

PUBLIC MEETING

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Thursday, October 29, 2026
10:32 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:32 a.m.]

CHAIR VERLON JOHNSON: Good morning, everyone, and welcome to MACPAC's October meeting. We are in fall, and so it's a great time for us to talk about all things Medicaid and CHIP for sure.

We do have a full agenda, the next couple of days. We have some new topics and some continuous discussions. We're going to take a deeper look at a number of different issues we've talked about before, and so I am anxious to get started and hear from my fellow Commissioners. I know it's going to be a very, very great conversation as we go.

I'm going to turn it over to Bob, our Vice Chair, though, to actually facilitate this morning's session. So, Bob?

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman, and good morning. This is, to me, an incredible topic and I think will be very interesting as we undertake understanding what drives expenses in hospitals in relation to how we look at hospital payments. So thank you for this work.

I just wanted to start off acknowledging this morning, I was reading Beckers and where they said 693 hospitals are at risk of closure in this next year, and that's prior to the implementation of H.R. 1. Last week, 43 percent of the hospitals were stating a losing margin.

So, as I stated, I think this work is going to be critical in understanding how payments should be set, what they should look like, and understanding what is driving that expense.

So, with that, I'll turn it over to Chris and Patrick to share what they found in the literature. And, Commissioners, they're looking for our insight and input after the presentation as to how we move forward.

Thank you.

HOSPITAL COST DRIVERS: LITERATURE REVIEW FINDINGS

* CHRIS THOMPSON: Good morning. Today, we will be presenting on work to look at the drivers of hospital costs and how these cost factors may be reflected in states' hospital payment methods and rates. This session will summarize findings from a literature review on the drivers of hospital costs and spending.

We will begin with an overview of the project and

background on hospital payment. We will then discuss the drivers of hospital costs and spending that have been identified so far. Finally, we will conclude with a discussion regarding next steps, and that's laid out in our slide here.

We are focusing on hospital spending because hospital services account for a significant portion of Medicaid spending, which, in turn, reflects the cost hospitals incur when providing services.

In addition to the literature review that will be discussed this morning, this project will include an update of MACPAC's inpatient and outpatient hospital payment compendia and stakeholder interviews. This work will support MACPAC's broader examination of hospital payment policy and helps provide context to MACPAC's ongoing work regarding the hospital payment index that we presented last month. This work will culminate in a descriptive chapter to be published in the 2027 report to Congress.

This next section provides context on Medicaid hospital payment policy.

Because hospital spending represents a substantial share of overall Medicaid program health care

expenditures, it is important to understand the factors that drive hospitals' costs and ultimately result in payment. Understanding payment methodologies is also important because the impact from cost drivers affect hospitals differently depending on how they are paid.

States must cover and pay for Medicaid hospital services rendered, and states have great flexibility when designing hospital payment systems.

Medicaid statute requires that provider payments be economic, efficient, and sufficient to ensure quality and access of care. While many capitated rates have a basis that considers the fee-for-service rate for the services rendered, managed care payment arrangements are largely negotiated between the plan and individual providers and are established separately from fee-for-service methodologies.

As a reminder, MACPAC uses the statutory requirements as a framework for evaluating payment policy. Payment policies can affect the economy or amount of payment, such as a ceiling for overall payment, via the upper payment limits, or they can act as a floor for payment concerning appropriate access to care.

Effective payment policy seeks to balance economic considerations with incentives for efficiency and desired outcomes. Cost drivers matter because they influence the resources hospitals need to render quality care and ensure Medicaid beneficiaries have adequate access to that care.

States have flexibility to use different methodologies for payment of inpatient and outpatient hospital services. Over time, there has been an effort to move away from cost-based methodologies. Inpatient hospital services are most commonly paid via prospective payments that pay a fixed amount for services requiring a similar amount or intensity of resources. These services are typically assigned into a diagnosis-related group, or DRG, that reflects how the resource intensity of that particular group relate to expected costs to provide the services. Because hospitals would be paid a fixed amount regardless of their actual cost, DRG payment can encourage hospitals to be cost-effective in the provision of services.

There are different DRG software products. The Medicare Severity DRG System, or MS-DRG, has been developed

for Medicare, and most states use a system called the All Patient Refined DRG, or APR-DRG.

Some states may pay on a per diem basis, which pays a set amount per day. Per diem payments are relatively simple from an administrative perspective and provides some level of case-mix adjustment as measured by the length of stay in the facility. However, per diem payments do not create an incentive to avoid unnecessary days during hospitalization.

Although most base payment methodologies do not pay cost, states still pay some hospitals based on their individual cost. Cost-based reimbursement can help improve operating margins and financial stability, which is why this payment method is more commonly used for critical access of government-owned hospitals. However, it does not create incentives for providers to constrain their cost.

States also pay outpatient hospital services using different methodologies. States may use prospective payment systems to bundle services into groups based on clinical and cost similarity.

The two most common systems are ambulatory patient classifications, which are used by Medicare, and

enhanced ambulatory patient groups, which are more commonly used by states and commercial payers. Like inpatient DRGs, these groups are paid a fixed rate and can encourage hospitals to be cost-efficient.

States may also pay for outpatient services based on a fee schedule, which is a fixed payment for each service delivered. Similar to the inpatient side, states may still pay some providers on a cost basis, and again, it is more commonly used for critical access hospitals or state-owned providers.

While states are not required to update rates to reflect cost, many states periodically update their base rates in consideration of the underlying cost of delivering care.

Base rates are often modified through payment adjustments to account for specific hospital characteristics or specific circumstances. For instance, states may pay rural or safety-net hospitals differently from urban hospitals through adjustments to base rates.

In some instances, states have implemented hospital value-based payment initiatives through adjustments to their base rates. These adjustments often

resulted in higher per-service payment when certain quality metrics were met.

States may also make supplemental payments that can significantly affect overall Medicaid hospital payment. Key supplemental payment categories include DSH, or disproportionate share hospital payments, which are made to reimburse a hospital for its uncompensated care cost.

Non-DSH supplemental payments, which are generally lump-sum hospital inpatient and outpatient -- I'm sorry -- non-DSH supplemental payments, which are generally lump-sum payments made in addition to base payments and are subject to the inpatient and outpatient hospital upper payment limits. These upper payment limits are a reasonable estimate of the amount that would have been paid for the inpatient or outpatient services under Medicare payment principles.

Key supplemental payments also include state-directed payments, which are additional payments made by managed care plans under the direction of a state. These payments are subject to the new Medicare-based limits proposed via CMS-2449-P.

And, finally, there are graduate medical

education, or GME payments, which have been historically paid to state teaching hospitals and have been historically limited by the UPL, or the upper payment limit.

These payments may address objectives that are not fully captured by base payment rates alone. Supplemental payments can account for a substantial share of Medicaid hospital funding and may help offset costs associated with serving higher-needs patients, rendering uncompensated care in the case of DSH, the training of residents and interns in the case of GME.

Supplemental payments represent nearly half of all Medicaid payments made to hospitals. Therefore, it is important to consider supplemental payments when analyzing overall Medicaid payment.

As the analysis of cost drivers progresses, it is also very important to note that hospital costs and hospital spending are not the same. Cost represents resources consumed by hospitals to render services, while spending reflects payments made by payers; in the case of Medicaid, the state, for services rendered.

Hospital costs can be grouped into three distinct categories. First, we have fixed overhead costs, such as

depreciation or property taxes. These overhead or general and administrative costs are incurred by the hospital regardless of the number of patients served or services rendered. Then there are fixed operating costs, such as the purchasing of medical equipment or the payment of wages for salaried non-hourly personnel. These costs are incurred to deliver services to patients. However, they are not dependent upon patient utilization or acuity. Finally, there are variable operating costs, such as the purchasing of medical supplies, which are costs that are incurred to deliver services to patients and fluctuate depending on patient acuity or utilization.

Understanding the category of costs -- understanding the category a cost falls into helps to determine whether any drivers associated with that cost should be impacted by changes in utilization or acuity. This will be particularly useful as our analysis progresses.

And now I'll turn it over to Patrick to discuss what the literature review identified as major hospital costs and spending drivers.

* PATRICK JONES: Thanks, Chris.

So, in this next section of the presentation, I will summarize findings from our literature review.

Our literature review found that Medicaid hospital costs and spending growth are driven by multiple economic, health care, and business factors.

Research consistently identifies labor, supplies, facilities, and overhead as primary hospital cost drivers. Many of these cost drivers were exacerbated by the COVID-19 public health emergency. For example, staffing shortages caused some hospitals to rely on staffing firms, where increased demand for health care personnel caused a steep rise in prices. As a result, in January 2021, hospitals experienced a 30 percent increase in labor expenses per adjusted discharge when compared to the previous year. Colorado hospital data showed similar increases in labor costs.

Procedure-level analyses also identify overhead, such as supplies, facility, and administration, in addition to labor as post-public health emergency cost drivers.

Activities such as prior authorization, billing, and collection also impose costs on hospitals.

One study found that PA for certain procedures

took more time for Medicaid and commercial insurance than traditional Medicare or other government payers, which may increase administrative costs for hospitals serving these populations.

The volume, intensity, and location of service delivery drive both Medicaid hospital spending and costs. Readmissions drive both hospital costs and spending because they result in additional, often more intensive care after hospitalization, and hospitals that serve Medicaid beneficiaries may be more exposed to these costs.

Multiple studies show that Medicaid beneficiaries with cardiac conditions are more likely to be readmitted after treatment and have longer lengths of stay than the general population.

The site where care is delivered can also impact spending because different sites may be paid different rates for similar treatments. For example, Medicaid payments for pediatric dental surgery delivered in ambulatory surgical centers were 27 percent lower than those delivered in hospital outpatient departments.

Furthermore, research shows that Medicaid patients often utilize more intensive care, such as

emergency departments, more often and present with higher acuity than the general population.

Some intensive care service utilization could be delivered in lower-cost settings. One Medicaid claims analysis found that 40 percent of acute care visits among Medicaid enrollees were for services that could have been delivered in ambulatory care settings.

Cost and spending drivers may have a greater effect on rural hospitals than urban hospitals. For example, one study found higher preventable hospitalization indicators, including higher chronic disease burden and fewer specialists in Appalachian counties. This suggests these hospitals are more exposed to utilization and acuity-related cost drivers.

High-cost drugs, therapies, and technologies are emerging trends in health care, but their impact on hospital costs and spending are currently unclear. Cell and gene therapies impose significant adoption and implementation costs on hospitals because they require specialized infrastructure and training and significant physician time for administration.

Furthermore, these therapies often require prior

authorization, which introduces additional administrative costs for hospitals. One study found that Medicaid plans were more likely to impose coverage restrictions on cell and gene therapies than commercial plans. It is possible that these restrictions add to administrative burden and costs. However, currently available research has not examined this relationship directly.

Research presents mixed findings on AI's impact on hospital costs. A review of several studies identified examples of AI-associated reductions in cost and spending. By contrast, a study of three health care systems' adoption of an AI scribe tool found that while use of the tool did reduce physicians' time spent on documentation, it did not result in cost savings for the health care systems overall.

Specialty drugs and therapies can impact Medicaid hospital spending. For example, research has found that specialty pharmaceuticals and biologics can dominate spending in certain Medicaid populations. However, other research has shown that specialty drugs and therapies may reduce acute care utilization, though there is limited Medicaid-specific evidence of these treatments' long-term net impacts on spending.

Some research on AI indicates the technology may increase payer spending. For example, one private payer study found that the adoption of AI tools in hospitals has coincided with an increase in the coding complexity of inpatient stays. However, this study does not establish a direct causal relationship between AI tools and spending, and existing research on this topic is limited.

Research shows that market concentration, ownership, and regulation can impact hospital prices, but their impact on underlying costs is not as clear. Studies have found that horizontal hospital mergers result in higher prices for inpatient and outpatient services, and that vertical mergers result in higher prices for labor and delivery services. These findings indicate that reduced market competition can increase prices, but they do not show a relationship between market concentration and underlying hospital costs.

Hospital ownership impacts prices, costs, access, and staffing. For example, ownership reviews find that for-profit hospitals are more likely to provide profitable services and have lower shares of Medicaid and uninsured patients. A separate study found that, following private

equity acquisition, certain hospitals had lower operational and patient care costs, lower staffing levels, and fewer Medicaid discharges. These findings indicate that there may be tradeoffs between incentives for operational efficiency and access to care.

Some federal and state policies aim to incentivize hospitals to better control costs, but research does not show strong relationships between these policies and hospital costs and spending. Price transparency rules aim to create competitive pressure between hospitals to reduce prices, but a study of the 2021 CMS Hospital Price Transparency Rule found that posted prices often did not match actual reimbursement, potentially limiting the intended effects of this policy.

Similarly, a study of state spending growth benchmarks did not find that benchmarks impacted hospital inpatient and outpatient prices except in one state.

Our upcoming policy compendium and interviews will identify how states use payment design to achieve policy goals of covering efficient costs and maintaining provider sustainability and access. Staff will return in January to present findings from the policy compendium and

a descriptive chapter. This chapter on hospital cost drivers and payment methods will help provide context to the differences in payment amounts presented in the hospital payment index analysis.

As we begin our interviews, we seek Commissioner feedback on areas of interest and potential categories of cost drivers not already addressed in our literature review.

We ask the Commissioners to provide feedback on the following questions during their discussion. One, are there specific topics, cost drivers, or payment policies staff should focus on during these stakeholder interviews? And two are there certain services or hospital provider types staff should pay particular attention to?

And with that, I will pass it back to Bob to moderate the discussion. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Patrick. I appreciate that.

All right. I look to my fellow Commissioners for input. Patti.

COMMISSIONER PATTI KILLINGSWORTH: I just have a question first. First of all, thank you for really good

information.

What percentage, roughly, of Medicaid payment to hospitals or fee-for-service versus managed care? I don't think I saw that in the information we looked at. Order of magnitude. It doesn't have to be specific.

CHRIS THOMPSON: So there was an issue brief that we issued back in 2022.

COMMISSIONER PATTI KILLINGSWORTH: Okay.

CHRIS THOMPSON: And I believe the percentage was about 48 percent fee-for-service as compared to managed care, but we can go back and confirm that.

COMMISSIONER PATTI KILLINGSWORTH: My guess is -- and this is just a guess -- that with the continued expansion of managed care, that number may have gone up.

And I guess what concerns me a little bit is that we may be -- by focusing only on fee-for-service and understanding -- sort of understanding all of the complexities of bringing managed care into the discussion, we're just leaving out such a really big part of the payments that are made.

And I wonder if we come to a place of policy recommendations, will there be applicability, if you will,

as it relates to managed care, knowing that there's a lot more flexibility with regard to how payment rates are set and all of that? It still seems to matter, especially with regard to cost, what's happening in the managed care side of things, if that makes sense.

So, in terms of, like, thoughts or recommendations, I guess I would just say, is there any way to look not just at fee-for-service but to also take managed care into account as we're looking at drivers of cost and potentially even spending?

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

Go to Anne, then Mike, then John.

COMMISSIONER ANNE KARL: Thank you so much for this work.

I think it's really helpful that you're splitting out the cost drivers from spending, because I think it's very easy to see that Medicaid hospital spending is significant and growing, and there's a set of reasons for that. But that's quite distinct from the impact on cost, the hospital's own costs.

And when Bob mentioned at the start of this session that there's a large number of hospitals that are

on the brink of closure, that's because, obviously, there's a lack of balance between the cost side and the revenue side. So it's good that we're looking at both the cost side and also the revenue side from Medicaid. So I just appreciate you lifting up the cost pieces.

I think in terms of the cost pieces, it's helpful to see all of the different factors that influence this. I think it would be helpful if there was some sense of scale, so understanding what share of significant cost growth was coming from labor versus supplies versus whatever else there might be. So I think that feels important to understand.

