance of quality race and ethnicity data. This recommendation could lead to sample language to explain to applicants why information is collected.
- *Implications:* Small short-term increase in federal costs as training materials are developed. States that do not currently provide training materials may see a short-term cost and some minimal effort to implement. However, the collection of more complete race and ethnicity data should help healthcare providers improve the quality of care.

Commissioners' Comments

Commissioners expressed support for the recommendations, and voted to approve them for inclusion in MACPAC's March report to Congress. Many also expressed support for recent state managed care organization (MCO) contract requirements mandating the appointment of a plan health equity director. Commissioners noted the importance of quality data but said that the Commission should focus its end goal on using this high-quality data to effectuate change.

Session 2: Nursing facility provider payment principles: Review of recommendations and draft chapter for March report

Presenters:

- *Drew Gerber, Analyst*
- *Rob Nelb, Principal Analyst*

Background:

- Following work previously conducted by MACPAC analysts on nursing facility payments, presenters reviewed a set of recommendations and provided a draft report for inclusion in the Commission's June report to Congress. A more in-depth look at MACPAC's previous work in this area can be found here.
- Currently, Medicaid is the primary payer for almost all nursing facility residents. Typically, Medicaid payments are significantly lower than other payers because Medicaid-covered residents have both lower acuity of care and fewer services paid for by Medicaid.
- The nursing facility sector faces several challenges, including a large share of for-profit facilities with complex ownership models, staffing concerns for facilities in more rural areas, and competition from newer homelike-setting models.

- In general, facilities that serve a high percentage of Medicaid-covered nursing residents have worse quality ratings than other types of facilities. Significant problems were highlighted by the COVID-19 pandemic.
- Since Congress's repeal of the Boren Amendment (1977), states have been given more flexibility on setting nursing facility payment rates. A majority of these payments were originally based on payment rates made in a fee-for-services (FFS) delivery system. However, use of supplemental payments and managed care are growing. States typically finance their share of nursing facility payments by way of provider taxes or intergovernmental transfers (IGTs), and certified public expenditures (CPEs) from publicly owned facilities.
- Base payments vary state by state and for different facilities within each state. MACPAC analysis did note that a large amount of data is missing on supplemental payments, resident contributions to their share of costs, as well as provider contributions to the non-federal share.
- Nursing facility staffing has been shown to contribute to higher quality and is a key area of focus in states. MACPAC analysts explained that while previous research suggests higher Medicaid payment rates could increase staffing, their research did not find a clear correlation.

Interaction between Medicare and Medicaid:

- Recent changes to Medicare's acuity adjustment system have made it difficult to align with payments made for Medicaid beneficiaries. For example, the new Patient Driven Payment Model (PDPM), did not take into account long-stay residents that are primarily covered by Medicaid.
- Reducing non-emergency hospitalizations for patients who are dually eligible is difficult because payment incentives are misaligned. Because of this, nearly one quarter of nursing facility residents are hospitalized each year at an estimated annual cost of $1.9 billion to Medicaid and Medicare.
- During the COVID-19 public health emergency (PHE), CMS waived the hospitalization requirement to begin a new Medicare nursing stay; however, it is unclear what will happen after the PHE.

Nursing Facility Payment Principles:

- Due to insufficient staffing, if staffing costs are too low, states should consider payment rates that cover costs of economic and efficient providers. It is important to consider the costs needed to meet the staffing requirements. Analyses should consider all of the Medicaid payments that providers receive.
- Payment methodology should align payments for Medicaid populations with payments for the same level of care in the general population. methods Payment methodology should incentivize better quality and reductions in health disparities. More evaluation is needed to help policymakers make the best decisions with the most effective strategies.
- The goal should be for states to get the maximum value for the amount they are spending. Cross-state comparisons need to be conducted to identify states with high payment rates but low-quality outcomes.

Proposed Recommendations:

- Recommendation 1: Improve transparency of data on Medicaid payments and costs
    - The Secretary of Health and Human Services (HHS) should direct the Centers for Medicaid and Medicaid services (CMS) to gather and report in a standard format that allows for analysis on:

        - Facility-level data on all types of Medicaid payments for all nursing facilities that receive funding and include resident contributions to their cost of care.
        - Provide data on the sources of non-federal share necessary to determine Medicaid payment at the facility level.
        - Allow for comprehensive data on nursing facility finances pertaining to comparison of Medicaid payments to the costs of care for Medicaid-covered residents, and examine the effects of real estate ownership models.
            - Rationale: Allow for transparency of data on Medicaid payments and costs is a long-standing Commission goal that will enable further analyses. MACPAC's review of available federal data showed large gaps in data on base payments, supplemental payments and provider contributions for the non-federal share.
            - Implications: No increase in federal spending but will need an increased administrative effort. For states, there is potential for greater administrative effort.
- Recommendation 2: Update of existing requirements as states conduct routine analysis
    - To further help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of Health and Human Services (HHS) should direct CMS to update the requirement for states to conduct regular analysis of all Medicaid payments relating to the costs of care for Medicaid-covered nursing facility residents.
        - Rationale: Current federal data is incomplete and in order for state-level analysis to be conducted, the federal data needs to be accurate. Currently, the federal regulations in place require states to make annual findings that FFS nursing facility rates are reasonable and adequate to meet the costs of providers operating within Medicaid's efficiency and economy standards.
        - Implications: Similar to Recommendation 1, there is a likelihood of increased administrative effort on the part of states, which could be reduced with the help of technical assistance and analytic support.

Commissioners' Comments

Commissioners expressed overall support for the proposed recommendations. This has been a topic of lengthy discussions by Commissioners and they noted the difficulty of dissecting and understanding the many facets of nursing facility provider payments. A few Commissioners highlighted the importance not only of the recommendations, but also the principles that underpin the recommendations. They believe that the principles are robust and should drive any analysis resulting from the recommendations. They recognized the long-term benefits of CMS developing a better approach to nursing facility payment data collection and analysis. They also believe these recommendations will lead to much better use of nursing home dollars and ultimately better care for nursing home residents. The Commissioners voted for the recommendations to be included in their March report to Congress on Friday morning and they were passed unanimously by all Commissioners present and voting.

Session 3: Medicaid coverage based on Medicare national coverage determination (NCD): Review of recommendations and draft chapter for March report

Presenter:

- *Chris Park, Principal Analyst and Data Analytics Advisor*

Background

- Under the Medicare Part B statute, CMS may make a national coverage determination (NCD) about whether a service or prescription drug is "reasonable and necessary" and therefore covered. CMS may also link coverage to participation in a clinical trial (known as coverage with evidence development, or CED). However, due to the Medicaid Drug Rebate program, state Medicaid programs do not have the same authority to restrict coverage or issue a CED like Medicare can. This has become an issue with many expensive, experimental drugs (most notably Aduhelm, a controversial Alzheimer's drug of debatable efficacy).
- CMS issued a CED for Aduhelm. However, state Medicaid programs must cover the cost of this drug for all eligible beneficiaries given the parameters of the drug rebate program, despite the drug's controversial efficacy, cost, and dangerous side-effects.
- This is more expansive than the requirements for exchange or Medicare Part D plans, which can exclude coverage of some drugs and take time to make coverage decisions.
- MACPAC is exploring a recommendation that would allow states the same authority to limit access to a drug, via a revision to the Medicaid Drug Rebate program statute.
- CED requirements have only been applied to drugs three times in history, including Aduhelm. States do not explicitly have the authority to implement NCDs under current law. Plans have the ability to establish their own prior authorization policies and formularies if there is not a single state preferred drug list (PDL), but generally cannot deviate significantly from the requirements of the Medicaid Drug Rebate Program.