And then I think, again, just continuing to go through and separating what's cost growth. So labor costs going up, that's going to make it cost more to deliver services at the hospital versus what's the spending growth, which could be growth in prices, could be growth in utilization. The growth in prices could be because of consolidation, market power-type issues. There's a whole bunch of different things. But I think just continuing to be methodical about separating those pieces out will just help people understand the landscape more effectively.

So thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Anne.

Mike, then John.

COMMISSIONER MICHAEL NARDONE: Thanks a lot, Chris and Patrick.

Just maybe, I wanted to follow up on Patti's point in that I wonder if -- and maybe this is something that you could tease out in the interviews -- is that in a managed care state that has heavy reliance on managed care, I wonder if the fee-for-service payment methodology is not going to track costs as closely, because of the fact that so much of the hospital payments is being driven through the managed care organizations.

And so I think that's maybe to the point of what -- you know, one of the things you're getting at, Patti, is that, you know, the fee-for-service fee schedule, it's not as significant in a state where 98 percent of the people are in managed care. So I think it's something to acknowledge and recognize, and maybe you get more of that detail as you talk to people in terms of the -- you know, am I right in assuming that? Or, you know, maybe there's more details you could provide around that, because I'm

interested in a distinction between a managed care versus a fee-for-service state.

I'm really interested in the difference in costs between rural areas, because that's so critical to the many hospitals that are going out of business, but also in heavy urban high-Medicaid centers in urban areas. I'm interested in understanding the underlying cost differences that there may be in those, both in urban settings as well as kind of the more rural settings. And I think that would be a real -- I think making -- it sounds like you're heading in that -- it sounds like that's part of this analysis.

And I really want to say that I really support that in terms of kind of really trying to understand that a little bit better, because I think that -- and also to the point, I would also assume that the importance of certain cost drivers might be more important in urban areas versus rural areas. Like, I could imagine that -- well, I don't know. But I could imagine where some of the fixed costs might be, you know, a higher percentage in rural areas versus urban areas, and that the relative -- which makes the relative values, I think, of labor costs and some of those other components interesting to look at and to have

some good analysis around that, which I think would be important.

I did want to ask one question, because in the memo, you mentioned that you would be looking at state-directed payments, and I was just wondering, if you're looking at state-directed payments -- and this is all about fee-for-service -- how does that -- like, you won't have anything to compare that to, right? So I'm trying to understand. Maybe I'm just not understanding, but how will that be factored into the analysis?

CHRIS THOMPSON: We may have to get back to you on that one. I would imagine that we would look at state-directed payments to the extent that it might affect the overall hospital operations.

COMMISSIONER MICHAEL NARDONE: Mm-hmm.

CHRIS THOMPSON: But we probably still need to iron out some more details there.

COMMISSIONER MICHAEL NARDONE: Okay. Thanks, guys.

VICE CHAIR ROBERT DUNCAN: Thanks, Mike.

John, Heidi, then April.

COMMISSIONER JOHN McCARTHY: This is one of those

topics that, as you guys move forward, just requires a ton of nuance in the analysis, and I think it's really hard to do it at a national level. And for us to make recommendations, it's almost like down at the state level and then broken out into some of those areas that we're talking about.

And even what you've already talked about -- and just when Mike was speaking, you know, he said cost at one time, then spending and payment. And so, like, this is super important when we're talking about these things, right? Because I want to go back to when you say hospital costs, back to, in my head, having done hospital rate setting, that is, for the hospital, what it costs them to operate, right? Like, not what the Medicaid program's costs are, but what the hospital's costs are.

So your questions to us were, you know, kind of in a couple different areas. One was, when you're doing interviews about hospital costs, like what to ask and what things to look for.

Well, the National Academy of State Health Policy, they have a hospital cost tool that they've been putting out for a couple years. I would highly recommend

that you go look at the tool, download it. They've got data through 2024, a lot of interesting data in there to take a look at.

To that point, one of the things that they look at is administrative costs, and I know in here we talk about the increase in administrative costs for claims processing, things like that. True, like that's a definite issue. But there's also costs associated with a hospital system, so that this one hospital, Hospital X, belongs to a larger system, or they're sending management fees up to that system. And those have a cost to it. Those don't get captured sometimes in certain areas. And so it's, are you looking at system -- hospital system costs, or are you looking at the hospital costs?

They also send funds to foundations. So there's a lot of different issues when you're looking at that administrative side and asking different pieces.

I want to harp again on what was said around urban versus rural. Again, if you're looking at costs, what are those different costs in there? And then flipping it over on the payment side -- and now Bob talked about the Becker Report. There's 600 and some hospitals looking to

close. But if we're going to make recommendations on that, we've got to know why that they're going to close. Is it utilization that's going down?

Interestingly, in many states that haven't expanded, Medicaid isn't a big payer, right, because they just don't have the volumes in those areas. And so it's really uncompensated care that's the issue, so looking at some of those different issues and expansion versus non-expansion states of what that looks like around those areas.

And lastly, we cannot forget state-directed payments and what falls in there because they have become, in our own report, such a huge piece of Medicaid reimbursement, and where does that fit in? And then what's the role of the state to keep a hospital open? Right? And there's different ways. If a state says, "Hey, here's a hospital. We think it's really important for this hospital to stay open," they are unable at whatever point in time to stay open, how can they do that? What are the policy levers they have?

One is they could just give general fund payments to the state, right? From general fund, not use Medicaid

at all to keep that hospital open. Or they can use Medicaid to fund those things. There's a lot of different policy levers to be thinking about when we're looking at these different areas.

And sometimes -- when I was D.C. Medicaid director, it was right after D.C. General closed, and the District tried everything it could to keep that hospital open, and it just couldn't do it, right? And so it had to then look at some other things to do.

Well, the trade-off on that one was creating a program to cover anyone below 200 percent of the federal poverty level with health care insurance. And so was it -- from a policy perspective, depending on where you're at, is the hospital itself so important to keep open, or is coverage more important? Again, then that leads to access questions.

So I gave you a whole bunch to look at, but this is a super important topic and I think filled with a lot of nuance. So you guys have a lot to work on in this one. But thanks.

VICE CHAIR ROBERT DUNCAN: Thanks, John.

Heidi, April, then we have Carolyn, Adrienne,

Sonja, and Madam Chairwoman.

COMMISSIONER HEIDI ALLEN: It looks like we all want part of the action.

Thank you so much for this work. I really think it's interesting and exciting.

I don't quite know how to articulate my question. So, hopefully, it'll make sense as it comes out my mouth.

Hospitals are making decisions on the service lines that they offer. I'm not sure the relationship between those lines and community need. It seems like hospitals -- a lot of hospitals have shifted towards more high-acuity care and underinvested in care that is lower acuity and that makes less money, like maternal health or maternity. Mental health, I think, is another example.

So these decisions is they reorganize essentially their service lines and understanding its relationship to whether the community actually needed a new specialized cardiac unit or not. I think that that's kind of an important part of trying to understand the hospital financial well-being and how it's serving the community.

And then that kind of brings me to my next thing that I'm interested in, which is profit. I think they may

call it "excess revenue," but our hospital is shifting to more profitable lines of business, and that it's a decision point not to have services that are less profitable. Because I think we talk a lot about, oh no, there's not enough maternity care, there's not enough -- there's nowhere to deliver a baby in Medicaid in D.C. Well, why?

You know, if they needed a heart replacement, would there be plenty of places for them to go for that? I think that's the kind of angle that I'm looking to bring into this analysis.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Heidi.

April?

COMMISSIONER APRIL HARTMAN: One of the things that we've noticed is some decrease in utilization of some of the outpatient hospital services, and there's this rumor that goes around periodically saying that facility fees are no longer going to be paid for outpatient fees.

And so I guess I'm just wondering -- and maybe this is my own lack of knowledge -- is what role do facility fees play in outpatient, and specifically for what services? Because I know there's some things that you can

have a facility fee and others not. But with all these other places popping up that are offering these services without charging that facility fee and the price transparency stuff that has come up, it just seems that there's a lot less utilization, and I just wonder what percentage or what part of spending and costs do those facility fees play in the overall scheme of things?

VICE CHAIR ROBERT DUNCAN: Thanks, April.

Adrienne?

COMMISSIONER CAROLYN INGRAM: That's okay, Bob. You can skip over me from time to time. I'm not as focused as my fellow Commissioners.

But I do want to play off of what Commissioner Hartman was talking about a little bit there to see if there's some way we can focus on these outpatient clinics and freestanding ERs that don't really provide hospital services, but they bill like a hospital.

So I know that when I go to an outpatient clinic that's not attached to the hospital but I get something done, I get a notice from them that says, "We're going to bill your insurance for this visit, but we're also going to bill as a hospital entity, and you have to be okay with

that or you can't get the service." So, of course, I sign the form because I want the service. So I'm wondering if there's some way to look at the cost of those entities but also then the revenue generating, and is it this issue that I think Commissioner Hartman and also that Heidi were getting to is that they've turned to more lucrative practices, billing those as those freestanding entities as hospital clinics and what the costs are in associations with that? Does that make sense? Okay.

VICE CHAIR ROBERT DUNCAN: Thank you.

Now, Adrienne.

COMMISSIONER ADRIENNE McFADDEN: I also have a bit of an outpatient theme in my questions, but first, thank you all. Thank you, gentlemen, for the work.

I think my lens is really more thinking about this as around an ecosystem of care, and so what was particularly striking to me was the observations around the utilization of higher acuity levels of care in certain -- you know, maybe it was rural settings. Maybe it was for higher Medicaid beneficiary utilization with those hospitals.

But I'm really interested in not just the urban-

rural interaction, but the interaction with health professional shortage areas, particularly looking at the primary care infrastructure. I would assume that if there is not a robust primary care infrastructure in that catchment area of the hospital, there may be more propensity to use higher levels of care because there's nowhere else to go. And so I would just love to get a little bit more data informed around that to see what that interaction is, would also love to see if the stakeholder interviews reveal any of that interaction.

And then lastly, I'm really interested in the urban-rural interaction as well, but not so much on the critical access side, but more in the small rural hospitals.

So when I was a rural health officer in Virginia many years ago, the margins for those small rural hospitals, not the critical access hospitals, were really just under 1 percent. And so they're really struggling, and so I'd love to see more information around those.

VICE CHAIR ROBERT DUNCAN: Thanks, Adrienne.

Sonja.

COMMISSIONER SONJA BJORK: Well, this is a lot

for our MACPAC staff to follow up on.

I wanted to add perhaps a look at how state regulations can impact especially rural hospitals. So the example that I'd share is that there can be some state regulations regarding staffing requirements at hospitals that are really hard for rural hospitals to handle.

An example is for a labor and delivery unit to be open, there has to be certain staff like the anesthesiologist, et cetera, available 24 hours a day, but that rural hospital might only do a couple of deliveries in a whole month. So that's a really big, difficult cost.

So, in California, we were able to get legislation passed that loosened that regulation for the rural hospitals, and that was in the hopes that we could keep some of these L&D units open, because as Heidi pointed out, maternity care is one of the ones that gets closed often in certain hospitals. And there's a lot of reasons for it, you know, low volume, but having to keep the infrastructure going at such a high expense, it just doesn't make sense a lot of times.

So each state is in a different regulatory environment with that regard, and I'm just wondering how

that impacts, you know, this look that we're doing.

The second thing is that California, for example, does have a distressed hospital grant and loan program. It's through HCAI, which is the Health Costs and Access, you know, committee or commission in California. And I'm just wondering, that's like a last-ditch effort to save a hospital that's really struggling. They can apply for funds to get them through. And I'm just wondering, do those help? Does the hospital then remain open, or is it really just a Band-Aid and keeps them going for another set amount of time, and they eventually aren't able to make it?

So I'm just wondering about the effectiveness of those kind of programs, because as was just pointed out, a 1 percent margin, oh, it's so fragile. And so would a program like that really help and keep something open, or is it just, you know, like I said, a Band-Aid, and there's an eventual closure anyway?

So I think this body of work is going to be so interesting because the change in hospital-directed payments is going to have a very, very big impact on the hospitals, and we've got to keep an eye on it, on what happens as the different dates pass for coming into

compliance with the new rules. We've got to keep an eye on what actually happens to rural hospitals in those scenarios.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Sonja.

Madam Chairwoman?

CHAIR VERLON JOHNSON: Yeah. This is a very, very interesting conversation. I appreciate all the remarks from my fellow Commissioners.

I guess for me, I'm looking at the ownership side and the market concentration. I'm just wondering, and I think you made a comment about it briefly. But how should we actually interpret the findings that private equity acquisitions are sourced with lower operating costs? Right? But they also have less staffing and fewer Medicaid discharges. And just kind of really thinking about what would help us distinguish the efficiency, real efficiency, from change in service or access from Medicaid patients, for sure.

And then we've heard over and over about the different areas, right, like in terms of rural safety net. Like, are there differences in that regard too, as well,

would be helpful.

We hear about private equity in so many parts of health care and just like to go a little bit deeper in understanding about that here as well.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman.

Patrick, Chris, you've heard a lot of interest from our team members, and I hope this has highlighted about the impact on hospitals right now, and particularly Commissioner Sonja speaking about directed payments and those things change.

So, first of all, I want to self-disclose that I happen to work for a children's hospital and acknowledge that in my comments.

But to be brief on my responses is, when you ask about cost drivers, one thing I would highly recommend is looking at ED boarders or hospital boarding, both on the adult and the children's world. Due to the lack of services in the outpatient setting, we are stuck with patients who don't need hospitalization. There is an expense to that, and then there's a cost to the payers for

that as well, so understanding that.

You mentioned in the article and your conversation around the implementation of AI, particularly as it relates to physicians and not seeing a direct correlation between AI and reduced expense there. I would put on the surface that that's because most of the physicians are doing that work on what we call "pajama time" in their off hours and their free times. So you're not seeing that. You're seeing it in their benefit of life, but understanding that.

And as the hospital provider types, we've heard -- I think we've got to take a deep look at the rural hospitals. We've got to take a deep look at our safety-net hospitals and our children's hospitals, because when you look at those hospitals, other than the rural, which I think Commissioner John brought out, the safety net and the children's hospitals see a high number of Medicaid patients, upwards of 50 to 75 percent or more. And when you use Medicare benchmarks, that doesn't work for those hospitals. So I think we have to take that into consideration. But those are the provider types I would look at as well.

And I do appreciate my Commissioner remarks on private equity. Being in a state where we've seen the demise of hospitals that were owned by private equity because they took the money and didn't invest in the infrastructure or the staffing, now we're all paying the price of trying to cover for that as well.

So I think this work is going to be critical as we move forward, and I thank you for the work that you've done to date and look forward to seeing and hearing what you discover as we move through.

So, with that, we'll close this session out, and we'll move to another hot topic. And that's on drugs.

[Pause.]

VICE CHAIR ROBERT DUNCAN: All right, Commissioners. We have Anu, Taylor, and Chris joining us to talk about drug price negotiation in Medicaid. As you know, that's a hot topic here in D.C., and we're looking at the Medicaid Drug Rebate Program as well as Most Favored Nation, and they're going to educate us and decide how we move forward as we look at this.

So, with that, who am I turning this over to? Taylor, that's you.

DRUG PRICE NEGOTIATION IN THE MEDICAID PROGRAM

* TAYLOR DeLAC: Good morning, Commissioners. Today, Anu and I will be presenting background on our new work on drug price negotiation in the Medicaid program. This work builds on the Commission's past work on Medicaid prescription drug spending and the Medicaid Drug Rebate Program and is intended to lay the groundwork for subsequent presentations.

So today, I will start with an introduction to the project and our policy questions, then go over some background on the Medicaid Drug Rebate Program, or MDRP, and the Most Favored Nation, or MFN, drug pricing framework. Then I will walk through the three CMS Innovation Center, or CMMI models, that apply drug price negotiation to Medicaid, which are the Generating cost reductions for U.S. Medicaid model, or GENEROUS; the Cell and Gene Therapy Access model, or CGT Access model; and the Better Approaches to Lifestyle and Nutrition for Comprehensive health model, or BALANCE. Anu will then discuss how these models interact with the MDRP, and we will finish with next steps and questions for Commissioner discussion.