Competing Recommendations

- Recommendation 1:
    - Congress should amend § 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug based on a Medicare national coverage determination, including any coverage with evidence development requirements.
- Recommendation 2:
    - Congress should amend § 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug based on coverage with evidence development requirements implemented under a Medicare national coverage determination.
- Both recommendations come with corresponding recommendations applicable to MCOs, requiring them to conform to the state's policy.

Rationale

- While the net effect is expected to be similar (since restrictive NCD and CED determinations are rare), recommendation 2 is a narrower recommendation than 1. The first potential recommendation would allow states to follow all Medicare NCDs for drugs, even if it does not include CED requirements. The second option would allow states to only follow the CED requirements included in a Medicare NCD.

<u>Commissioners' Comments</u>

- Commissioners were very divided between the two potential recommendations. Commissioners supporting Recommendation 1 cited the fact that many randomized

controlled drug trials systematically exclude beneficiaries of color and those with comorbidities (also disproportionately people of color). They expressed worry that allowing coverage only within CED frameworks could disadvantage many beneficiaries and leave them out of potential new therapies and drugs. Meanwhile, supporters of Recommendation 2 argued that MACPAC should be supporting the trial and evidence development process, and that Medicaid beneficiaries should not be exposed to potentially dangerous and highly experimental drugs. Commissioners eventually adopted recommendation 1 when it became clear that it was supported by a majority of the Commissioners, and the final vote was 15-1 in favor of adopting Recommendation 1 over not adopting any recommendation. As a result, Recommendation 1 will be included in the March report to Congress alongside a corresponding recommendation for Congress to require MCOs to mirror a state's coverage policy.

Session 4: Interviews with experts on challenges for states administering Medicaid home- and community-based services and access barriers for beneficiaries

Presenters:

- *Tamara Huson, Analyst*
- *Asmaa Albaroudi, Senior Analyst*

Background:

- MACPAC analysts presented findings from interviews with 18 stakeholders including federal and state officials, representatives from a range of HCBS populations and national experts. They discussed the barriers beneficiaries face while accessing services as well as the challenges states face in administering HCBS programs.
- Medicaid HCBS is designed to support people with LTSS needs by establishing meaningful integration into their communities. A wide range of services are covered, including personal care, supported employment, and caregiver support. HCBS populations span a range of ages and disabilities and the length of care they need may vary widely. The support needed by beneficiaries vary within LTSS subgroups as well as across states and populations. Research from 2019 shows that over 7.5 million people use HCBS services provided under Medicaid.
- After the presentation, analysts hope to gather feedback on areas of focus for inclusion in their June report to Congress.

Interview Findings:

- Methodology: MACPAC contracted with the Center for Health Care Strategies (CHCS) for support in conducting stakeholder interviews.
- Interviewees noted lack of information on HCBS options provided to beneficiaries as well as lack of access, even with support from states to establish no wrong door systems. Stakeholders suggested a current lack of training and high turnover rates among information counselors is partly to blame. Information provided on state websites varies and is not user friendly; inaccessible information presents a large barrier to beneficiaries.
- Complex eligibility requirements also present a burden. Difficulty navigating the different waiver eligibility pathways creates confusion for beneficiaries in properly accessing all the services available to them. With multiple waivers, it creates confusion as to which waiver will best meet the beneficiaries' needs.
- Enrollment caps and extensive waiting lists are another burden. Several interviewees expressed frustration with waiting lists as some beneficiaries wait so long that they end up never receiving care. For example, beneficiaries with severe traumatic brain injuries often pass away before receiving the HCBS care they require. Given the range of

waiting lists between 1-14years, some states have changed their programmatic approach to a priority-based system (e.g., Louisiana).

- Additional data to better identify inequities is necessary to address the disparities in access. Currently it is difficult to identify the extent to which these disparities occur because the data is lacking. Interviewees recommended more data on race and ethnicity, geography, age, and individuals with multiple disabilities.
- Current complications in administering HCBS: Since HCBS can be offered through a range of Medicaid statutory authorities and different state agencies, there's confusion about different reporting and renewal requirements.
- During the interviews, several suggestions were made about rethinking how to reduce administrative complexities:
    - Restructure HCBS authorities to better streamline the process by possibly consolidating authorities, aligning reporting and renewal requirements, as well as allowing for tiered benefit packages within Section 1915(c) waiver programs.
    - Increase HCBS access for beneficiaries with behavioral health conditions by looking into the association between the institutions for mental diseases exclusion (IMD) and the provision of HCBS through Section 1915(c) waivers to beneficiaries with behavioral health conditions.
- With regard to state staff capacity, interviewees presented severe limitations and the need to improve education on the different HCBS options. Current HCBS provider expertise is also lacking and their capacity is limited. One obstacle to expanding services has been a shortage of direct care workers.
- When asked for feedback on implementing a core benefit, some interviewees expressed general support. However, some specified that the success of such a benefit would depend on the design, implementation and state policy environments. A few interviewees were doubtful, and feared that an implementation of a core benefit could create further complexity. Almost all interviewees expressed that the only way a core benefit would be successful was if it was mandatory.
- Interviewees also favored using a budget-based core benefit model, with additional funding providing for individuals with higher needs, which would give states more predictability while still allowing beneficiaries choice and flexibility. Other considerations that were noted included the need to consider workforce availability and financial support for states if the core benefit was made mandatory.

<u>Commissioners' Comments</u>

Commissioners sensed some apprehension from interviewees as it relates to a core benefit, given the diverse challenges and barriers addressed. Commissioners discussed the ways in which they could best support HCBS and potential work in helping build out what an ideal core benefit format could look like. One Commissioner suggested adding findings on military family members needing services and how they are treated on waiting lists, as military members are a highly mobile population–are family members needing HCBS benefits automatically put at the bottom of each state's list after being stationed in a new state?. On the topic of waivers, Commissioners asked analysts to gather more information on potential simplification of waivers, as well as provide more feedback on the voluntary/mandatory idea with a proposed core benefit given the hesitation from some interviewees.

Session 5: Panel on the American Rescue Plan Act (ARPA): States' early experiences with implementation

Introduction:

- *Tamara Huson, Analyst*

Panelists:

- *Elizabeth Matney, State Medicaid Director, Iowa Department of Human Services*
- *Dr. Kevin Bagley, Director, Medicaid & Long-Term Care, Nebraska Department of Health and Human Services*
- *Heidi Hamilton, Acting Director of the Disability Services Division, Minnesota Department of Human Services*
- *Camille Infussi Dobson, Deputy Executive Director, ADvancing States*

Background

- The American Rescue Plan Act (ARPA) temporarily increased the federal matching assistance percentage (FMAP) for state Medicaid programs to support home-and community-based services (HCBS) for one year. States had to submit plans to CMS for approval on how they would spend this money. All 50 states and the District of Columbia have received approval from CMS for their initiatives. States have until March 31, 2025 to spend the money. They are required to submit quarterly and semi-annual reports to CMS on their progress. MACPAC convened a panel of three state officials (from Iowa, Minnesota and Nebraska) and Camille Dobson of ADvancing States, the group representing state aging agencies, to discuss successes and failures in implementing ARPA's HCBS money.

Q1: Describe how your ARPA implementation is going

- (Matney) Iowa is focused on creating durable, tangible change using the ARPA money. Iowa has committed $126 million in state funding to this effort, while constantly mindful of the cliff that ARPA creates since it represents one-time funding. Iowa's ARPA implementation has focused on three areas: workforce, quality and access. The state has contracted with Mathematica to do a review of all community based services. They have invested heavily in retention bonuses for providers, representing $4,000 per direct care professional. However, backing up this investment with sustainable rates is top of mind. The Legislature has agreed to fully fund the temporary rate increases provided by the ARPA money following its expiration. Iowa is also trying to innovate, by investing in remote monitoring and new IT for providers.
- (Hamilton) Minnesota has invested $600 million in 54 projects. The goal is to increase access to HCBS services for diverse populations and to strengthen the HCBS infrastructure. Minnesota has sometimes found flexibility lacking in the federal ARPA implementation. For instance, the state has had trouble expanding housing support programs. However, the state has appreciated the extra money, which has helped them to hire new eligibility staff.
- (Bagley) Nebraska is trying to strike a balance between immediate relief and building long term capacity. One third of ARPA money was used for immediate relief to providers. Rural communities present unique challenges because it's often a long distance to providers and there's a shortage of workers. Nebraska is attempting to implement a grant program for HCBS providers to help them improve their infrastructure and make much needed facility improvements.
- (Dobson) ADvancing states is looking at all the states and how they have been implementing ARPA. According to their analysis, states are focusing mostly on the workforce, adding new services/waiver slots, upgrading IT systems and purchasing personal protective equipment (PPE). 34 states experienced provider rate increases,

with some spending all their ARPA money on this (e.g., Idaho). 18 states had explicit requirements for providers to pass along increased rates to direct care workers in the form of wages. 13 states added waiver slots, and 43 expanded services. Most indicated that implementing complex initiatives and getting CMS approvals to be their biggest barriers.

Q2: Discuss the lack of sustainability of the funds and how effective programs can still be implemented

- (Matney) Iowa Medicaid has worked collaboratively with the Legislature and Governor to make sure that all new initiatives are self- sustaining. Beyond the temporary rate increases being backed by continued commitment from the Legislature, Iowa will look at the Mathematica study to inform future moves. A big priority is waiver reform and consolidation, to make them based on need. This has the Legislature very excited. Iowa has struggled with the "maintenance of effort" provisions of receiving the money, which require that no provider sees a loss in rates and no person sees a loss of care as a result of HCBS changes. Even giving as few as five beneficiaries slightly fewer care hours presented a problem with CMS that it took Iowa six months to rectify.
- (Hamilton) Minnesota is relying on the public health emergency (PHE) for a lot of flexibility when it comes to innovative programs. An example is a program that pays spouses and minors for caregiving, something that may go away when the PHE ends. Minnesota is also condensing its waivers based on level of need. This initiative is an example of a one-time expenditure that is sustainable.
- (Bagley) Nebraska is considering similar factors. The most important thing, however, will be demonstrating the value of the increased HCBS funding. All this temporary funding should be tied to quality measures so that the case can be made to policymakers of its value (and thus sustained).
- (Dobson) States had two months to submit their plans to CMS. This results in a lot of trial and error and illustrates the need for close collaboration. States are keenly focused on proving to policymakers that the increased investment in HCBS is worthwhile via rigorous data evaluation.

Q3: How could ARPA and its implementation have been improved?

- (Matney) We need more clear parameters about what maintenance of effort means. States are being handcuffed from doing beneficial HCBS program changes while they are under their spending plans. HHS also would not match Iowa's investment in provider IT, despite it having an obvious clinical benefit for the beneficiary. HHS should have had more authority to waive rules.
- (Bagley) We also need more flexibility on using money for technology. It is also hard to keep stakeholders engaged when spending the ARPA money can be such an arduous and bureaucratic process.
- (Hamilton) We are struggling with needing to implement dozens of programs at once, and with the administrative burdens of reporting and compliance.
- (Dobson) CMS has adopted an "extreme" interpretation of the maintenance of effort requirement and it has hurt states. States can't allow even one provider to be paid less. It is also a difficult process to build new programs into waivers, and states do not have the staff to implement many of the requirements. As an example, Wyoming Medicaid only has one staffer focused on HCBS, and many CMS requirements significantly overtax the state. All while trying to implement the ARPA HCBS money, states are facing the new HCBS settings rule and enforcement of it.

Q4: Any Additional Challenges?

- (Dobson) States legislatures are intervening in carefully made plans to redirect all the ARPA money to providers, often not in a thoughtful way.
- (Bagley) State officials have many different bosses, and implementing things can be hard because you are responsible to so many people.
- (Matney) At the end of the day, HCBS is an optional Medicaid service while nursing services are mandatory. Until that bias changes, HCBS will not have the priority it deserves in Medicaid.

Q5: If you could waive a magic wand and fix something, what would it be?

- (Dobson) Only 17% of housing is accessible. CMS should allow room and board to be paid with HCBS dollars.
- (Bagley) I would change how we talk about quality and outcomes, so that we can demonstrate that HCBS funding produces a substantial return on investment.
- (Hamilton) We should treat HCBS as a preferred option over institutionalization and end the bias against HCBS in favor of nursing facilities in Medicaid.
- (Matney) Instead of spending 90% of time figuring out how to follow rules, we should be spending 90% of a Medicaid agency's time figuring out how to improve provider performance and outcomes.

Commissioners' Comments

Commissioners appreciated the panelists' insight into their specific ARPA HCBS implementations. Commissioners mentioned the importance of collaboration with policymakers, as well as the need for caution when expanding services in the midst of a historic workforce challenge. Commissioners were interested in learning more about which beneficiaries are predominately in HCBS versus nursing facilities. Commissioners also noted that many workers are on Medicaid themselves and may lose coverage when they receive a pay raise, as a result of going over the income threshold. Commissioners expressed interest in a future "ambitious" recommendation on HCBS services becoming mandatory on par with nursing facilities, and agreed this programmatic distinction is the structural barrier holding back HCBS. Commissioners asked Matney (Iowa) about the role of MCOs in distributing the enhanced funding, to which she reported no issues. Matney also noted, in response to a question about substance use disorder and mental illness, that Iowa is implementing a therapeutic foster care pilot program and has contracted with a crisis provider to offer 24/7 support to caregivers in case of emergency when dealing with those with mental illness. Beyond pay, Matney said it was important staff feel supported.