The purpose of this project is to understand how the MFN framework and recent CMMI models interact with the MDRP and how they may affect drug utilization and spending in Medicaid. Our policy questions for this project start with what issues the MFN framework and CMMI models aim to address and what the expected outcomes are for federal and state Medicaid spending and beneficiary access. And because these models are voluntary for both states and manufacturers, we want to understand what policy, administrative, or budgetary factors influence states and manufacturers' decisions to participate.

So now I will cover some background on the MDRP and MFN.

Outpatient prescription drugs are an optional Medicaid benefit, but all states provide them. The MDRP governs Medicaid coverage of these drugs. Under the program, drug manufacturers must provide rebates in order for their products to be recognized for federal Medicaid match, and those federal rebates are calculated under statutorily defined formulas based on average manufacturer price, or AMP, which I will walk through on the next slide.

AMP is the average price paid to manufacturers in

the United States by wholesalers for drugs distributed to retail community pharmacies. In exchange, states must generally cover a participating manufacturer's products, but they may limit use through tools such as prior authorization and preferred drug lists, or PDLs.

Separately, federal regulations require states to pay pharmacies the drug's ingredient cost at actual acquisition cost plus a professional dispensing fee in fee-for-service Medicaid.

For brand drugs, the basic federal rebate is the greater of 23.1 percent of AMP, or AMP minus best price. Best price is the lowest price at which a manufacturer sells the drug in the U.S. to certain payers. This means that when a manufacturer offers a deeper discount to another purchaser, the Medicaid rebate generally increases.

For generic drugs, the basic rebate is 13 percent of AMP, and there is no best price component.

Both brand and generic drugs are subject to an inflationary rebate when a drug's AMP rises faster than inflation.

In addition to federal rebates, states can negotiate supplemental rebates with drug manufacturers,

which manufacturers provide to have their products placed on the state's PDL. These supplemental rebates are often structured as guaranteed net price arrangements, which means they move inversely to federal rebates.

Since the CMMI models largely lower net prices through a supplemental rebate, we wanted to provide context on states that currently have supplemental rebate agreements, or SRAs, in place.

As of June 2026, almost all states except for Hawaii and New Mexico have supplemental rebates. Some states pursue SRAs on their own, while others have joined multi-state coalitions for negotiation purposes. Multi-state agreements are negotiated through interstate purchasing pools, which states join to increase their negotiating leverage.

States must have an SRA on file with CMS to receive MFN rebates through GENEROUS. So Hawaii and New Mexico would need to put one in place to participate.

This figure shows the many parties and transactions involved in the Medicaid drug supply chain, including manufacturers, wholesalers, pharmacies, pharmacy benefit managers, or PBMs, and managed care organizations,

or MCOs. The key point here is that payment and rebates are separate transactions. Payment flows from the payer to the pharmacy for the drug and a dispensing fee, while rebates flow separately from the manufacturer to the payer.

I will note that federal rebates flow directly from the manufacturer to the state and do not involve either the PBM or MCO.

We've indicated the supplemental rebate flow with the red box seen there, since that is where the CMMI models largely operate.

MFN pricing is a form of international reference pricing that seeks to align U.S. drug prices with prices paid in comparable countries. In May 2025, Executive Order 14297 directed the Department of Health and Human Services, or HHS, to communicate MFN policy to manufacturers. One of the stated goals of this order was that manufacturers extend MFN pricing to Medicaid, and for Medicaid, the MFN target is the second lowest net price among eight high-income countries. These international net prices are reported by the manufacturers themselves.

According to the White House, as of August 31, 2026, 26 manufacturers have signed agreements committing to

participate to provide MFN pricing to Medicaid. These manufacturers account for about 89 percent of the U.S. brand drug market. However, the agreements remain confidential. Only two redacted agreements from Pfizer and Eli Lilly have been released under a Freedom of Information Act, or FOIA, request, so there is limited public information on their specific terms.

So now I will turn to the CMMI drug pricing models.

Before walking through the models, I want to briefly introduce CMMI. The Affordable Care Act created CMMI under Section 1115A of the Social Security Act to test payment and service delivery models that aim to reduce program expenditures while preserving or enhancing quality of care. To test these models, CMMI may waive certain program requirements. All three models we discuss today were developed under this authority.

The table here provides a quick summary of each model's pricing mechanism, target drugs, timeline, participation, and objective, and I will go into more detail on each model in the next few slides.

GENEROUS uses an MFN supplemental rebate on brand

drugs selected by participating manufacturers with the goal of lowering Medicaid net drug spending. The CGT Access model uses outcomes-based discounts and rebates for cell and gene therapies starting with sickle cell disease. BALANCE uses a CMS-negotiated net price and coverage terms for GLP-1 medications indicated for weight loss.

State participation varies widely. All 50 states, D.C., and Puerto Rico are participating in GENEROUS. Thirty-two states, D.C., and Puerto Rico participate in the CGT Access model, but only one state, Indiana, has confirmed participation in BALANCE.

Under GENEROUS, participating manufacturers provide supplemental rebates so that Medicaid's net price for a covered drug reaches an MFN benchmark. That benchmark is the second lowest net price among G7 countries, plus Denmark and Switzerland, adjusted for gross domestic product, or GDP, per capita.

Importantly, the MFN rebate sits on top of the MDRP. The MFN price is not included in the calculation of best price and does not affect the 340B ceiling price.

CMS also negotiates uniform coverage criteria with each manufacturer, such as PDL placement and prior

authorization. States must adopt these terms across fee-for-service and managed care and cannot pursue separate supplemental rebates on those drugs. Manufacturers select which of their drugs are included in the model, and states then choose which of the drugs to opt into. At this point, we do not have information on which drugs states have selected.

Cell and gene therapies are often one-time treatments with very high upfront costs. The two sickle cell disease gene therapies currently in the model have list prices of about $2.2 million and $3.1 million per course of treatment.

As the Commission discussed in its 2021 work on high-cost specialty drugs, these costs, coupled with uncertainty about how many Medicaid enrollees will utilize these drugs, can create budget volatility for states, and the long-term benefits of these therapies remain uncertain.

In 2024, CMS announced the CGT Access model in an attempt to circumvent some of these challenges. Under the model, CMMI negotiates outcomes-based agreements, or OBAs, with cell and gene therapy manufacturers, beginning with gene therapies for sickle cell disease. Manufacturers pay

guaranteed and volume-based rebates plus outcomes-based rebates if patient outcomes do not meet agreed-upon benchmarks.

All of these are supplemental rebates paid on top of MDRP rebates. Manufacturers are also required to pay for a defined scope of fertility preservation services, since sickle cell therapies can cause infertility in patients.

Participating states adopt the CMS-negotiated terms, align coverage across fee-for-service and managed care, and submit claims data. CMS then centralizes data collection and tracks outcomes against the benchmarks using claims and patient registry data. Uptake of these gene therapies has been slow across all payers, with about 300 people treated or starting treatment as of early 2026. These therapies are complex to administer and require chemotherapy before treatment, and only a small number of specialized centers can provide them.

Under BALANCE, CMMI negotiates prices for GLP-1 medications indicated for weight loss in Medicaid and pairs this with lifestyle support programs. Unlike most drugs, coverage of weight loss drugs is optional in Medicaid, and

most states do not offer coverage.

States participating in BALANCE may be able to obtain a lower net price for these products through the model, but they must follow a standardized access policy across fee-for-service and managed care. This policy acts as a floor, meaning states may cover these drugs more broadly but not more narrowly.

As we mentioned earlier, only Indiana has confirmed participation. States that do not currently cover GLP-1s for obesity would need to expand access to participate, which would increase their costs.

So I will now pass it to Anu to discuss how these models interact with the MDRP and other considerations.

* ANUPAMA WARRIER: Thanks, Taylor.

So, as we noted, GENEROUS operates on top of the MDRP, meaning that the federal statutory rebates continue to apply. For drugs that are included in GENEROUS and that states opt into, the MFN rebate will replace any supplemental rebates that states have negotiated, and states must also adopt CMS-negotiated coverage criteria.

However, because states can choose which drugs to opt into, they will need to assess on a drug-by-drug basis

whether the MFN price will be lower than their current net price and how agreeing to the standardized coverage criteria may affect their utilization and expenditures.

For example, South Dakota projects that they will save $750,000 annually on three products by participating in GENEROUS, compared with around $150 million in prescription drug spending in the state.

So we put together a graphic to help illustrate a hypothetical interaction between the MDRP rebates and the MFN pricing that is baked into the GENEROUS model.

First of all, because the GENEROUS model operates as a supplemental rebate, its value to a state depends on what that state already pays after the statutory MDRP rebates are applied.

For example, let's say there are two hypothetical brand drugs with a $100 list price and a $75 net price after the statutory rebates. For brand drug A, the MFN price is $60, which falls below the state's current net price, so a state could receive an additional $15 rebate through the GENEROUS model. For brand drug B, the MFN price is $75, which is equal to the current net price, and a state would not receive an additional rebate through

GENEROUS. So the state would likely sign up for brand drug A and not brand drug B when participating in GENEROUS.

And a state that has already negotiated a supplemental rebate, which brings its net price below the MFN price, faces the same calculation as to whether the MFN net price is lower than the state's price after MDRP and supplemental rebates. So this variation across drugs is why all states are participating in the model but will likely opt into MFN pricing only for selected drugs.

However, as we said, it remains unclear which drugs are included in the GENEROUS model. The model's request for applications for manufacturers appear to include all of the participating manufacturers' brand drugs. However, company disclosures suggest that some manufacturers negotiated terms covering only certain products and excluding others like GLP-1s.

We also do not have a firm grasp of how MFN agreements intersect with GENEROUS participation agreements. For example, Pfizer's MFN agreement released under a FOIA request suggests that their MFN agreement supersedes GENEROUS where the two conflict.

A further transparency issue is that the

participation agreements have confidentiality terms. So it is not clear what information may be made publicly available in terms of which drugs are included in GENEROUS and from there which drugs states have selected.

We also wanted to highlight some considerations for the other two models. The CGT Access model aims to address the high upfront costs and uncertain long-term benefits that the Commission raised in its 2021 work through centralized negotiation of guaranteed rebates and OBAs.

Notably, CMS released the first evaluation report this week. However, there is still little information on treatment uptake through the model to date, and while the patient registry helps track outcomes over time, it will take several years to evaluate whether the OBAs are working as intended.

States may also still face challenges covering ancillary costs such as chemotherapy.

A further challenge for patients is that while the model covers fertility preservation, it cannot cover in vitro fertilization, which patients who preserve their fertility may later need but will likely not be able to

afford on their own.

Despite these remaining challenges, CMS announced this week that they plan to expand the CGT framework beyond sickle cell disease.

For BALANCE, states have shown little interest to date. Because coverage of GLP-1s for weight loss is optional, states can currently manage utilization and spending closely, and expanding coverage under the model's standardized coverage criteria could increase overall spending and strain state budgets.

So our next steps on this project include convening a panel at the December public meeting as well as a technical expert panel, or TEP, with the objectives of gathering additional information about these models and beginning to answer the policy questions that we presented at the start of this presentation.

We plan to present key themes from both panels at the March meeting. We welcome your questions on the background information today and any feedback you have on related topics that we should explore.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you. I

appreciate it. I found this chapter extremely interesting and educational for myself because a lot of this was new. So I appreciate the work that went into that.

With that, opening up to Commissioners, and I've got Doug and then Angelo.

COMMISSIONER DOUG BROWN: Wow. So much to unpack here. This is really good. You did a very nice job kind of going over the basics of the Medicaid rebate program, where the intersections are.

Just a couple of slides, I want to visit first. If you can go to Slide 16, please. I know that -- and maybe we should start with 17. Let's go to 17.

So states have been doing preferred drug list programs for 20 years, starting with Florida 2000, and moving forward from there, there's multi-state pools. There's individual pools. The model that we see here is to how states evaluate when to add drugs to the preferred drug list program, this is the financial evaluation that states have been doing for 20 years. There's nothing new here that if a drug is less expensive, net of a rebate, than the federal rebate, they could take that, make that drug -- put that drug on the preferred and pick that drug over another

product that is equal but not at that same level. So this is the way supplemental rebates work today. States are very familiar with the financing that's going to come through here.

If we go back to the previous slide to this where we have the comment, folks have been asking questions and wondering, is MFN pricing valuable to states, and are states really going to save money with this?

In that South Dakota example, $750,000 against $150 million drug spend, just to put that into context for states, federal rebates today are about 45 percent of total drug spend.

Supplemental rebates that states get average about 6 percent or 7 percent now on top of that. So states are close to 50, 51 percent in their rebates. $150 million at 7 percent is about $10 million. So three drugs is going to generate almost a million dollars on top of the $10 million that a state would generate today. That's real money for states, and that's only on three drugs.

We don't know all the drugs that are going to be under contract here, but you've got the 17 largest manufacturers participating plus the additional midsize

companies that have offered pricing.

I'd love to know when those drugs will be available, at least not what their price is, but that they are available for states to choose from. And I think the place that's really going to benefit states is being able to get discounts on drugs that they currently can't get discounts on through the contracting that they do through supplemental rebate contracting today, because the drugs fall outside of competitive therapeutic classes, like oncology, for example, or mental health diseases.

So those are kind of the highlighted questions that I have here.

I know you're going to get with a TEP around these different programs, and I have a couple of comments here relative to things I'd like you to kind of query on with them.

See if you can run to ground the idea of expanding safe harbors for cell and gene therapies. As you highlighted, there is a safe harbor created inside the CGT Access model for fertility preservation, right? There are a number of gene therapies that have either high-cost genetic testing that goes along that the company would pay

for to see if the patient qualified, but they can't because it would create an inducement or they'd be outside of the safe harbor.

There's also extensive monitoring that goes on with many of these therapies, where there's extended monitoring times for patients, and there's oftentimes not money that covers that, or the money that covers that is not substantive enough.

And so manufacturers tend to raise their drug prices, and then the profit that a vendor can make by marking up the drug, then offset some of the costs associated with some of those other things that a manufacturer couldn't take.

So, from a CGT perspective, if you can run to ground the safe-harbor issues and how maybe you expand that in that group.

I'm also concerned about and ask the TEP question around the rebate models. In the cell and gene therapy rebate model, they came with five rebates that were required for manufacturers to participate. The MDRP, which we're not going to get around -- that's kind of table stakes -- a guaranteed supplemental rebate, an outcomes

rebate at the patient level, an outcomes rebate at the population level, and a volume-based discount. Five rebates in that program sends a message to manufacturers when they launch a gene therapy that they better raise their price to be able to offer five rebates in the back end of that, right? It's the PBM, right? It's the PBM question about how much do I need to mark it up so I can pay these rebates to all these different entities, and here's CMMI asking for five rebates, right? So that's a concern.

And is there a better way to get through that? I have some ideas, but I'd like the TEP to kind of weigh in on that if there's a way to kind of streamline that.

From the GENEROUS model, I'd like to kind of better understand where states are, how many states joined at the appropriate time so that they could take advantage of retroactive rebates like South Dakota did. And if states couldn't join in time and they're not taking advantage of retroactive rebates, what are the barriers to that? What was the issue there? You know, what was stopping states from going back and getting that?

And then I'd ask about how much money they saved,

but the program is just starting, so we don't know that yet. And I already asked the question about kind of identifying drugs. Is there any potential for identifying these drugs as we move forward? Again, not their MFN price, but just what drugs they are as they sit outside of that.

And I should say that for South Dakota and this $750,000, South Dakota participates in one of the national pools. So they already have a vendor that's gotten the best discount they can, and this is on top of that. So, again, I think there's some real money here for states.

Thank you for letting me come on for a longer --

VICE CHAIR ROBERT DUNCAN: No, thank you. Appreciate that.

We'll go to Angelo. Then I have Jami and John in queue.