Session 6: Highlights from Duals Data Book 2023

Presenter:

- *Drew Gerber, Analyst*

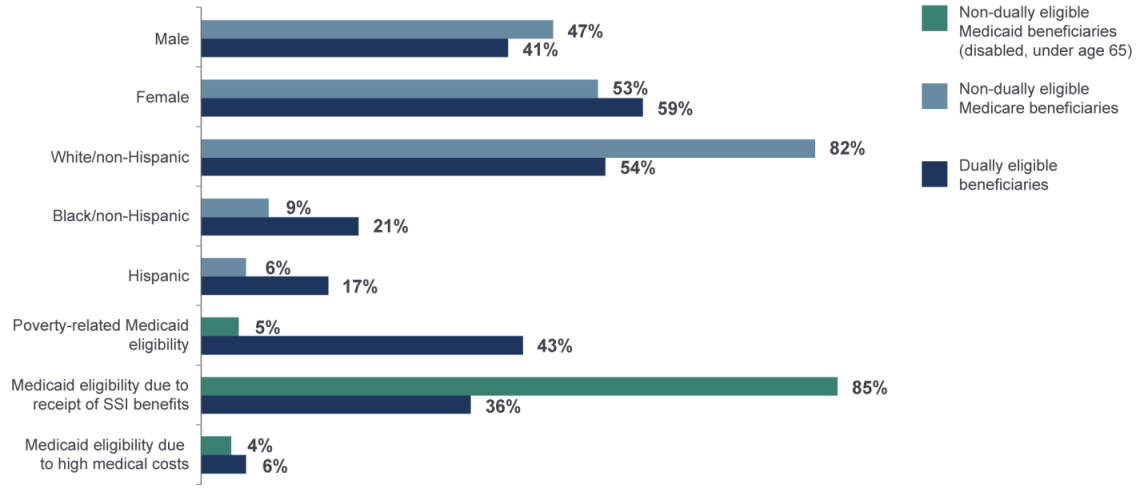
Overview:

- MACPAC analyst provided a brief overview of the 2023 edition of the duals data book that will be published in the upcoming weeks. Included in the book is information on people who were dually eligible for Medicaid and Medicare in calendar year 2020 as well as, demographics and characteristics, eligibility pathways and enrollment, utilization and spending, and use of long-term services and supports (LTSS) and spending.

Key Statistics:

- It was found that full-benefit dually eligible beneficiaries account for a disproportionate share of Medicaid spending relative to enrollment (29%).
- A majority of dually eligible beneficiaries were eligible for Medicaid because of poverty-related characteristics.

- Dually eligible beneficiaries were more likely to use institutional LTSS than Medicaid-only beneficiaries (17% compared to 4%).
- The graph below compares dually eligible and non-dually eligible beneficiaries.



Trends:

- From 2018-2020, dually eligible populations grew by 1% yearly to a total population of 12.2 million.
- Dually eligible beneficiary spending grew on average of 4.9% a year and 5.1% a year for Medicaid and Medicare respectively.
- Medicaid inpatient hospital services, institutional LTSS and prescription drug spending grew each year even though the share of dually eligible beneficiaries using those services declined.
- Dually eligible beneficiaries using state plan HCBS, HCBS waivers and managed care capitation each grew by around 1% annually.

Commissioners Comments

No comments were offered by Commissioners.

Session 7: Medicaid managed care quality oversight overview

Presenter:

- *Moira Forbes, Principal Policy Director*

Overview:

- MACPAC analyst provided a brief overview and update to the Commissioners on recent Medicaid managed care oversight and policy developments. On the federal level, analysts noted that current implementation delays and policy changes have made it difficult to assess the success of new managed care rules. MACPAC analysts have begun two separate projects that will look at the accountability of MCOs from the perspective of quality. However, the majority of data has yet to be reported by states since rules are still being implemented and there hasn't been sufficient time to gather meaningful information. The first annual program report required from MCOs will not be available until this year. These reports are required to be made public once available, and analysts noted this is something they are actively keeping an eye on, as their projects develop.

- The purpose of this brief overview was to get Commissioners up to date on where they are on acquiring Medicaid managed care quality oversight data and therefore no Commissioners provided any feedback and/or questions.

Session 8: Examining the role of external quality review in managed care oversight

Presenter:

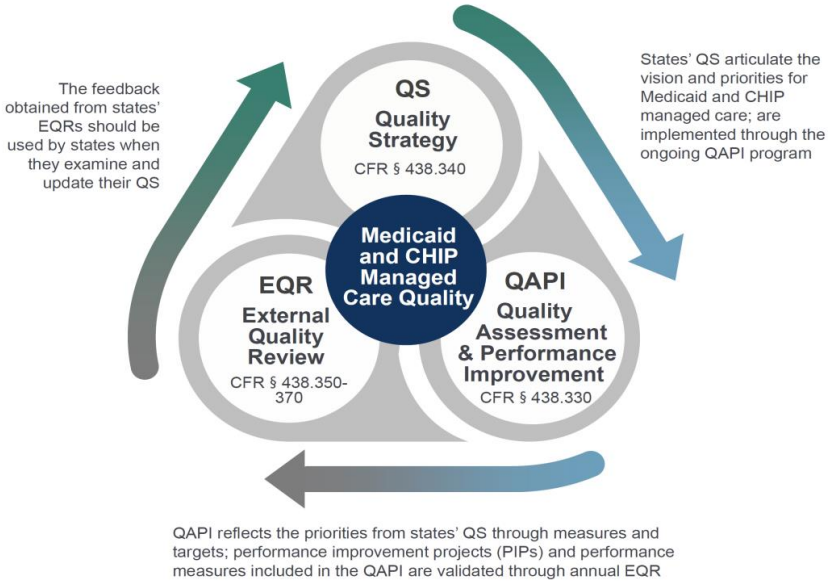
- *Sean Dunbar, Principal Analyst*

Background:

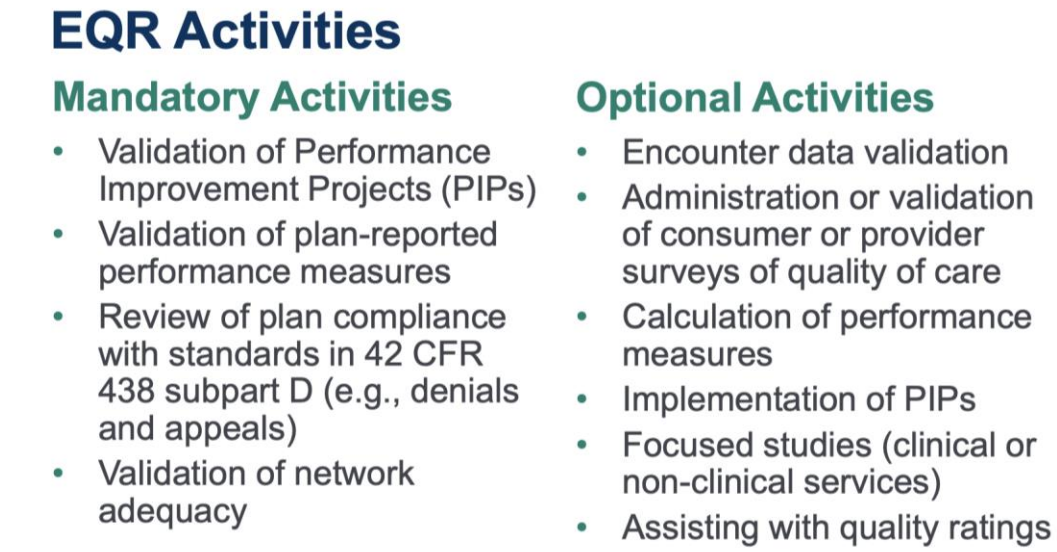
- Following continued MACPAC work on addressing oversight and accountability of managed care, a MACPAC analyst presented his findings on the role of external quality review in managed care oversights.
- Currently over 70% of Medicaid beneficiaries are enrolled in comprehensive managed care plans. The immense growth and oversight of managed care began after the passing of the Balanced Budget Act of 1997 (BBA). It was highlighted by the analyst that this act eliminated the "75/25 rule" and included state plan authority to pursue managed care. One of the requirements included was the external quality review (EQR).
- There are numerous managed care approaches that states can pursue, but it is important to note that EQR applies to all. States can carve out certain benefits to fee for service (FFS) or limited benefit plans. Limited benefit plans can serve both FFS or MCO beneficiaries.

External Quality Review:

- The chart below depicts how EQR relates to other quality oversights in managed care.



- Improved quality provided by plans serve as a road map for states and plans to assess the quality of care received.
- The 2016 managed care rule provided one of the biggest changes; significantly strengthening EQR by expanding EQR to PAHPs and certain PCCM arrangements, and clarified the ability of enhanced federal match.
- Mandatory EQR activities apply to all types of managed care plans; however, states are given flexibility in requiring EQR activities by choosing one or more optional activities. Shown below are the mandatory and optional activities under EQR.



- States are required to contract with at least one external quality review organization (EQRO) but must use multiple EQROs if using them for more than one activity. An EQRO must be able to provide policy expertise, technical and financial resources, and meet conflict of interest standards. It was highlighted in MACPAC's research that EQR is conducted by only a few EQROs –three EQROs serve 31 states.
- States are able to receive enhanced FMAP for specific EQR-related activities, but must submit EQRO contracts for CMS approval before receiving the 50% enhanced match. It was noted that federal rules and regulations do not specifically outline the criteria invoiced in the review and approval of EQRO contracts.
- States are required to release their annual reports, also known as annual technical reports (ATR), by April 30th of each year detailing their EQR findings. Following submission, CMS publishes an aggregate national summary. MACPAC's analysts found a large variation in availability of publicly posted ATRs, organization of required information, and inconsistency in protocols across state ATRs.

Themes:

- MACPAC's research is still underway and they are in the midst of interviewing key stakeholders and conducting deep dives into five state programs. However, some emerging themes are already starting to develop:
    - States voiced value in the EQR process and their contracts with EQROs; they rely heavily on EQROs for technical support and expertise, and some states use EQROs strategically while others use them to ensure they are complying with federal rules and protocols.
    - There are opportunities for states to improve the transparency of ATRs as not all states publicly post ATRs, even though they are federally required. The difficulty in obtaining ATRs limits the ability for stakeholders to monitor health plans' performance.
    - Consumer groups voiced concerns that EQRs findings are overly process focused and do not meaningfully evaluate performance over time.
    - CMS currently has limited oversight over the rules under federal regulations, and not a lot of information is publicly provided on how CMS reviews EQRs and if they provide input to states.

- There is not a strong correlation between EQR standards and other quality and managed care oversight rules and it is not always clear how states use their EQR findings to inform quality strategy.

Commissioners' Comments

Commissioners asked MACPAC analysts to provide more detail on how ATRs should be structured and what should be included in these reports and the analysts agreed this was a good idea. From a content perspective the ATRs are extremely dense, with methodology summaries. A few Commissioners voiced the difficulty states would have trying to make the reports multipurpose and expressed uncertainty about the intended audience. Whether it's the health plans or the general public, there won't ever be a format that will suit everyone's needs. There was a general agreement on looking more closely at whether states conduct the reports solely because they are required or to provide guidance and as a reference tool to improve quality.

Session 9: Denials and appeals in Medicaid managed care

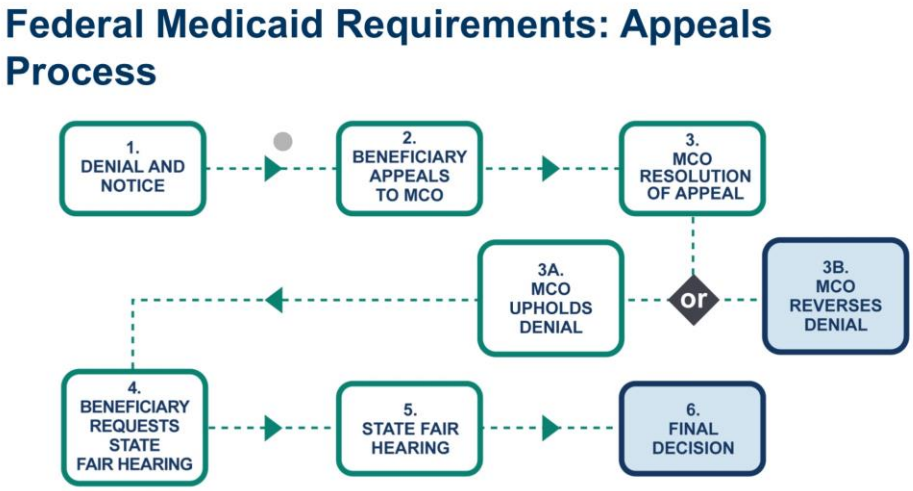
Presenters:

- *Amy Zettle, Principal Analyst*
- *Lesley Baseman, Analyst*

Background

- MACPAC has identified denials and appeals of care in managed care as an area for exploration. In April, staff will present state and stakeholder interview results. In September, staff will present the results of a beneficiary focus group. Commissioners are hoping to better understand the extent to which Medicaid beneficiaries are experiencing denials and filing appeals, how these denials and appeals are monitored, and whether beneficiaries find the appeals process to be accessible. This work will inform potential recommendations, to be issued later in the year. At the January meeting, staff presented a literature review and an overview of current available data on managed care denials and appeals.
- Denials (known formally as adverse benefit determinations) are when an MCO denies authorization of a requested service, reduces/suspends/terminates the authorized service, or denies payment for services already received. An appeal is a review of an adverse benefit determination.
- There is little data on the extent to which MCOs deny care. However, research suggests MCOs deny care at higher rates than Medicare Advantage (MA) plans. Appeals are exceedingly rare across MA, Medicaid and exchange plans.
- Under the 2016 managed care rules, a beneficiary must exhaust appeals with the plan before receiving a hearing from the state. As a result, the beneficiary's first step is to appeal the denial with the plan itself. MCOs must resolve appeals within 30 days, and