COMMISSIONER ANGELO GIARDINO: I'd like to echo. I think the briefing material is really informative. And access to medications and therapeutics is fundamentally a clinical issue. The advances that we've had in medical care over the last 60, 70 years is due, in large part, to the academic and pharma communities developing these

medications. And the complexity that your work has demonstrated is really concerning to me.

So I think one policy option might be how to simplify this. I asked my friend, AI, to help me with this. There are several researchers at Stanford that have written a book on the Friction Project. And what you have described is unwieldy friction, that makes it difficult for people to get the medications and the therapeutics to the people who need them.

So let me just tell you what the principles are. The principle is that complexity must be managed at the strategic risk. Without deliberate simplification and governance it will erode performance and can cause the program to collapse. And what you just described is a program that's about to collapse.

I have two doctorates and four master's degrees, and I cannot understand what you just explained. It is so non-transparent. It is so proprietary. It is so aimed at making it so hard that, as Commissioner Brown just explained, it causes gaming in the system, and the gaming is not going to be solved by spurious executive orders that have really cool acronyms, you know, GENEROUS, most favored

nations.

Our system is about to collapse with this way of funding medications. And I would just ask if it's possible -- and this is not a political statement but a policy statement -- is it possible to envision a simplification process where the way Medicaid provides a reasonable, economically sustainable model to get the medications and therapeutics to people, would be new and different, but simple. And I think the fact that some of these agreements are secret does not feel American to me. Then it's a policy issue.

So I would just ask if one option or alternative you discuss at some point is like intentionally simplification and governance that doesn't require gaming of the system so that states can figure out all the different buckets where the money is. I still can't figure out how much a state would pay for a medication, because there's so many secret agreements, and now it sounds like there's a whole other set.

So with that I'll just say I would just like to hear about scrapping this system, which is so complicated that it is about to collapse under its own weight.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo. Jami, then John.

COMMISSIONER JAMI SNYDER: Thanks so much for your work on this. I just want to point back to Slide 8, which I think, for me, you know, the complexity of pharmacy in the Medicaid space is really enormous, and this slide really laid it out in a way that for the first time I felt like I understood how the system works. So I just appreciate that.

You know, kind of going back to some comments around transparency, I do feel like to the degree that we can get a better handle, in particular, under the GENEROUS model, which states are choosing which drugs, because there's real opportunity, I think that would be helpful. I think examples, in addition to the one that you've provided, I think it was for South Dakota, I think would be really helpful in terms of understanding the magnitude of the opportunity.

And then I'm just curious. I think one of the challenges for states as they're assessing, and particularly with the GENEROUS model, whether they want to move forward with certain drugs and accessing the MFN

pricing, is around the standardization for PDL placement in prior authorization and how much that impacts their decision when they decide to participate and which drugs they choose to pursue under that GENEROUS model.

VICE CHAIR ROBERT DUNCAN: Thank you, Jami. John.

COMMISSIONER JOHN McCARTHY: Can we see Slide 8? I just want to reiterate what Jami was saying. And you've even simplified this chart to help us. I mean, what you don't have in here is between the pharmacy and the wholesaler -- you have in there drug ingredient acquisition costs. There are also rebates in there that don't get reported. There is the issue of when you go to a pharmacy -- I mean, and this isn't as much in Medicaid -- but if a person goes to a pharmacy sometimes there's a copay that they're paying that's a $20 copay but the drug without insurance would've cost $1.25, so you're better off not using insurance. And there are a whole bunch of other issues there. I think in Medicaid they took care of that, but in commercial there's not.

One of the other things I would really love to hear, when you're interviewing states, is how hard is it to

get the supplemental rebates? I just want it clear for everyone not deeply involved in this, it's not like you pay less for that drug. The state pays the price for what it is. So they pay $100, and there's a supplemental rebate of $50. They don't just pay $50. They pay $100, then they later on have to send in the claims and then get the $50 back.

And there was a time there, for a little while, I know, and maybe it's changed, where there were fights between the states and the manufacturers on the rebate levels, is it the right amount, who is calculating those different pieces. And also it's super complicated, and we talk about it super generically, but the rebate can be different by drug, by dosage level, by quantity. There are all these different pieces in there.

So if you could talk about that, like where are states in actually getting the rebates, and are they actually getting the rebates they think they should be? Are they auditing those things to find out who is doing that? And is it the state doing that? Is their PBM doing it for it, and those different pieces. So I think that's one thing.

Lastly, I just want to reiterate what Angelo was saying. I think for MACPAC one of the things to be looking at is why do we have this system in Medicaid to do this. And I think it would be interesting to be able to tell everyone why we have this system. Because one big thing we focus on is transparency in payment rates. All the other payment rates, all other payment rates for the Medicaid program are transparent. You can go online. You can see how much hospitals are paid. Whether the public can see it or the state can see it, like they see those things.

The state can't see this for pharmaceuticals. This is the only thing. For all the other ones you can ask your fellow states, "Hey, can we see these things?" And you can work into some things. I know Patti brought up managed care. But you can still look at an encounter, and on the encounter see what the hospital was paid. There has not been a supplemental rebates for a hospital impatient stay. It's in the claim.

So why is it for these there is not transparency, both for the public and for the state? I just want to point this out. On the Medicaid side, being a former Medicaid director, this is one of the super frustrating

things, is that I'm trying to negotiate my rates and see what it is. So let's say Jami is in Arizona. I couldn't see what Jami was paying, and she couldn't see what I was paying, and I had no idea. You could join a multi-state pool. I mean, you can see what the multi-state pool is getting, but you still can't share that information outside of that. And you sign NDAs to not share this stuff, so why is it that we do some of those things?

VICE CHAIR ROBERT DUNCAN: Thank you, John. Before I go to you, Mike, Doug wanted to --

COMMISSIONER DOUG BROWN: John, are you referencing the supplemental rebates or are you referencing the federal rebates?

COMMISSIONER JOHN McCARTHY: Both of those, Doug.

COMMISSIONER DOUG BROWN: The federal rebate is available. It's available to states, state employees. They are often the ones that generate the federal invoices that go out. When we would do presentations to state pharmacy directors, all of that is transparent to the state pharmacy directors, and in executive session sometimes that information is also presented to P&T.

COMMISSIONER JOHN McCARTHY: Yes, I'm sorry. You

are correct that everyone knows what the federal supplemental rebates are. But even in getting those, right, it's not a discount on what you pay. You pay the full amount and then you have to apply to get the rebate.

COMMISSIONER DOUG BROWN: Right. Medicaid doesn't buy drugs. Medicaid reimburses drugs, so they're reimbursing at the pharmacy and then you're getting the rebates on the back end to net out to the price that you're making decisions on.

COMMISSIONER JOHN McCARTHY: Right. But that's the only service that is done that way.

COMMISSIONER DOUG BROWN: Right.

VICE CHAIR ROBERT DUNCAN: Thank you, John. Thank you, Doug. All right, Mike.

COMMISSIONER MICHAEL NARDONE: Thank you for this, and this really is one of the more complex areas of payment policy, as I think this discussion clearly stresses.

I'm actually interested -- see, and my iPad also doesn't understand. Sorry about that. The thing that I was interested in is with the outcome-based payments under the CGT model. I'm curious as to how those are, like what

the criteria or performance metrics are that are being utilized, and how they're dealing with some of the challenges of just tracking for a Medicaid population.

Because I know that when Tim and I were at CMS there was a lot of discussion about value-based payment mechanisms, and one of the issues that we ran into was the fact that the timeline for the outcome might be longer than maybe someone might be on the Medicaid program. So I'm really curious about how, just understanding that, and the viability of this model going forward. Because I know that a lot of states have gotten SPAs for value-based payment arrangements, and I know it's probably outside the scope of this, but I wonder if there are lessons that can be learned from that or applied from that to other medications.

CHRIS PARK: Yeah, so first of all, the metrics and benchmarks that they're using are not publicly available at this point in time. One of the benefits of the CMMI model is that CMS is taking a more active role in tracking the outcomes. So they're requiring enrollment into a particular registry for everyone going through the model, so that will be available even if the patient potentially switches health plans or moves to another state, moves to

another payer. The theory would be that they would still be in the registry and those particular outcomes could still be tracked over time.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike. Carolyn, I see you.

COMMISSIONER CAROLYN INGRAM: Thank you. I just wanted to see if you could clear up my confusion on New Mexico. And the report, and maybe I read wrong, but New Mexico does participate in the supplemental rebate program, and I think it was called out that Hawaii and New Mexico don't participate, or something. I'm confused a little bit.

CHRIS PARK: Yeah. That map is what CMS has on their website as of June 2026. I think because all states are participating in GENEROUS at this point, New Mexico and Hawaii would've had to file an SRA with CMS.

COMMISSIONER CAROLYN INGRAM: They did rebates before then, so I think maybe the CMS map might be wrong. Anyway, that's okay. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn. Again, team, I think you have raised a lot of questions. I had a few here as I thought through. One was an

observation of the coverage policies moving from the states to the feds, CMS, which is interesting as we think about how Medicaid is set up.

The next is -- and Carolyn, I was hoping you were going to go there -- since we mentioned earlier in the session, many of the states are managed care. What impact does this have on the managed care plans and that whole system?

And then, again, for full disclosure, I work for a children's hospital, so I'm going to take a pediatric lens at this, and pediatrics needs their own view of this. So if you look at pediatric-only drugs they tend to carry a lower rebate than your adult-focused drugs. And when you look at pediatric formulations there is a lot less of that.

And then when you get to the carved-out, orphan-only drugs, and we think about most rare diseases are pediatric diseases, so what impact there are we looking at in providing treatment for those kids?

And then balances standardized access policy, whether and how it covers adolescents. I wasn't sure how that would pick up.

So those are a couple of things from a pediatric

lens. And then I'll get to you in just a second, John.

The other is, and it's been brought up multiple times by Commissioners, I'm thankful that you have highlighted it in the conversations. But as we look at the last couple of years around program integrity of Medicaid, it's a topic constantly being brought out in the news, yet we're looking at a program, we don't have the transparency in the program integrity insight into that. So I do think we have to talk about that transparency that's been raised on behalf of the integrity of the Medicaid program.

With that, John, you had another thought.

COMMISSIONER JOHN McCARTHY: Yeah, two points. I wanted to clarify. Doug was totally correct, and I was conflating two things at once. On the federal rebate side, Medicaid directors can see what the prices are and they know what that is, and that piece. My point was you still have to send in a rebate and get the money. This is back to kind of what I was talking about on are states getting those. It's on the supplemental rebate side where you don't know what those are.

And it reminded me of another issue, as you were talking about this, Bob. The other issue that would be

helpful for us is what is the impact of the 340B drug program on supplemental payments and then who gets those, who doesn't get those. I know enough not to be dangerous, so just if you could provide us some information around what the impacts of that, to both the state and the providers on that one. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, John. Heidi.

COMMISSIONER HEIDI ALLEN: Thank you so much. I would like to echo support for the call for transparency. I just have a question, and I find this all so complicated, as I know many people do.

But how does this come into play with generics? When you have a generic does it then just kind of become unimportant? Is this something that you can answer now or is this something you'd have to look into?

CHRIS PARK: At least all three of these models are focused on brand drugs. GENEROUS is specific to brand drugs. CGT right now is really only branded products. And then the BALANCE model is GLP-1s, which, for the most part, the negotiation will be on the branded versions.

COMMISSIONER HEIDI ALLEN: Gotcha. And so I know

for a while that there was, and I think in California there was a discussion about production of their own, I think, lines of insulin. Do states have the opportunity to make their own drugs if they have the capacity to do so? Or are they kind of stuck because of the same patent laws that require exclusivity for a brand drug? I know this is a silly question, but do you know the answer to that?

CHRIS PARK: Not being a lawyer I do not know all of the legal requirements, but essentially a state maybe could go into a partnership with a drug manufacturer to produce certain generic medications. So I think it's just kind of the operational complexity of maybe doing so in terms of either partnering with one or creating your own manufacturing firm, and how all that works. I'm not quite sure about that.

COMMISSIONER HEIDI ALLEN: Well, I think what's coming to mind specifically for me is all of the compounding GLP-1 pharmacies. And are states prohibited from engaging with those, based on some kind of law. I know people can engage with them directly, but does it just have to be entirely outside -- is it possible that the Medicaid program could be given some special permission to

work with compounding pharmacies to pay a lower rate? You just think the discrepancy between what somebody is paying in a compounding pharmacy for some of these drugs versus what is offered through the brand is so much.

And when you think of an issue, like obesity in the Medicaid population, you're talking about enormous savings and an enormous increase in access, which is currently so suppressed by states' utilization management and the fact that they're not required to cover it. But if they were able to work with the compounding pharmacies maybe they would be willing to cover it because there would be a lot of incentive. And I just don't understand. I'd like to know a little bit more about the policy limitations in that area.

CHRIS PARK: I'm not sure if Doug might have more insight into some of this. But there are some technical, like definitional type of things in terms of like what's included in the MDRP. You know, would it have to be FDA-approved in order for it to receive federal match. So some of these compounding pharmacies would not necessarily have FDA approval for their products so that could create complications.

I think the legality of some of these compounding pharmacy offerings is also put into question because they are not necessarily FDA-approved. And they are allowed, in certain situations, when there are shortages, but kind of depending on that situation I think the FDA has asked certain compounding pharmacies to stop producing these products because it doesn't meet one of those requirements where they are allowed to be sold without FDA approval. So it's a little bit of a complicated area there.

COMMISSIONER DOUG BROWN: Chris' response was right on.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi. We'll go to April for the last question.

COMMISSIONER APRIL HARTMAN: Commissioner Allen's comment made me think about the cost of generics. Generics used to be significantly cheaper. But there are some generic medications that the price has increased to almost brand levels. And so I know we're talking here a lot about rebates and stuff like that, but when we think about Medicaid drug payment I think that we also need to maybe look at the trends and how much is paid for generics, because my guess would be that that has gone up

significantly.

And I don't know if that's supply chain or what, but I just know, like I do a lot of behavioral health, and I know with the ADHD medications generics cost the same as brand, like it's the same price. So there's no cost savings just because it's generic. So just maybe looking at that, too, to just see where that's headed.

CHRIS PARK: Yeah, so just briefly, this gets to John's point about the payment of the drug is separate from the rebates. So there is an inflationary rebate on the generic drugs in the Medicaid program. The net price in spending to the state may not look as bad as the price increases in terms of what you're seeing on the initial payment.

VICE CHAIR ROBERT DUNCAN: Thank you, Chris. Thank you, April. Just highlights back to Angelo's comments. Can't we create a simpler system with transparency and go from there?

Team, I want to thank you. As I stated, this was well done. I was highly educated reading through this process. I left it equally confused and trying to understand more. So I look forward to both the

conversation in December and the continued work on this, but thank you very much.

And with that, Madam Chairwoman, I turn it over to you for public comment.

CHAIR VERLON JOHNSON: All right. Thank you so much. Thanks, Bob, for facilitating and to the staff for your preparation and grasp of the issues for this great conversation.

CHAIR VERLON JOHNSON: As Bob said we will now open the floor for public comment. We do invite you and the audience to raise your hand if you would like to offer a comment. Please make sure that you introduce yourself and the organization that you represent. And then we also ask that you keep your comments to three minutes or less.

So with that it looks like we have a couple.

PUBLIC COMMENT

* ROB NELB: Hi. Good morning, or good afternoon. This is Rob Nelb, Director of Policy for America's Essential Hospitals. Thanks so much for the opportunity to comment on your continued work on hospital payment policy. I really appreciate the thoughtful approach the Commission is taking.

First, I just wanted to echo the point that Heidi made about the importance of considering the cost of essential community services that every community needs but two hospitals provide. These include services such as obstetrics that was mentioned but also behavioral health, trauma, and other service lines that hospitals often operate at a loss, across all payers, and they have high fixed costs, which makes them difficult to maintain in their communities.