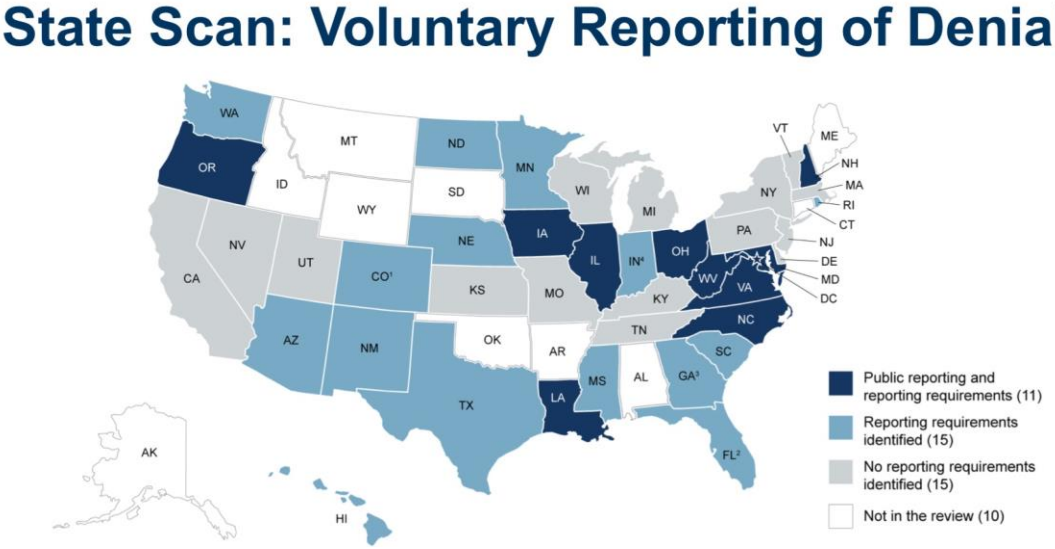
states can require even quicker turnaround.



- The federal government does not require monitoring of denial rates, appeal outcomes, or denial audits.

Available Data

- Eleven states report information publicly on denials and appeal metrics. However, the extent of this data reporting is inconsistent. Nine of these 11 states report on appeal outcomes.
    - MCO denials overturned in favor of the beneficiary ranged from 19% (Iowa) to 74% (Ohio)
- Over half of states require MCOs to report some information to the state on denials. 11 states require MCOs to report the reason for the denial, while 14 require reporting of denial by service type.



- All states are required to contract with an external quality review organization (EQRO) to monitor their programs for compliance with federal requirements. MACPAC staff did an overview of EQRO results and found that more than half of reviewed states had at least one plan out of compliance with regulations on appeals or authorization of covered services.

- However, EQRO studies are not uniform and methodology can differ by state, making these an unreliable data source. Examples of noncompliance include not meeting authorization timelines and hiring reviewers without the appropriate expertise.
- This overall lack of data presents challenges in understanding the extent of managed care denials and appeals.

Commissioners' Comments

Commissioners were keen to not draw general conclusions, constantly noting the lack of data and context for many of the figures presented. Of particular interest was the disparity between states in successful appeals. Questions included: Why Ohio beneficiaries were so much more successful in overturning their coverage decisions than Iowa beneficiaries?; and How do varying state procedures for handling appeals (once MCO review is exhausted) result in the differing results? Commissioners requested an analysis of denial trends, and an understanding of commonalities between denial reversals. Commissioners in general, however, expressed deep concern that beneficiaries may not know their rights to an appeal and that MCOs may be denying medically necessary care. Of particular interest to Commissioners was data on the differences in denials between large, for-profit MCOs and small community plans. Commissioners also suggested that the use of retroactive clawbacks for services rendered and the bureaucracy associated with utilization management in Medicaid may make providers less likely to participate in the program. One Commissioner suggested that a best practice may be for states to require MCOs to report directly to them on the outcomes of denials and appeals for easier monitoring. Commissioners also wondered about the breakdown of administrative denials (denials because of improper paperwork etc.) versus medically necessary denials. MACPAC staff will take these comments into account when examining this topic and conducting stakeholder interviews.

Session 10: Discussion of potential responses to HHS rulemaking

Presenters:

- *Linn Jennings, Analyst*
- *Kirstin Blom, Policy Director*
- *Aaron Pervin, Senior Analyst*

Background and Areas for Comment

- HHS is proposing numerous rules related to MACPAC's previous work. Staff presented the rules for potential comment by Commissioners. These rules are:
    - The 2024 notice of benefit and payment parameters for health insurance exchanges, which includes provisions related to transitions between Medicaid, the State Children's Health Insurance Program (CHIP), and exchange coverage.
    - A CMS notice of proposed rulemaking, published December 14, 2022, that would make technical changes to the Medicare Advantage and Medicare Part D programs for contract year 2024, including dual-eligible special needs plans (SNPs)
    - An HHS notice of proposed rulemaking, published December 2, 2022, that would make changes to substance use disorder (SUD) patient privacy protections under 42 CFR Part 2 (Part 2), which implements provisions of the Coronavirus Aid, Relief, and Economic Security Act (CARES) and further aligns Part 2 with the privacy protections under the Health Insurance Portability and Accountability Act (HIPAA).

- **2024 notice of benefit and payment parameters rule:** While MACPAC does not usually comment on exchange rules, the rule includes provisions related to Medicaid/CHIP coverage transitions. MACPAC has previously highlighted the difficulty beneficiaries face when transitioning to exchange coverage. The rule offers exchanges the option to move the effective date of coverage for individuals transitioning to the first day of the month that Medicaid/CHIP coverage is terminated. However, this would only apply to individuals who notify the exchange of the terminated coverage during the month prior to the end of Medicaid/CHIP coverage. Current policy starts exchange coverage the month following the loss of Medicaid and CHIP coverage, which results in gaps of coverage. This rule also allows exchanges to extend the special enrollment period (SEP) from 60 to 90 days for individuals who lose Medicaid and CHIP coverage. This would help beneficiaries have time to submit a renewal form to Medicaid or CHIP (if they were improperly or procedurally disenrolled, for instance) before needing to apply for exchange coverage. Finally, the rule implements MACPAC recommendations (included in the 2022 Omnibus Appropriations Act) for increased reporting requirements on transfers between Medicaid/CHIP and the exchange.
- **Proposed Medicare Advantage Rule Changes:** CMS has proposed a rule that would make changes to MA and Medicare Part D, involving dual eligibles. The rule would require MA plans to provide materials to enrollees upon request in any “non-English language that is the primary language spoken by at least 5 percent of individuals in a service area.” It would also tighten marketing rules for MA and Medicare Part D programs in order to protect beneficiaries from misleading marketing. Additionally, the rule expands eligibility for the Medicare Part D Low-Income Subsidy program (which has an automatic eligibility link with Medicare Savings Programs, something that MACPAC has supported). The rule makes permanent the limited-income newly eligible transition (LINET) program, which provides transitional point of sale Part D coverage for some beneficiaries. It covers potential drug coverage gaps that may occur when a Medicaid beneficiary becomes eligible for Medicare and transitions into a Medicare Part D plan from Medicaid. Finally, the rule closes loopholes on D-SNP “look-alike” plans, which are plans designed to look like D-SNP plans to beneficiaries but without many of the benefits that actual D-SNPs have.

- **SUD Patient Privacy Protections:** In an effort to encourage individuals with substance use disorders to seek treatment, the Substance Abuse and Mental Health Services Administration (SAMHSA) has proposed regulations implementing new requirements included in the CARES Act of 2020. Currently, 42 CFR Part 2 governs the disclosure of SUD records. Part 2 requirements are stricter than HIPAA. Part 2 records must be segregated from other health information, and apply to federally assisted entities that offer SUD treatment. They prohibit law enforcement access to SUD information absent a court order and require written patient consent to disclose records. MACPAC previously expressed concern that Part 2 can limit care coordination for those with SUD. MACPAC recommended HHS clarify Part 2 and supported proposed changes that allowed records to be shared with a larger group of entities, including those without a treating relationship. Finally, in 2022, MACPAC recommended that HHS develop a voluntary IT certification for Part 2 information. The Commission has long been concerned about misalignment between Part 2 and HIPAA contributing to confusion around SUD record sharing. The CARES Act seeks to align Part 2 and HIPAA while adding new protections. It allows patients to provide a single written consent to all future uses of Part 2 records by treating providers and plans. However, when sharing with intermediaries (e.g., health information exchanges) the patient must specifically identify that entity for disclosure and cannot include it in the blanket authorization. Patients are also given the right to request restrictions on the use of their Part 2 records in accordance with HIPPA and to request an accounting of record disclosures. The rule implements these CARES Act provisions and applies HIPAA breach notification rules to Part 2, and implements a complaint process (and non-retaliation clause) similar to HIPAA's.

Commissioners' Comments

Regarding the notice of benefit and payment parameters rule, Commissioners expressed support for affirming the importance of smooth coverage transitions between Medicaid/CHIP and the exchange. They also expressed the need to acknowledge the importance of data transparency and evaluation during the PHE unwinding. Many Commissioners said they would like to see the SEP extended to everyone losing Medicaid coverage during the unwinding. On the MA rule changes, MACPAC Commissioners expressed support for the crackdown on look-alike D-SNPs and increased access to prescription drugs by beneficiaries during coverage transitions, two themes of prior MACPAC work. Commissioners expressed interest in a comment supporting CMS's effort. Regarding the SAMHSA rule, Commissioners were interested in mentioning the importance of stronger nondiscrimination rules for those seeking SUD treatment. They also wanted to reiterate interest in a voluntary IT certification for behavioral health and integrated care settings. Finally, the rule's imposition of a tougher privacy standard on intermediaries alarmed the Commissioners, who may seek further information and clarification in a comment. Comments are largely due before the next MACPAC meeting, so staff and Commissioners will circulate draft language internally and submit the comments over the next few weeks.

Session 11: State update on unwinding the public health emergency (PHE)

Introduction:

- *Martha Heberlein, Principal Analyst and Research Advisor*

Panelists:

- *Chris Underwood, Chief Administrative Officer, Department of Health Care Policy and Financing*
- *Traylor Rains, State Medicaid Director, Oklahoma Health Care Authority*

- *Sandie Ruybalid, Deputy Administrator, Nevada Department of Health and Human Services, Division of Health Care Financing and Policy*

Background:

- Under the Families First Coronavirus Response Act, states received a 6.2% rate increase in federal Medicaid match if they did not disenroll individuals during the PHE. However, the Consolidated Appropriations Act of 2023, delinked the continuous coverage requirement from the PHE, which ends the continuous coverage requirement starting March 31, 2023.
- Both state and federal Medicaid officials have been preparing for the unwinding of continuous coverage for some time. As it stands, states are unable to disenroll anyone until April 1, 2023.
- MACPAC's analyst presented a panel with experts to provide an update on how states are approaching the unwinding of the Public Health Emergency (PHE) and the challenges they anticipate.
- Each panelist provided a brief update on their approach followed by a Q&A by commissioners, with participating panelists having time to answer each question.

State Perspective:

Chris Underwood, Colorado: Colorado is an Option B state and therefore will issue renewal in March and any disenrollments will begin on June 1st. A little over 700,000 people out of a total Medicaid population of 1.7 million remain subject to the continuous coverage provision. We estimate that about 315,000 of these individuals will be ineligible once the PHE ends. Currently, nearly ⅓ of the larger group have failed to provide verification since March, 2020 and another ⅓ are estimated to be over income and will be deemed ineligible for coverage. Prior to the Consolidated Act being passed, Colorado had been planning for the end of the PHE so we had lined up our systems to get them ready to go. Colorado is working vigorously with its county partners and we requested and got approval for additional funding to help them ramp up their staffing. Colorado's counties are still struggling to hire new staff given wage inflation and this remains a challenge. We have also done more performance management with the counties and have increased our ex parte renewal rates by utilizing additional data sources. The counties are also working vigorously to streamline everything so the redetermination process can happen entirely online. We also implemented a separate return mail center so that eligibility staff don't have to waste time opening returned mail and it instead goes to a center solely focused on dealing with return mail and conducting follow-up outreach.

Traylor Rains, Oklahoma: Oklahoma has a real time eligibility system through its online enrollment platform. The state has two separate redetermination tracks, a 9-month unenrollment approach for Modified Adjusted Gross Income(MAGI) individuals and a 12-month unenrollment process for Unmodified Adjusted Gross Income (UNMAGI) individuals. Oklahoma currently has a little over 1.3 million Medicaid members and an estimated 300,000 individuals who will be deemed ineligible come April. With its online platform, the state has been encouraging Medicaid members to update their contact information during the last two years. The state has also implemented a robust communication drive, relying heavily on providers and stakeholders to help get the word out and update information. This communication strategy includes a large media push with ads included in local papers reminding individuals to update their information. We are also communicating with providers and keeping legislators informed of the process. Oklahoma is placing its renewal individuals into buckets of priority to help eliminate the possibility of disenrollment in the middle of treatment, therefore the last group up for redeterminations will be the high chronic needs individuals who are in the middle of care or require high-cost drugs. We expect the volume of appeals to be almost triple come redeterminations, so we are working intensely on trying to be prepared for this higher volume.

We are also ensuring we have enough call center staff and managers who are properly trained to handle paperwork before hearings. We're also using our health information exchange (HIE) to update Medicaid enrollees contact information.

Sandie Ruybalid, Nevada: Operating very similarly to what the other states have mentioned. However, in Nevada, we operate a state-based eligibility system, not a county-based system like Colorado. We have been implementing our communications strategy for some time now by informing individuals of the state's unwinding plans on our website. Nevada chose Option C for its renewal process, which means redeterminations being in April with a rollout of a 12-14 month runway. The state's goal is to keep as many people insured as possible and currently there are a little over 900,000 individuals on the Medicaid program. Their hope is to help those individuals no longer eligible for the Medicaid program find another form of coverage to ensure continuity of care . One concerning data point is that of the population we estimate is over income now, 86 percent have accessed benefits, highlighting the need to maintain coverage for these individuals after redeterminations. Like Colorado, we've been checking on eligibility every six months, but still keeping everyone on, giving us a better idea of eligibility overall. Nevada is also experiencing staffing shortages, with many new staff people quitting soon after the training period, which is a large concern. In Nevada, the process for updating addresses is not as easy as one who'd think. Individuals have to call, come in person, or login to their website. The State therefore decided to launch a special website to help streamline the access, allowing Medicaid beneficiaries to fill out and submit a web form at the site . The recent FCC ruling around texting is vital as they are now able to better communicate with their members via text messages. Since Nevada is an MCO state (75% of enrollees are in MCOs), they have relied heavily on their MCO partners to help with communication strategies, including a four question survey being sent to members to help encourage them to engage. They have also worked with a sister agency that handles eligibility to better coordinate and improve ex parte renewals, which has been successful.