As we look ahead to some of the upcoming cuts in hospital payments under H.R. 1, we're particularly concerned that even if hospitals don't close their doors they're going to cut these unprofitable service lines, placing more burden on essential hospitals and access gaps in many communities. According to the March of Dimes, one-third of U.S. counties are already maternity care deserts, and these access gaps are only expected to grow in response to cuts to state-directed payments that help support this care.

Second, I also want to encourage the Commission to recognize uncompensated care costs by uninsured individuals, which are projected to grow in the coming

years, and disproportionately harm essential hospitals. All these costs end up affecting a hospital's bottom line, and its ability to keep services in its community for patients.

At America's Essential Hospitals we're currently working on updating our annual report describing the characteristics of essential hospitals, including their costs and the services that they provide, and we'll be sure to share it with you to inform your continued deliberation on this important issue.

Thanks for your time.

CHAIR VERLON JOHNSON: Thank you, Rob. Always great to hear from you. Next we have Milena, I believe.

MILENA BERHANE: Yes. Hello. Good afternoon. My name is Milena Berhane, and I'm providing public comments today on behalf of the Children's Hospital Association. We recognize that MACPAC is exploring hospital cost drivers and other hospital payment issues, and want to take this opportunity to reiterate the importance of Medicaid for children and children's hospitals.

Medicaid and CHIP provide essential health care

coverage to approximately 35 million children in the United States, and children's hospitals are major Medicaid providers. Medicaid covers over 50 percent of children's hospitals' patients, and for some children's hospitals' patient mix Medicaid coverage closer to 80 percent of the children they serve.

Medicaid is essential to children's hospitals' ability to provide care to millions of children. And pediatric care is unique, requiring specialized providers, facilities, equipment, and services that are designed specifically to meet the needs of children, particularly those with complex and chronic medical conditions. And because of this, children's hospitals often face higher costs associated with providing highly specialized care while serving a patient population that relies heavily on Medicaid.

As Medicaid reimbursement frequently falls short of the actual cost of care, children's hospitals depend on a stable and adequately financed Medicaid program to continue providing essential and lifesaving services to children in their communities.

H.R. 1 and the changes it has and will make to

the Medicaid program will severely impact children's hospitals and their ability to provide care for children across the country. And as H.R. 1's policies are implemented, children's hospitals anticipate major Medicaid cuts, and have and will continue to make difficult decisions that will restrict access to critical lifesaving care for children.

We urge MACPAC to consider these impacts on children's hospitals as the Commission continues its work to better understand hospital costs and payments, and we would appreciate the ability to be able to work with you and weigh in as you continue this work, as well.

And thank you for the opportunity to provide these public comments this afternoon.

CHAIR VERLON JOHNSON: Thank you, Milena. I appreciate your perspective.

Next up we have Lynn Lewis to comment.

LYNN LEWIS: Yes. I'm Lynn Lewis. I'm an independent professional consultant, our agency providing insurance advice to consumers on a daily basis. I can see a lot of the hospital providers are really concerned about the Medicaid benefits cuts and concerned about 340B program

integrity as well as price transparency. We work closely with the insurers as well as public policymakers with CMS as well as the Congress to make sensible health policies to make it affordable and sustainable.

Talking about the hospital payments, hospital revenue is not only based on the Medicaid and Medicare patient payment as well as hospitals currently allowed to bill commercial insurance three times more in terms of providing for care. So Medicaid is not really providing significant adequate data for CMS to know what Medicaid dollars have been spent. Given the current Mark Cuban Cost Plus transparency model we know exactly how much the drug is going to cost from a manufacturer's perspective, as well as how much really the hospital systems are charging for the Medicaid patient as well as the Medicare individual marketplace clients as well as commercially insured patients on the pricing.

So giving the considerations of overall when we make policy changes we have got to consider the whole picture of how to spend our federal funding as well as the state funding to make sustainable policies affordable for the insured as well as to pay providers and doctors

adequately. Thank you.

CHAIR VERLON JOHNSON: Thank you, Lynn, for your comments. We appreciate it. Seeing no additional comments, I want to say thank you again to all the commenters. Your input is always very valuable to us. And we encourage others who may have additional comments later to submit those through our website at MACPAC.gov.

Now we will actually take a break for lunch, and we'll reconvene at 1 p.m. Eastern. Thank you so much.

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

AFTERNOON SESSION

[1:02 p.m.]

CHAIR VERLON JOHNSON: All right. Welcome back. I hope everyone had a great lunch. Our next session is an update on work requirements implementation, and so with that, I will turn it over to Linn and Janice.

WORK REQUIREMENTS MONITORING: UPDATES ON STATE IMPLEMENTATION

* LINN JENNINGS: Thank you, Verlon, and good afternoon, Commissioners.

Today, Janice and I are presenting on our findings from our ongoing monitoring of state implementation of work requirements, and after this presentation and time for questions, we'll transition to a state panel.

I also want to note that beginning with this meeting, MACPAC will discontinue the use of term "community engagement" and begin referring to these new requirements as "work requirements." Based on conversations with CMS and the findings of their Medicaid beneficiary focus groups, the messaging recommendation is to use "work requirements" instead of "community engagement," and given

the public nature of our meetings and the wide audience with which we engage, we're making this change to be consistent with federal and state outreach and education campaigns.

So today, we'll present on our findings from the four areas that we've been focusing on in our monitoring, and then we'll present findings from early state implementation, and then updates since the release of the Centers for Medicare and Medicaid Services' (CMS) Interim Final Rule, the IFR, and then we'll wrap up with next steps for our monitoring work.

For our monitoring, we're using publicly available information from reliable sources to assess each of our four monitoring areas and conducting regular stakeholder meetings with federal officials, national experts and advocates, and state-level stakeholders.

And so I'll begin with our findings on state readiness. Findings from our stakeholder interviews indicate that although states may have made significant progress on meeting the expectations set by the IFR and CMS's Minimum Viable Product, or MVP checklist, many states will need to continue to make updates to their information

technology, or IT systems, well into 2027.

Further, states are facing additional challenges related to implementing several simultaneous eligibility changes, such as the switch to six-month redeterminations, the reduced retroactive eligibility coverage, and are updating their verification systems to use new data sources that haven't historically been used by state Medicaid programs.

Further, they're also using a look-back period to verify eligibility rather than using the current month only.

And so for states that make a good-faith effort to implement but are not ready for Go Live, the IFR specifies that CMS can grant states time-limited exemptions for up to six months through December 31st, 2028, and indicates that CMS will issue a template for submitting this type of exemption. However, this template has not yet been published, and stakeholders share that this may limit the ability of states to prepare for one of these requests.

Also, on October 1st, 2026, five governors sent a letter to HHS raising concerns about the feasibility of implementing work requirements by January 1st. This letter

is not a formal request for a good-faith effort exemption, but the governors are requesting HHS delay the work requirement implementation date and provide states with the opportunity to fully develop and test their systems prior to implementation in order to protect beneficiaries and reduce avoidable coverage disruptions.

All right. So, in general, stakeholders shared that most states have access to data needed for ex parte verification for certain compliance activities, so the household monthly income, and some exclusions, including the parent of a child under age 14. And states are continuing to establish connections to additional data sources to support ex parte verification.

CMS is also working to add more data sources through their federal data services hub.

Despite state progress on connecting to new data sources, stakeholders did caution that gaps in available data and data privacy requirements may limit states' ability to verify other compliance activities and exclusions on an ex parte basis. For example, we heard states have had challenges identifying a data source for verifying community service, volunteer hours, and parents

and caregivers of individuals with disabilities. So most states will be relying on self-attestation for these categories in 2027.

Stakeholders also raised the important role of eligibility workers in supporting new applicants and beneficiaries with understanding work requirements and helping them understand what type of documentation is needed to demonstrate compliance, exception, and exclusion status.

Given that most states will use self-attestation in 2027, stakeholders shared that eligibility workers will be especially important for supporting applicants and beneficiaries who are not determined eligible or renewed on an ex parte basis and need to submit a supporting documentation or fill out a self-attestation form.

In anticipation of an increase in eligibility staff workload and beneficiary support needed with work requirements, some states have increased their eligibility workforce to expand staff capacity.

Stakeholders did raise concerns about how prepared eligibility workers are to handle the volume and complexity of beneficiary questions.

Now moving to our findings on medical frailty. As a reminder, in statute, individuals must meet one of these five criteria to be considered medically frail, and the IFR expands on this and requires that an individual must also demonstrate that their condition significantly impairs their ability to comply with work requirements.

As part of state implementation and operationalization of this exclusion group, the IFR requires that states be able to share their condition and diagnosis list with CMS for oversight and monitoring to ensure all eligibility determinations are auditable.

Interviewees indicated that states began developing their approaches to verify medical frailty on an ex parte basis in advance of the release of the IFR, and in response to the changes made to the medical frailty definition, states are working to implement various approaches to use claims and encounter data to identify whether an individual has a qualifying condition and to assess whether the condition significantly impairs an individual from complying with work requirements.

One approach that states can use is CMS's tiered framework, which they published in September 2026, and the

approach categorizes conditions based on the extent which available data can confirm whether the individual's condition impairs their ability to comply with requirements.

Another approach that some states are using is a two-stage approach developed by researchers at Harvard that uses both a list of ICD-10 codes and types of utilization that may indicate the level of severity or acuity.

In our stakeholder interviews, they shared that states are still unclear about how to operationalize the IFR definition and are uncertain about whether their approaches will be considered compliant.

So, for example, stakeholders shared that some states are worried about implementing the approach presented in CMS's slide deck without public assurances that a state will not be financially penalized if its approach is later determined noncompliant.

Additionally, some states have indicated a need for more guidance from CMS on which definitions of medical frailty auditors will use, especially given upcoming financial penalties in fiscal year 2030.

Given these state concerns with how to

operationalize medical frailty, findings from our monitoring indicate that most states plan to use self-attestation for medical frailty and many other compliance activities, exceptions, and exclusion criteria while they continue to make updates to their eligibility systems to improve ex parte rates.

The IFR indicates that when sources of documentation are not reasonably available, states may accept an individual's self-attestation, referred in the IFR to as self-declaration under penalty of perjury until January 1, 2028.

Although self-attestation is intended to facilitate the application and enrollment process while states continue to improve their systems, stakeholders raised concerns with relying on it given that it does require a manual review.

Eligibility worker training on how self-attestation works will be critical to beneficiaries understanding whether they may qualify and what they are self-attesting to, especially given that the declaration is under penalty of perjury.

The IFR indicates that states may accept provider

documentation from practitioners qualified to determine if an individual qualifies them -- condition qualifies them as medically frail. National experts and national and state-level advocates share that some providers are concerned about their role in assessing medical frailty and an individual's ability to comply with work requirements.

For example, some provider associations have raised that there's an administrative burden associated with providing this documentation and concerns about their qualifications to assess whether an individual's condition impairs them from complying with work requirements.

Additionally, there are concerns with having to sign off on whether someone is medically frail and whether they may be investigated if they make too many medical frailty determinations.

Now I'll turn it over to Janice.

* JANICE LLANOS-VELAZQUEZ: Thanks, Linn. Next, I'll discuss our findings related to beneficiary outreach.

The IFR requires states to send beneficiary notices that use clear and consumer-friendly language. Based on our review of publicly available initial notices on work requirements, we found that they varied in content,

terminology, readability, and accessibility.

In addition, stakeholders identified challenges in readability across state notices and their use of confusing language. For example, some state notices would use vague language, such as "requirements may apply to you," which make it sound like the requirements are optional.

In addition to sending letters, many states have developed websites dedicated to educating and providing resources on work requirements. Some websites include screeners that guide users through a series of questions to help them determine if they are subject to work requirements or if they meet the criteria for an exclusion. However, stakeholders noted that while these websites contain important information on work requirements, it's not clear if beneficiaries are aware of or engaging with these websites and resources.

Stakeholders raised concerns that beneficiaries often do not know which eligibility pathway they are enrolled in, and so they may be unaware if they are in the new adult group and whether work requirements apply to them. In addition, stakeholders noted that states need to

communicate multiple and complex policy changes using plain language.

In addition to work requirements, states need to inform beneficiaries of more frequent redeterminations and of changes to eligibility for advanced premium tax credits for exchange coverage due to non-compliance with work requirements.

The other challenge states are facing with outreach is that policy and guidance on work requirements continues to evolve, which makes it difficult for states to share accurate information with beneficiaries.

Next, we'll cover our findings on federal and state reporting.

CMS releases a monthly enrollment and eligibility snapshot that uses performance indicator, or PI, and eligibility processing, or EP, data. They have indicated that they will continue to publish these data, and these published data are lagged by several months.

The IFR established state reporting requirements for monitoring work requirements. The states must report new work requirement-related metrics through PI and EP data.

The IFR also notes that CMS anticipates making changes to the Transformed Medicaid Statistical Information System, or T-MSIS, but those changes have not been released yet.

In addition to federal reporting, stakeholders shared that several states have published, or are planning to publish, data related to work requirements through dashboards or other reporting mechanisms. For example, there are states whose state legislatures are requiring their Medicaid agencies to report on work requirements beyond what is required by CMS.

While several states are implementing before the January 1st implementation timeline, Nebraska implemented the earliest, and we have some early data that we can share.

Nebraska implemented work requirements on May 1st, and prior to launching, Nebraska modified their application and their online portal to allow beneficiaries to report compliance or exclusion status. Nebraska is accepting self-attestation for most compliance activities, except for income, and some exceptions and exclusions. And as you may recall, exceptions include populations such as

individuals younger than age 19 or those duly eligible for Medicare, and exclusions include populations such as those who are pregnant, in former foster care, or are medically frail.

Nebraska was also the first state to publish their condition list for medical frailty, and CMS recently sent the state a letter in response to their state plan amendment notifying the state that they need to update their approach to align with the IFR.

In speaking with stakeholders, they noted several challenges since Nebraska implemented work requirements. One challenge they noted is that Nebraska has integrated Medicaid and Supplemental Nutrition Assistance Program, or SNAP, eligibility workers that support the call center, and the state did not hire more staff. Beneficiaries have reported challenges getting timely and accurate information they need from eligibility staff.

Another challenge is that notices were confusing, lacked specificity, and were written at a 14th grade reading level, making it difficult for beneficiaries to understand these new requirements.

Taking a look at recently reported call center

metrics by Nebraska, on this graph, the bars represent the total number of calls in the month, and the line represents the average wait time during that month. From January through August, Nebraska observed an increase in the total number of calls and the average wait time. Before implementation, the total number of calls was about 78,000, with an average wait time of 15 minutes and 37 seconds, and that was in January, and as of August, the total number of calls increased to 101,000, with an average wait time of 24 minutes and 31 seconds.

Stakeholders we spoke with noted that despite these metrics reported by the state, beneficiaries have reported long wait times, up to three hours, and they could not explain why the metrics do not reflect these reported experiences.

During the September Medicaid Advisory Committee, Nebraska shared data on application and renewal outcomes since implementation of work requirements. On this graph, we are focusing on just application and renewal outcomes related to work requirements.

Nebraska made work requirement determinations for around 4,000 new applications and around 7,300 renewals

from May through August of this year. Of new applications approved, the most common reason for approval was for compliance with work requirements, with a little over 1,800, or 52.7 percent, of applicants determined compliant. However, among renewals, the most common reason for approval was qualifying for an exclusion, with a little over 4,100 renewals, or 61.8 percent, determined as excluded from work requirements.

Among denied applications and renewals, the most common reason for denial was due to non-response. Those denied for non-compliance, though, were a small percentage. For new applications, 91, or 16.3 percent, were denied due to non-compliance, and for renewals, 43, or 8.1 percent, were denied due to non-compliance.

There have been a few updates with regard to federal guidance and ongoing litigation since the release of the IFR.

Based on the IFR, states are anticipating guidance from CMS or additional resources on coordination with exchanges and submitting a request for a good faith effort exemption, and CMS has not yet released these guidance. To assist states with implementation, CMS

continues to provide technical assistance and hold weekly state calls.