Q1: Could you please explain your plan for follow-ups if an individual doesn't respond to the initial renewal request?

- Chris Underwood, Colorado: We have a large communication strategy in place, which includes toolkits for MCO plans and stakeholders. Started outreach pretty early on with "update your address" campaigns. Once a renewal package goes out, the state and their MCO partners send several notices to members following up on them. Outreach begins two weeks after the packets go out and includes all sorts of communication outreach. We're providing them with weekly data and two weeks prior to termination, we are asking the MCOs to call each affected member.
- Traylor Rains, Oklahoma: Very similar to the outreach campaign that Colorado is doing. They have communications outreach starting 60, 45 and 10 days in advance of an individual's unenrollment date.The state is already conducting several email and text campaigns, and the recent FCC ruling is only going to make things easier for us.
- Sandie Ruybalid, Nevada: Nevada Unfortunately does not have resources similar to Colorado and Oklahoma. However, we have been able to work with our MCOs to provide them with updated lists of individuals for MCOs to reach out to and are sending the MCOs 834 disenrollment transaction codes.

Q2: Can you speak more about your how your workforce is affecting the redetermination process, including the lack of experience of those being hired and competition for workers generally?

- Chris Underwood, Colorado: This is an issue that we are working every day to address. We are seeing a lot of county workers hired with no prior experience and are finding errors in their work, including not entering verifications. We are trying hard to get county

partners prepared before the unwinding begins by doing a lot of training sessions. We also need more workers at the state level to handle appeals, but it's not easy to hire individuals for temporary roles that will end in a year.

- Traylor Rains, Oklahoma: Oklahoma is unique here in the sense that our eligibility system's rules engine can process the entire application and give us a decision, and our call center representatives can be more focused on gathering information needed for the appeals process and handling the calls that come in. We have been successful thus far in hiring managers to handle the appeals work through partnering with other state agencies. Oklahoma is currently in the process of transitioning over to managed care and will be making those awards in the next few months, so we already have an eye on what happens when those managed care plans start taking call center representatives from our enrollment broker to work for them.
- Sandie Ruybalid, Nevada: Similar challenges, but unique in the sense that they began increasing ex-parte renewals back in December, which freed up some staff time. They are hoping that their work levels will continue to level out and that increased automation will help mitigate their 50% vacancy rate for caseworkers.

Q3: With the recent FCC language cautioning use of phone/text communication unless already agreed, how much of an operational hassle is that?

- Chris Underwood, Colorado: They interpreted that as very positive, from the State's perspective. The State is not a person in their definition so all they need is a phone number on their application to have consent to conduct outreach.
- Sandie Ruybalid, Nevada: The ruling was extremely helpful, prior to that there was a lot of confusion around how and when they were able to conduct outreach. The State only has to manage outreach if an individual selects that they do not wish to be contacted, therefore a huge relief has been lifted on the administrative side.
- Traylor Rains, Oklahoma: Agrees with the points made by the fellow panelists.

Q4: Once redeterminations kick in, when will you know if you need to hit pause, and given MACPAC's engagement, what are reasonable expectations for how and when this might happen?

- Traylor Rains, Oklahoma: One issue is that we are concerned that when we send termination files to the Marketplace we may not get a response. Therefore we send people over and are not informed on if they were able to receive other coverage.
- Chris Underwood, Colorado: As a state based Marketplace, they are seeing the same issue mentioned above in Oklahoma, and are finding that the Marketplace does not want to share that information. They currently have planned to track those files through the all-payers claims database to try and see where people have landed. We also have monitoring dashboards for counties that are populated pretty regularly–if not in real time. It roughly takes a week for data to be updated.
- Sandie Ruybalid, Nevada:
- We're also a state-based exchange and we don't have the data metrics in place yet to get that information, but are working towards it .We also have dashboards but there's a real lag in data of at least a month or so. We also have business process monitoring going on in the background, so we can see if the phone queue or applications are backing up, but we won't have the ability to react in real time, unfortunately.

Q5: Are you thinking about how the removal of the over-income population will affect risk pools for full-risk MCOs or ACOs?

- Taylor Rains, Oklahoma: The timing was perfect for us since we are moving to managed care. We asked our actuaries to remove the estimated 300,000 lives we estimate will leave our rolls from their calculations.

- Sandie Ruybalid, Nevada: We're not doing redeterminations by categories of individuals like Oklahoma, but rather processing individuals when due to be up, but also planning to do 1/9 of the total population each month, so we're hoping any impacts will be gradual, which our MCOs are also hoping will be the case.
- Chris Underwood, Colorado: We're actually looking at that now and meeting with our rate setters. Our fiscal year starts July1. Since we've been continuing to process renewals and collect data, we have some idea of who may be leaving and how that will affect rates.

Q6: In a state like Nevada, with a large population of people over income but using care, are you working with providers on how that could impact delivery systems?

- Sandie Ruybalid, Nevada: This is a topic that they are constantly working to address. They are working tirelessly to try and find the data, for example of those over income but have employer sponsored plans. We have found in several instances individuals who were not even aware that they were still on Medicaid. This is an issue that is still ongoing for them and that they are trying to address.
- Traylor Rains, Oklahoma: We are working with partners over at the Health Alliance for Uninsured (free and charitable clinics). We were shocked to see a large number of people in Medicaid way over the FPL and ready to move to the Marketplace. We're working closely with our federally qualified health centers and other safety net providers.
- Chris Underwood, Colorado: Expressed similar findings as Oklahoma. We were able to track that about 18% of individuals well over the FPL had found coverage elsewhere. We are working with providers to encourage individuals leaving Medicaid to use such coverage to maintain continuity of care.

Q7: For the Managed Care states, do you have financial incentives or disincentives for health plans compliance?

- Sandie Ruybalid, Nevada: Our managed care plans are motivated to keep members enrolled, and they are aware that the only way to do that is through constant communication. Our partnership with MCOs has been extremely helpful and they have relied heavily on them during this process.
- Chris Underwood, Colorado: Colorado MCOs have been helpful in providing counties with communication plans, toolkit memos and demos on how to use the data, templates, etc. Colorado has weekly meetings with their managed care entities on their various outreach programs.

Commissioners' Comments

The Commission thanked the panelists and applauded them for their work. A large number of Commissioners requested MACPAC analysts conduct more interviews with other states, preferably states that are not as confident in their rollout plan, to gather more feedback so that MACPAC is able to look more broadly at what other states may be doing or struggling with. MACPAC analysts did inform the Commission that not all states are being as transparent, but they will gather this information, conduct more interviews with people on the ground (i.e., stakeholders, frontline organizations) and prepare to bring it back for a broader discussion with the Commission.