There are two active lawsuits regarding work requirements. The first one was filed on June 29, 2026, by 25 states and the District of Columbia, challenging aspects of the IFR's interpretation of work requirements, including medical frailty. And the most recent activity on this lawsuit was the hearing on the motion for summary judgment that occurred last week, on October 22nd. And the second lawsuit, filed in September, by beneficiaries, providers, and the City of Columbus, are challenging specific provisions, also including the medical frailty exclusion.

Joining us shortly is a state panel where Commissioners will have the opportunity to engage with panelists on work requirement implementation, and in December, we will return with updates for monitoring efforts.

And with that, I will turn it back to Verlon. Thank you.

CHAIR VERLON JOHNSON: Thank you. I appreciate the updates and the information.

I am going to check in with my fellow

Commissioners to see if you have any questions or thoughts.

All right. Sonja, we'll lead with you.

COMMISSIONER SONJA BJORK: What about handling the counties within a state that have high unemployment rates? Do we have information about that yet, or the approach?

LINN JENNINGS: Yeah, this did come up in some of our interviews, and I think we've seen that some states are starting to request these short-term hardships, such as the high unemployment rates.

So I think we've seen in the press an example of this in New York State. I believe the ones in Nebraska were related to other types of short-term hardships related to weather, like severe extreme weather. But I think as we get closer, we'll see more states requesting those.

COMMISSIONER SONJA BJORK: So, to your knowledge, nobody yet has a really good process for getting that in place? It's just, it's hard because you look backwards to see what the Bureau of Labor said about your unemployment rate in a certain county. So I'm just not clear on how it's going to play out.

LINN JENNINGS: Yeah, I think that's a great

question that we can take back and continue to monitor. Thank you.

CHAIR VERLON JOHNSON: Thank you.

Angelo?

COMMISSIONER ANGELO GIARDINO: Yeah, I just wanted to thank you for the effort you're putting into providing us some really good information, and I think it was really instructive to see the Nebraska experience.

So your presentation was 19 minutes long. So, if I had to wait 24 minutes, I would probably have a stroke. So I just can't imagine that it's okay to have a service standard of waiting 24 minutes.

Now, I know I'm kind of like a privileged person, and I expect to be taken care of immediately, but I think people on Medicaid deserve to not wait 24 minutes. I just wanted to recognize, it's now 21 minutes until you got to me for a question. So that person would have been waiting. So I think it's not -- I just want to say it's not appropriate to waste anybody's time, and I think Medicaid recipients deserve better. And they're not third-class people. They're first-class citizens who need a safety-net program, and I think waiting 24 minutes is appalling.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Angelo.

Jami?

COMMISSIONER JAMI SNYDER: Can we go back to Slide 21? I just want to make sure I'm understanding this slide.

So based on what I'm reading, it looks like for those individuals that were denied eligibility, right, that for new applications, 83.7 percent were denied eligibility because they failed to respond to requests for information to document their compliance. Is that right?

LINN JENNINGS: Correct.

COMMISSIONER JAMI SNYDER: Okay. And it's 91.9 versus those that were actually non-compliant, responded were non-compliant, 16.3.

Okay. Thank you.

COMMISSIONER TIMOTHY HILL: Do you know how that relates to other non-renewal data? Not just about work requirements, but when people come in and they do their eligibility review and they're renewed, like the non-response rate, is it higher here, or is it about what they see on the regular eligibility process? And I'm sorry for

jumping in.

JANICE LLANOS-VELAZQUEZ: No, it's fine.

So the data that Nebraska presented was specific to their adult expansion population. So all renewals were reviewed for work requirement determinations, and the new applications did have some information on non-work requirement determinations, but they did not share metrics that go beyond that population. So we can't speak to what that looks like.

CHAIR VERLON JOHNSON: Do you have more for us, Tim? Okay.

I guess for me too, what kind of indicators could be possible to help us distinguish between people who don't meet the requirements, so looking at that non-response? Right? And maybe they're just having difficulties navigating the process, because you could not respond because you're not living in the same place or you didn't get the notification. But what about the people who were maybe trying to, couldn't really understand how to navigate the process? Is there any way that anyone's thinking about that?

JANICE LLANOS-VELAZQUEZ: I don't know about

necessarily reporting it in aggregate on this level, but what we did hear from stakeholders was that among beneficiaries that didn't respond, it was largely due to confusion, at least the ones that they were working with. And it was that they didn't know that they were subject to work requirements, and they weren't sure, or some assumed that they wouldn't qualify, so they didn't respond.

So part of it seems to be attributed to beneficiary confusion, and that also might be a good question for our panelists from Nebraska who has some more direct experience.

CHAIR VERLON JOHNSON: And the outreach too that you mentioned earlier for sure. Okay. Thank you.

Let's see. Heidi?

COMMISSIONER HEIDI ALLEN: Thank you for this. This is super helpful.

I'm with Angelo that we need to understand the call center wait times better. I'm particularly intrigued that advocates are saying, wait a minute, we're having people tell us that they're waiting three hours, and yet we're seeing an average of 25 minutes, which to me, I would wait 25 minutes to talk to my insurance company sometimes

too. So I don't feel as concerned about that, but I definitely would be extremely concerned about three hours.

And so one thing that I think that we could do as MACPAC as this rolls out in January is do some secret shopper research efforts where we call and actually see how long on average people are waiting in different states. I think without secret shopper or really clear descriptions of how they're using their methodology, the average, is it that certain hours during the day people are waiting three hours? But if you happen to call at 9:01, you get 20 minutes or 10 minutes or one minute? Like, trying to understand that might be helpful or things that states could do to let people know when might be good times to call. Like, they could have some live dashboard on their website that says, these are the hours that have the shortest wait, things like that to be more consumer friendly.

CHAIR VERLON JOHNSON: Thank you.

Carolyn?

COMMISSIONER CAROLYN INGRAM: Thanks. I just had -- thank you for putting this together, and it's exciting to already be able to see, I guess, the outcomes.

Exciting, I guess, but good to have that you all are able to bring that together so fast, so appreciate that.

I just had a couple of questions. One was on rates. Have you seen anything yet about states looking to adjust rates, especially for providers in rural communities, hospitals that we just spent a lot of time talking about, or what they're paying managed care companies to account for the changes in the population that are happening?

I don't know if Nebraska is sharing that information yet, but it would be interesting to see -- or maybe Georgia since they had some form of work requirements in place before.

JANICE LLANOS-VELAZQUEZ: We haven't seen anything publicly available, and that hasn't been something that has come up in our stakeholder interviews, but that is something that we could take back.

COMMISSIONER CAROLYN INGRAM: Okay. That would be great to find out more.

And then the other area that I had questions about is there are new systems out there that make things easier for members to use than probably the systems that

we've -- well, that we've been using in the past for eligibility, to help them determine eligibility faster, pulls in their Department of Labor information to help them populate the application. They help upload documents.

And I know CMS pays match rates for these systems, so they'll help pay states to implement them. Have any states brought up -- I know Virginia has a new thing they're building. Have any of the other states brought up kind of how they're taking advantage of those kind of easier-to-use systems for members and consumers?

JANICE LLANOS-VELAZQUEZ: So Indiana just released -- I believe it was earlier this week -- that they are using MARA. And Indiana will be on our panel, so that could also be a good question for her.

But what we've been hearing is that CMS has largely been focused on adding data sources to the Hub. So we're not sure how much involvement there is with CMS working with states on like collaborating with these vendors.

CHAIR VERLON JOHNSON: All right. Thank you, Carolyn.

Mike?

COMMISSIONER MICHAEL NARDONE: Thanks for this presentation, and it's good to see that you're, you know, kind of using this very recent data. I think it's also important to remember this is a pretty small sample size. This is 16,000 people, right, or 10,000. So I don't know what kind of -- you know, I think we have to be careful in terms of the conclusions that we draw.

I was wondering, did you -- I didn't -- I don't know if you mentioned this, any numbers around this, but do you have a sense of how much states are using assisters or hiring additional people? Is it like half the states? Do you have any sense of that from the review? And you might have mentioned it in the presentation, and I missed it, so I apologize.

LINN JENNINGS: I think there's some initial findings that came up with KFF in a survey they did last March, which was before the IFR and a lot of other changes. And I think at that point, there were some states indicating that they would increase eligibility capacity, and we've been kind of tracking as we see things in the news about that.

But I think more specifically with Nebraska, they

had not increased eligibility capacity, and we did hear that there were a number of states that weren't doing that.

One of the things we also heard, though, among the states that were increasing capacity is that there were still challenges with actual recruitment and also challenges with getting those eligibility workers up to speed, given how complex and nuanced this policy is.

So those were the kind of, I guess, high-level findings that we were hearing from stakeholders.

COMMISSIONER MICHAEL NARDONE: And I really appreciate your kind shout-out around how the evolving nature of this policy really makes it difficult to not only get the, you know, assisters up to speed, but, you know, just in Philadelphia, I know we have a lot of community-based organizations that would like to -- that touch a lot of these individuals. And it would be really great for them to be kind of engaged in this work.

And so it's hard, though, when the -- you don't want to go through the training once and then have to retrain, and so I appreciate that. I appreciate that shout-out, because I think that really is one of the things that we're seeing in terms of being able to get word out to

people, other than make sure your address is up to date, make sure that the Department -- you know, that DHS has your information so that they can reach out to you. So I think that's really an important component of this that really makes the challenge.

I think there are a lot of people that want to help, and I think the documentation requirements that are needed, you know, you need some -- it would be very beneficial for people to have some assistance with that in terms of documentation.

I did see -- the other point I want to make and/or other thing I just wanted to raise is I did see an interesting analysis of the data from Nebraska that I believe Hilltop had put together from University of Maryland. And it kind of got me thinking around how do we assess the impact of the work requirements, because what they were -- what their data was -- or their analysis of the data was showing is in addition to just this impact that it has on new applicants and people who are going through the renewal process, is they were looking at what was the impact on actual applications for assistance.

And what they were reporting was that overall

levels were significantly down in Nebraska. And it was at variance from -- it was statistically -- I think I'm getting this right. It was statistically significant compared to what the trend was in other states.

And so, again, it's preliminary data, but I think it does raise like how do we best assess the impact, because there are these other kind of -- you know, these other impacts on people applying for assistance that we're going to, I think, as we're looking at this, want to take a look out as well. And there are a lot of confounding variables with that, right? I understand. So I'm not suggesting that that's what's happening in Nebraska. I'm just thinking that that was an interesting way of looking at it, and it is something we want to maybe kind of think about as we're going forward with this analysis.

Thank you.

CHAIR VERLON JOHNSON: Okay. Any additional questions from the Commissioners or thoughts?

[No response.]

All right. Well, it looks like we have our panelists with us, so I think we can go right into that. I'm thinking it may be helpful then if you all introduce

our panelists and then we can actually start with the Commissioner questions, if that's okay. Thank you.

WORK REQUIREMENTS MONITORING: STATE PANEL

* LINN JENNINGS: Thank you. To provide insight into state implementation we're excited to have three panelists joining us today to discuss their state's approaches to implementation and beneficiary outreach and engagement on work requirements.

With us today we have Amy Behnke, the Chief Executive Officer of the Health Center Association of Nebraska; Adela Flores-Brennan, the Medicaid Director and Director of the Health Policy Office for the Colorado Department of Health Care Policy and Financing; and Audrey Frenzel, the Medicaid Director and Director of the Office of Medicaid Policy and Planning in the Indiana Family and Social Services Administration. And Commissioners, you have received their bios in your materials. So thank you to all three of you for joining us today.

* JANICE LLANOS-VELAZQUEZ: Hi. Thank you all for joining us today. Before we discuss beneficiary outreach, which is the topic we will largely be discussing, for Audrey and Adela, is there anything that you would like to

share with the Commission about the progress your state has made with regards to implementation activities, and likewise, any challenges that you're currently confronting? Audrey, would you like to go first?

* AUDREY FRENZEL: Yeah, absolutely. Well, first of all, good afternoon everybody. It's a pleasure to be invited to speak on this panel. My name is Audrey Frenzel, and I'm Indiana's Medicaid Director. For those of you that might not recognize me, I started the role in March. I just celebrated my seventh month anniversary, which apparently puts me close to being over a third of the way through the average tenure, which makes me a little nervous, especially with all of the different components that are going on in the Medicaid space right now.

For Indiana, I think it's important to say at the outset that we have different requirements and a more stringent framework than what H.R. 1 and perhaps a lot of the other states are experiencing as they roll out their work requirement framework. For example, we are doing quarterly compliance checks. Members who are subject to work requirements must demonstrate that they are compliant with the eligible work requirement activities for each of

those three months within that quarter, and we are doing redeterminations every six months.

And there are several differences between H.R. 1 and our state law, but I think one of the primary ones is that we are not allowing self-attestation, and then there are just additional data reporting requirements that we have to look at in terms of eligibility and sharing that information externally. So just to kind of set the scene with that.

One of the things I'm really excited about, and I'm not sure if most or all of you had the opportunity to be at the National Association of Medicaid Directors conference last week, but when I spoke at that conference last week we were very, very close to being able to talk more publicly and lay out the actual framework of our medical frailty parameters.

I was not ready to speak to that last week, but on Monday of this week we announced what that framework looks like. We'll be using a structured, claims-based tool that we have been utilizing for a little while in the state of Indiana. We had a medical frailty process that we utilized starting in 2024, that helped us understand the

additional benefits that a person might need under their benefits package, based on if they had an ongoing needs support and things like that.

The original tool that we utilized was called the MARA [sic] Underwriting Guidelines, I believe. I might be messing that G up, but it's called MUGs, and it was custom built for us based off of an underwriting tool that Milliman provided for that service.

We have transitioned now to a new tool. It's still developed by Milliman, and it's called MARA, and it looks at structured claims-based data, and it's a multi-tiered process where we are looking for diagnosis codes, place of service, DME, adherence to and frequency of medication and treatment, et cetera. And then in addition to that, for some of the codes that you can't make a determination of medical frailty based off of just the diagnosis code, we are also looking at, like I said, the frequency of treatment, the medication, additional ongoing supports, and things like that.

And then if we are unable to identify, if the determination comes back that a person is not medically frail and our clinical team reviews that, or there is a

lack of information within the system that exists, we are allowing for providers to submit clinical documentation and evidence of medical frailty. However, in keeping with the kind of constraints around self-attestation, that will be a form that is filled out and submitted under the penalty of perjury for the provider.

I am excited to have laid that framework out this week. There are still some ongoing pieces of information we're waiting on from CMS that could change things for us with medical frailty.

I have just two very quick other things that coincide with that. We published the list of diagnosis codes. There are, I believe, 4,200 diagnosis codes captured within that Tier 1 for medical frailty. And then the second thing is that we will be running the tool for all of our current Medicaid members and sending them communications prior to 1/1/27, letting them know whether or not the tool determines that they are medically frail or not.

So that's just one piece of the overall work requirements framework. I'm happy to go into greater detail or less detail or talk about other things throughout

the panel here. But that's our big news of the week.

JANICE LLANOS-VELAZQUEZ: Thanks, Audrey. How about you, Adela?

* ADELA FLORES-BRENNAN: Thank you. Thanks again for having me today. Adela Flores-Brennan from Colorado. I think I'm beating the odds at a little over four years as Medicaid Director in Colorado.

We didn't make any big announcements this week. We are just proceeding through IT build and testing. We started testing around the 19th, so we're doing the systems integration and user acceptance testing in the system.

I guess our big thing this week was we did a webinar for about 4,000 people to help just create the general awareness and educate stakeholders about H.R. 1. This has been one in a series of several different webinars that we've been doing to help bring our community along with the changes that are happening.

And I think the big thing that we still very much need to look forward to, and we'll talk a little bit more about that later in the panel, is the operationalization link, getting those frontline workers prepared. As we're still testing the system there is not a lot yet to train

them on. There are just so many different elements, and I think, as most people would say, the biggest challenges that we're confronting right now are just the time, the time that it takes to put all this into place, the budget, and then the competing priorities that we all have as state Medicaid programs.

And yeah, I'll turn it back over to our hosts.

JANICE LLANOS-VELAZQUEZ: Thank you. And Amy, since Nebraska has already gone live, what do you think has gone well, or what might need additional attention as implementation activities continue?

* AMY BEHNKE: Thanks so much, and good afternoon everybody. My name is Amy Behnke. I'm the CEO at Health Center Association of Nebraska. We work with the seven federally qualified health centers in the state, and appreciate the opportunity to be here today.

In terms of what has gone well, you know, Nebraska is usually not first at doing anything, so this is new to us. One of the things that we did as an association, and in partnership with other health care entities in the state, is we engaged early with our Department of Health and Human Services, and, in fact, we

still meet with them on a monthly basis. That's been incredibly helpful for updates, for understanding what is happening at the local level as implementation begins.

And then another really big thing is that Nebraska proceeded in most instances with the least restrictive options. As an example, requiring proof of meeting one of the community engagement requirements for one month out of the last eligibility periods, as opposed to a longer number of months.

And then they have been really transparent that as things evolve and as information from CMS evolves, that their processes will evolve, as well. So again, just going back to that regular communication, that is really important as they continue to roll things out, and as they learn more from CMS and adjust their processes.

In terms of some areas that have been challenging, certainly implementing prior to the interim final rule being released led to some uncertainty. There were questions that the state just didn't have answered yet because we were waiting for additional information from CMS.

I think it was mentioned earlier, Nebraska did

not hire additional caseworkers. I think we're starting to see the impact of that. There is just increased time that's needed to work through additional requirements, so that's put an additional burden on the caseworker staff at the department and lengthened some of those time periods in terms of call center wait times as well as application processing timelines.

And along with that, as information changes and as additional information comes out, it requires an update on our end in materials and resources that are going out, either into the community or to our health center outreach and enrollment staff, and requires a retraining and a refreshing of information for individuals.

And I think the final thing, really, is data on how implementation is going. We've kind of gotten that one tranche of data that came out in mid-September, but haven't received additional data since then. I know that there is some data reporting going into CMS this week. But from an outreach perspective and from a state association perspective, it's challenging to know how to adjust outreach and education messaging when we don't have really a deeper understanding of what's happening behind the data.

EXECUTIVE DIRECTOR KATE MASSEY: Janice, it's always a busy time for everyone in the Medicaid program, and Audrey has to leave a couple of minutes early. So we just want to make sure, we're going to reorder the panel to make sure the Commissioners have an opportunity to ask her any questions. So I'm going to now turn it back to Verlon who is going to moderate the Commissioner section and then we'll come back to the bene outreach questions.

CHAIR VERLON JOHNSON: Yeah. I know as we had the earlier session there were a couple of questions we wanted to make sure that we got in front of them. So if you guys can raise your hands and we can have that done now. So questions? Heidi.

COMMISSIONER HEIDI ALLEN: Thank you so much for coming and joining us today. It's super helpful, and we're really happy to be able to learn from what you've learned so far.

Audrey, my question is related to the use of claims data rather than self-attestation. I'm wondering how you're handling mental health, and in particular I'm thinking about major depressive disorder or PTSD, where, one, we know that there are barriers to access to care in

those areas, so people may not be getting care because they're unable to get care. And two, we know that symptoms of those conditions might mean that people use less care because they are unable to leave the house.

So how do you flag that in your utilization?

AUDREY FRENZEL: I think that's a really, really good and important question. I apologize in advance, for those of you who haven't gotten to hear me talk before, because I think it's important to share a little of the context and then where we're at now.

When we started our Medicaid program we did not anticipate for the membership of that to become so predominantly SUD and behavioral health SMI focused, I guess, so to speak. So we kind of have an interesting Medicaid program where expansion is mixed in with other folks, and we're kind of trying to figure that out, in addition to implementing work requirements.

So when we first ran our tool, and I can't remember if it was Adela or Amy who mentioned it earlier, but the importance of making sure that you are running the process that you are utilizing and looking at the results that you're getting and then understanding what the

breakdown of that data is and recalibrating that tool. Because the first time that we ran the MARA tool with the five federal domains that are set up and the rules that are within there, if I was a person within our expansion population I would have been deemed as medically frail, meeting that criteria, based on the five different domains. And I say that because I think it's important to make sure that when you're running and calibration whatever process you're utilizing, you're balancing sensitivity with specificity.

So for us, when we are running our MARA tool we have a Tier 1 and a Tier 2, and we run them both at the same time. So it's not like if you don't meet Tier 1 then you go to Tier 2. It's two-fold. Tier 1 is looking at that diagnosis code. So let's say you're a member that has a major depressive disorder, but you have been doing really well, and you are holding down a job, et cetera. So that diagnosis code alone, because it's within that disabling mental disorder domain is what we're calling it, it's not going to determine somebody as medically frail just based on that diagnosis code alone, within that domain.

The additional things that we will be looking for

will be revealed in that Tier 2 component, which should show, you know, has that person had to have an inpatient treatment recently where that has hindered their ability to go to work? Are they doing outpatient treatment? Have they had other conditions, ongoing needs support, et cetera?

You know, I think it's going to be important to make sure that we continue to look at the results that we're getting back from our medical frailty tool. We ran it ahead of time to make sure that we could see who is currently medically frail. Are they still medically frail when we run our tool? If they're not, why? If they became medically frail, why, and understanding the different rules that we're putting into the tool to make sure that we are capturing those pp that need coverage and access to care.

So I hope that kind of answered that first piece. When it comes to provider attestation or the lack of self-attestation, I think that's going to become really important, and I think it might have been Adela that mentioned it earlier, about working with -- well, maybe it was Amy -- working with your FQHCs, your community partners, making sure your providers are aware of how they

can perhaps be able to provide that additional documentation. Because we will have members that come on that we perhaps don't have claims for, because they haven't been a Medicaid member before. And that's where I anticipate us running into challenges and potentially relying on provider attestation and clinical documentation more than what we hope to, candidly.

CHAIR VERLON JOHNSON: Thank you. Adela, do you want to respond to that, as well?

ADELA FLORES-BRENNAN: Sure. To a certain extent it's going to be kind of a wildly different response. We are using self-attestation, and I think that's going to be really critically important. I'm thinking about all the potential gaps and things that we can't necessarily plan for right now.

One example, people in my own life who were struggling so much with their health that they actually had to quit their job, but couldn't get in for six months to even get a diagnosis, and still are in the process of getting a diagnosis. So that is not a unique situation, and one that I think is really compelling for why we are planning to use self-attestation, but also just the time

that it was taking us to settle, in Colorado, on a framework and a dataset and everything. We've since chosen the Harvard methodology that I think a number of other states are using. But I think that's going to really help serve as kind of a safety net, if you will.

Moving forward, though, there is still so much work to do in 2027, to figure out then what. How are we verifying once we hit 2028, and what impact are we going to have on our providers, who are pretty nervous about what they're going to be asked to do. So that is still a pretty open question. We're looking at an RFP coming out here soon to solicit vendor support. We, at Medicaid, don't currently connect to our EHR so we can't pull that data in. But if we can hire a vendor to do that, then maybe they can support us in that way or support us in helping to build a record. But yeah, it's going to be a lot more policy development coming down the pike.

CHAIR VERLON JOHNSON: Thank you. I know, Audrey, you're almost out of time, so let me turn it to Carolyn and then Anne.

AUDREY FRENZEL: I was going to jump in really quickly and let you guys know that while I am having a

development in another part of my day I'm okay, on time now.

CHAIR VERLON JOHNSON: Perfect. So we'll go to Carolyn and Audrey, and then we'll go back to --

COMMISSIONER CAROLYN INGRAM: Thank you, Audrey and Adela, for staying with us. It's so much appreciated. It's very valuable for us to hear your feedback.

I think my question is for both of you because it's interesting to hear both sides of the story. But I know there are lots of new tools out there that operate better, faster, easier for our members, through apps and such, instead of using kind of the antiquated eligibility systems that were around in the past. So I'm wondering how you all find out about these or what CMS is doing to share that information. Since they provide the 90/10 match anyway, what are they doing to connect states with some of these newer companies that are providing this newer technology instead of the older eligibility systems that we have all become accustomed to as Medicaid directors?

ADELA FLORES-BRENNAN: I'll go first. We're getting multiple emails a day from different vendors, so it's really hard to parse what is relevant, what is going

to work, and then also put that into the context of state procurement rule that generally takes 12 to 18 months, which we never had in this process.

So we are looking at where we may be able to layer different tools into our system to help support things like consent-based income verification, but there was not time to completely redo an eligibility system. I mean, frankly, we don't even have time to build all of the rules that we needed to build for January 1. For example, we're not going to have short-term hardship exemptions at go live. That's going to be some time in the coming year, because we ran out of time and capacity to add that in.

So yes, there are all these different tools that are being developed and promoted out there, but it does take a lot of capacity to evaluate them and then figure out if it's going to work within your rules engine. And then we, in Colorado, have a system that is joined with our Department of Human Services, so we've got SNAP and TANF and some other programs all in there. So if you pull a thread in one place you have to be really careful you're not making a knot somewhere else, or unraveling something somewhere else.

So these are just layers of complexity. And then it just so happens, in Colorado, we're also getting ready to completely re-procure our whole eligibility system in the next couple of years, so that also weighed against us really looking at lots of other types of vendors.

CHAIR VERLON JOHNSON: Thank you.

AUDREY FRENZEL: I'm happy to hop in here. Kind of similar to that, we have an eligibility framework and that maintains our worker portal and our benefits portal. So that integrates Medicaid and CHIP, SNAP, TANF. It also includes casework flow, auditing and retention, correspondence, and call center interactions, post eligibility functions, like appeals. So that's been really helpful for us, and we worked with our current vendors to be able to do that.

One thing that Indiana has been very, very focused on, I joined the state with Governor Braun, when his administration came in, and one of our primary goals was reducing the budget growth within Medicaid. So we've been very, very fiscally strategic about the contracts that we operate currently. We had additional funding and flexibility within our current contracts to be able to

modify our systems, which was lucky for us because a lot of them are already highly customized within our state.

With that being said, though, that high level of customization within Indiana made things like the EMMY tool, you know, something that we were unable to take advantage of. We would've loved to have taken advantage of it, but the EMMY tool wouldn't fit into our existing integrated system, so it wouldn't have supported the additional verification requirements that our state statute required, in addition to H.R. 1.

I would be interested to see the reactions of my fellow directors' faces when I say it has been interesting to see a lot of innovative approaches and a lot of interesting tools that would help us in our ability to implement and operationalize work requirements. But at the same time, for everyone outreach and email I received that had something that might be worthwhile there are 35 others that are a sales pitch for people who have never stepped foot in this industry before. So it's kind of created a vacuum in terms of qualified vendors, I think.

ADELA FLORES-BRENNAN: I'd add to that. Audrey mentioned the EMMY system that the feds were working on

pulling together for the state. We were going to use that, and had to back away when it didn't come to fruition. So that was one that we were going to take advantage of.

COMMISSIONER CAROLYN INGRAM: Thank you. That's helpful. I have a follow-up question, but maybe it's later after the other Commissioners get to ask their questions. Thank you.

CHAIR VERLON JOHNSON: Thank you. Let's go to Anne and then Michael.

COMMISSIONER ANNE KARL: Thank you for being here and sharing your experiences. When Adela was speaking she was noting how it's quite a sprint that you all have been undertaking, and that there are certain pieces that maybe you haven't even been able to implement.

So my question is sort of focused on that. It feels like any new program, even if you have the best intentions and a great process, you're still going to have some bumps. And I think about that in the context that we're in right now, where there's such a focus on program integrity, and CMS just being really scrutinizing states' actions, making sure your processes are all up to snuff.

If I were in your shoes I might feel a little

nervous about this. So I wanted to get your reaction about how you feel about rolling out a brand-new, high-profile program, what the audit risk associated with that would be, what CMS is sharing with you about short of how to think about the early bumps and how to mitigate that and what the consequences of those early bumps might be, and just your overall reaction to that sort of audit risk side of things.

ADELA FLORES-BRENNAN: Yeah, Colorado is really worried. I don't think we're alone in being worried about that audit risk. We are part of the cycle two group of states for the PERM audits, so we'll be looking at our audits, I think, launching in June or July of this coming year. So it's really a big concern.

And we have pages of unanswered questions seeking guidance on how we need to be implementing and some nuances around some of the implementations, whether it's on the six-month renewals or work requirements, and so that is something that we are trying to document and make a record of so that we have that.

And then we will be trying to continue to ask for relief on PERM, and within the authority that CMS may have to grant relief, that was done when we implemented the ACA.

So that is our plan is to ask for -- you know, can't get that question asked unless we put it to them.

And then just this past week -- and I will say I haven't really gotten a chance to look very closely at it -- CMS did issue a multi-page mitigation strategy document. So for a variety of different components of the implementation, they have mitigation strategies, and they even gave us a fillable form that we can check off by policy to note where we may take any particular mitigation strategy.

So just off the top of my head, in case you're not familiar with this, things like if we weren't able to do direct noticing or something, can we at least use social media or broad outreach to connect to members? That kind of thing is what is rising to the top, but again, I didn't even make it all the way through the document.

CHAIR VERLON JOHNSON: All right. Thank you.

Let's see. Mike and then Jami.

COMMISSIONER MICHAEL NARDONE: Yes. Thank you. Thank you for this presentation. Thank you for answering all these questions.

I just had a question for Audrey and Adela. I

was wondering, as you're kind of rolling out the testing of the medical frailty tools, MARA in Indiana, and I assume you also -- Adela, I don't know if you have a name for it. But I'm wondering, do you have a sense from the testing, how many of the folks will be able to do the medical frailty determination ex parte versus kind of requiring another level of documentation or manual review of cases? Or do you have a goal that you're trying to get to?

ADELA FLORES-BRENNAN: Well, not a goal. We're trying to, you know, to the earlier question, maintain as much integrity as we can. So we're really looking at the data, and we've really thoroughly considered the various options that were out there. So we don't have a name for ours. We're just calling it the Harvard tool.

And in running the tool up against our eligibility as of, you know, I think September, it looks like about 40 percent of our MAGI adult population would come through as medically frail. So that's around plus or minus 5,000 people. It's around 160,000.

And so for context, there are 1.2 million people on Colorado Medicaid and 377,000 who are in our MAGI adult population who would need to potentially comply with work

requirements. So then we start filtering from there and about 160,000 look to be medically frail based on the criteria.

CHAIR VERLON JOHNSON: And, Amy, do you have any thoughts in terms from a Nebraska perspective as well on ex parte?

AMY BEHNKE: Yeah. So we have a 300-ish page document with all of the different claims codes and everything. My understanding is that for existing Medicaid patients, they are starting with claims data, looking back at the previous 12 months. Otherwise, we are doing self-attestation as well until 2028. And so if you do not have claims data, then that self-attestation process is being followed in Nebraska.

CHAIR VERLON JOHNSON: Thank you.

Jami?

COMMISSIONER JAMI SNYDER: Thanks to all three of you for joining us today. Really great information and insight into how things are working on the ground.

We had an opportunity a few moments ago to look at some early-stage data from Nebraska, and what it told us is that over 80 percent of people were denied eligibility,

both new applicants and those seeking renewal. More than 80 percent were denied eligibility because they did not respond to outreach from the state, asking them to either document compliance or an exception.

And to me, this feels a little bit like "Unwinding 2.0," but with a heightened level of complexity. I am just curious to know sort of what best practices you are looking at or you are seeing across states in terms of how to connect with members that they know that they need to document either their compliance or an exception to the work requirements.

And, Amy, thank you. I know you talked a little bit about this earlier.

AMY BEHNKE: Yeah, I can maybe start just with some of the things that we are doing on the ground.

You know, this is an incredibly complex new set of requirements that are rolling out, and so I think that you cannot over-communicate. And we are really curious to learn a little bit more from the data as to what is actually included in that failure to respond. You know, is it they never got the mail? Is it that they did not turn in the correct paperwork? So we are hoping to get some

additional information on that.

What we have tried to do is simplify the messaging. Some of the information that has come out from our department is incredibly complex, and I know that there are requirements and restrictions around what the department must put out. And so sometimes that makes it a little more challenging for them. So we are able to take that at our end and simplify down some of the education materials and resources that we use.

We work with the department, have them review it and approve anything before we print it and publish it and send it out.

The other thing that we have done is we are working really hard with our other community partners. So the message that is coming from our organization is the same message that is coming from other organizations across the state. We are all using social media and print materials and community presentations and everything. But we are trying to mirror the language that is being used across all of those presentations, so it is the same message even if it is coming from a different entity.

And then just a variety of communication modes.

Like I said, social media is usually fairly effective for the individuals with whom we work. Also short videos, community meetings. And we just spend a lot of time one-on-one. We are very lucky that we have outreach and enrollment staff who can walk through tools and resources.

We have also developed a website that walks somebody through even how to find an assister within Nebraska to help them through the application process.

CHAIR VERLON JOHNSON: Great. Any other thoughts?

ADELA FLORES-BRENNAN: Yeah. At the risk of, I guess, jumping ahead to one of the questions that we had, this is very much -- the unwind is very much on our minds. We had a fairly high number of people who disenrolled, and, you know, a lot of folks did come back on.

But we heard a lot of messages about just not knowing -- despite our best efforts, not knowing that they needed to take action or what action or just quite simply too complicated. And I don't think we are aided at all by the complexity of what we're rolling out several things at the same time, you know, having to try and communicate how to distill the population to whom this applies.

And so some of the things that we are doing, we have been lucky to be partnering with a national organization, the Center for Advancing Consumer Participation, and they got a grant from one of our local foundations. So they've been working for months, conducting focus group, key informant interviews, and working with Medicaid members, members of our advocacy community providers, et cetera, to develop a toolkit of resources. And that has been run through our members and then our member advisory group.

That is a toolkit, and it contains social media posts, newsletter content, flyers. So, to Amy's point about trying to make sure that there's a similarity in the message and look and feel, all of this content can be co-branded. There's instructions on how to use the materials, a playbook for using it, like here are the things that we're trying to establish, like awareness right now, and here are the things that -- everything has an action associated, like update your information with us, so we're contacting you in the way that you want to receive notifications, and we know that you've moved or you have a new email address, et cetera.

We have videos for lobbies, and then we're translating materials. So the first batch of all of this was, of course, for the qualified immigrant changes that came at the beginning of October. And then we are now populating more information into the work requirements portion of the toolkit.

And then alongside of that, we have two screener tools, one for qualified immigrants and one for work requirements, and people can interact with that screener tool to figure out if they may be one of the individuals who is required to either comply with work requirements or it really helps to establish whether they're an excluded individual or have an exemption. So those are some of the ways that we're trying to get to people.

We just rolled off our first ambassador program, and we'll be launching another ambassador program. That is a program that issues many grants to community-based organizations so that they can do the outreach and education as trusted local messengers in the communities.

And so the first one was, of course, with the immigrant population. We had six organizations around the state that were doing just engagement at that local level

to help just prepare those individuals for the fact that they would be losing coverage and to help people understand who was at risk of losing coverage.

So we'll do the same thing with work requirements and utilizing organizations who can reach harder-to-reach populations throughout the state.

CHAIR VERLON JOHNSON: Thank you. That's really helpful.

AUDREY FRENZEL: I just want to add one quick thing to that, which is what Amy and Adela mentioned with toolkits and pre-screeners. Indiana has been utilizing that as well.

I do think the one thing that is important to note, which is a state can meet the requirements of notification and communication to the members. But I think what the three of us are trying to stress is that it's not just meeting those requirements. It's understanding whether or not the communication that you're putting out there is informing and engaging and encouraging your member to have an individual behavior change that wouldn't happen without that.

And so one of the things that our data team --

and I cannot speak to the in-depth details of this, but they are able to look and see, okay, when we have a town hall, how many people are viewing that town hall online? And how many of them are then able -- how many of them go to their benefits portal and check whether or not they are going to be subject to these requirements? And if we have informational videos out there, at what point are our members leaving that video? Is it because they're bored and they don't want to listen to it anymore, or because we're not communicating something the right way?

So it's challenging ourselves not to just meet the threshold of what's required, but is what you're putting out there actually doing what you want and need it to do.

CHAIR VERLON JOHNSON: No, that's great. That's one of my questions was about the engagement. How did you track that? So you answered that question without even me saying it. So I love it.

One more question from the Commissioners, and then we're going to turn back to Janice and Linn. So I'll leave it with you, John.

COMMISSIONER JOHN McCARTHY: This question is for

Audrey. Audrey, one of the things here at MACPAC we are looking at quite a bit is monitoring, looking at how states and individuals will be impacted. Indiana is kind of having H.R. 1. So it was kind of not just H.R. 1 happening. There's a law that says through this that was passed, I believe, in the last legislative session.

I'm assuming you guys did some type of data fiscal analysis around that for the legislature in that, so kind of two questions. What did you use, and what did that data fiscal analysis say? And then, two, are you going to be using that? Are you going to be using that data, or are you going to be monitoring against some of those things to determine if some of the assumptions that you had made in that are what you're saying? And then if it isn't in line, what are those things that you're going to take a look at in doing?

AUDREY FRENZEL: John, thank you for that question. That is a fabulous question.

So, yes, we did a fiscal analysis for our legislature. We spoke with them ad nauseum about what implementing H.R. 1 in its own framework would look like versus the added layer of our state statute, and in some

ways, there is alignment between the two, and in other ways, the state legislation offers opportunity for additional consideration of the intersection between state and federal policy.

So we did a fiscal analysis. One of our primary drivers of cost -- and I should back up and say our fiscal projection is about $50 million for the first year of implementing H.R. 1 and S.B. 1 in Indiana.

And so a couple of components to that, we needed to hire 400 employees in Indiana to help us with eligibility processing and timeliness. I think somebody asked earlier about PERM. That's something that keeps me up at night. So we have hired 377 as of last Friday of the 400 FTEs that we were allotted to help us with processing that. That is a cost that we projected.

We had to project additional workspace because we have to have, you know, the patient-protected health information lockdown units.

One that might surprise people but is actually a very important factor is the cost of mail. It is incredibly expensive to send communications to members, especially if you're a state that's doing quarterly

compliance checks with six-month redeterminations.

And we have the extra opportunity to figure out how we are going to notify members that they might not be compliant with work requirements the month before they've actually completed them. So that's going to be really unique for our state.

So, yes, John, we did share the fiscals with our legislation, and, you know, I think moving forward, the way that, you know, we will try to, you know, make sure that we are keeping our finger on that but also working with our legislature is to make sure that we are looking for, you know, opportunities where we can do things like dynamic enveloping. You know, that's something that Louisiana and I talked about a lot during NAMD last week. But it also comes with its challenges.

So I think the concern is -- the SEA framework, Indiana's framework is possible. It is the time, the resources, and the humans behind it that are going to, you know, demonstrate whether or not that we have been able to do this in the best way that we can.

So looking forward to entering a budget session in our state. Hopefully, we will, you know, be able to

have some additional resources to help us with this, but definitely challenging.

Sorry, I went off on a diatribe, and I think I forgot your second question. I'm like, wow, somebody's asking me about the legislature. This is great.

COMMISSIONER JOHN McCARTHY: It was just how are you going to then monitor against that, you know, the other data that you had. So you projected certain things. You know, the point is, we are going to see this much cost because of admin costs. We are going to see this change in the Medicaid budget. We are going to see enrollment changes this much. All estimates in those things, how are you going to monitor against that going forward, and are you going to make those reports public?

AUDREY FRENZEL: So there are a couple of different ways we will monitor moving forward. Just because I know that I am long-winded, I will give you one good example.

We had more workers within the eligibility agency before, and we were able to look at each time we increased the number of employees, what that did to our PERM or our PERM rate. So, as we increased the number, our timeliness

got better, and our PERM rate went down. That is something that we have as a moment in time before. I'm hopeful that we will be able to use that in comparison to what we have now. But there are those additional challenges of making sure that you call out what the different factors are that impact something now versus then, and I think that is going to be very, very key when CMS is comparing states to states, because there were different opportunities of flexibility and levers that states could pull within those.

So, to answer that last question, will we be tracking? Yes. Will we make it public? Absolutely. Probably in a couple different ways in terms of publication, but also sharing it at State Budget Committee and throughout our legislative session coming up.

CHAIR VERLON JOHNSON: Thank you.

I'm going to turn it back to Janice and Linn, but Carolyn I would like your last question to them to be the magic wand question, what would be helpful for them. So I will turn it back to you.

JANICE LLANOS-VELAZQUEZ: Well, some of our questions have kind of been answered through the conversation. So there might be some time to flip it back,

but we will see.

So, Amy, you discussed the different outreach strategies that Nebraska has been using and that you have been using in working with the state to message work requirements to beneficiaries, but can you talk about some of the aspects of messaging that have been challenging in communicating these requirements to beneficiaries?

AMY BEHNKE: Yes. So I think the biggest thing is Nebraska has about 70,000 individuals in our Medicaid expansion population, but those individuals outside of calling our call center right now don't really have a way of knowing that they're part of the Medicaid expansion population until they get that notice from the state.

Our state is working on making some updates to our online portal, so somebody can log into their online portal and actually see that they're part of the expansion population, but that's several months out.

So, when we talk about long call wait times, that not being able to even understand or prepare for who might be eligible for or who might be subject to work requirements has been a challenging one.

I think the other piece is that there's just a

lot of information that needs to be communicated out to individuals. Who does this apply to? What are the exceptions? What are the terms that you have to -- you know, what are the requirements for meeting some of the work requirements? What do you have to provide primary source documentation for versus what you can provide via, you know, an individual declaration form? And so it's just -- it's a lot to share out.

And then I think we've had already a couple other mentions that work requirements is a piece of this puzzle, and so Nebraska has implemented this at the same time that we're talking about changes to immigrant eligibility and gearing up for six-month redetermination.

So it is just a significant amount of information that goes out, and as our processes in Nebraska evolve, that needs to be communicated then back to our outreach and enrollment staff, to the finance staff, the front desk staff at the health centers, so they're understanding what those changes are, and so they can share that information out to their patients as well.

JANICE LLANOS-VELAZQUEZ: And, Amy, you brought up enrollment assisters and staff on the ground. Can you

talk about their role in communicating with beneficiaries and the kind of questions that they have about these new requirements?

AMY BEHNKE: Absolutely. So I always say that our enrollment assisters are the most valuable tool that we have in this implementation process. Many of them have worked at the health center for a very long time. They are often from the exact same community as the patients who are walking through the doors of our health centers, and our patients will come back year after year to seek assistance. It's not uncommon for a patient to come in and meet with one of our assisters, and they have a letter from the Department of Health and Human Services that they haven't opened yet, because they know that they're going to walk it through, walk through the process with an assister.

They are able to explain the changes and what information is required. They are able to help somebody walk through, what if I'm self-employed, what if I'm a gig worker, how do I begin to track this information, and can provide a resource to that individual where they can share that information.

For us, they are also kind of our canary in the

coal mine, and so as issues develop, they're able to elevate those to us at the statewide association level, and we can share those with the department and maybe identify and troubleshoot some areas.

A good example is when we first started, there was something with our Spanish language line that was just broken, and we found out about it because our assisters were trying to access the Spanish language line and weren't able to do so. Once you hear that from multiple assisters, we're able to really elevate that and understand whether something is a one-off issue or whether it is a system-wide barrier.

They also receive notifications. All of our assisters, when they support somebody through the application or redetermination process, actually work with that individual to sign an authorized representative form, so they're receiving the mail that the individual is receiving at home. And so they're able to know if additional information is needed, if they've gotten their renewal information, and so they can reach out and contact that individual. It's been a lot of mail now that has come in to our assisters, but at the end of the day, that one-

on-one assistance is really important.

We've been inundated with this -- you know, this app will solve somebody's issues with having to apply for coverage, but being able to walk through and answer those questions and support somebody through making sure that they are gathering the right information, that they are submitting the right information, that still takes that one-on-one interaction, and those assisters are able to do that.

JANICE LLANOS-VELAZQUEZ: Thanks, Amy.

Adela, you mentioned earlier collaborating with different community organizations, and can you share how your state has prepared your eligibility workforce specifically to understand the new policy and how to respond to beneficiary questions?

ADELA FLORES-BRENNAN: Yeah. So that's very much still a work in process, and in Colorado, we are a county-administered eligibility workforce. So we have 64 counties, and they hire the eligibility workers within the counties.

So we're working with them right now on staffing plans and getting more information about how much

additional funding they may need to staff up, and then, of course, there's the work that we've already done on the toolkit to help with broader awareness.

In addition to that, we have been meeting with our county eligibility workers on a bimonthly basis for Q&A sessions so that we can help get in front of some of the questions that they have.

We have a resource center webpage for our eligibility workforce. So that houses learning materials and resources, and they can also access, as can the rest of the public, our webinars and other fact sheets and information that we're putting out on the website to help with just the general awareness.

It is really complicated, and like I said earlier, we're just starting the testing on the systems. So the formal training is still in development, and we should be rolling that out in November and then early December. So it's going to be coming really close to go live for the eligibility workers themselves.

JANICE LLANOS-VELAZQUEZ: And, Audrey, I know you mentioned also hiring some additional staff. Do you want to elaborate some more on other efforts that you're doing

to train the eligibility workforce?

AUDREY FRENZEL: So we have hired, like I said before, 377 as of last Friday, and we are allotted 400 employees to be able to help us with this effort.

I think from a training standpoint, it's something that we are actively doing but also continuing to do and developing at the same time, because there are extra pieces that are coming out.

And so I think kind of to Adela's point, we know what we know now. It's going to be very important for us to monitor what that looks like as a state.

So I feel like there will be additional, probably, training opportunities, you know, FAQ documents internally, externally, and things like that that will help our eligibility workers. But for right now, I feel like it's too soon to say what else is going to be needed and will be useful for the challenges that we potentially will run into.

JANICE LLANOS-VELAZQUEZ: Thanks.

Amy, can you discuss what beneficiaries and assisters are experiencing when contacting call centers in Nebraska? We shared some data earlier, but could you shed

some more light on what you're hearing on the ground?

AMY BEHNKE: Yeah. I think our biggest issue right now is call wait times. It is not uncommon to have a two-hour wait time to try to get through to somebody at the state, and we discovered several weeks ago that there's actually some sort of glitch in the system that is a system issue, not a department issue, that after two hours, you're automatically disconnected. And so then you have to call back.

So, you know, three-, four-hour wait times were mentioned earlier. That includes getting booted from the system after two hours and calling back in and then being on hold again, and so that's something that we have raised. I know it's something that the department is working on. I think the challenge is when it's a system issue and your call system is something that is shared across departments in your administration, it makes it really challenging to solve those issues. So that's probably been the biggest concern that we are facing.

We're also seeing some increase in application processing timelines, and again, it's, you know, more complex information, additional information. Additional

staff haven't been hired, and so the staff at the state are really doing more with the same level of caseloads.

And then I think to the education piece, it's just an ongoing learning process, both at the state level and for us, and so there has been some inconsistencies in information that has been given out to our outreach and enrollment staff as they are calling in to ask some questions.

So I know that our department is doing things like Lunch and Learn listening sessions where the call center staff can come in and say, you know, "This is a question I got today from a client. How would you answer this?" and really learning from those pieces as well.

We have had one instance in a rural community where the local office in the rural community has stopped taking some walk-in appointments from individuals and actually is referring people to the community health center for support, so, again, something also that we've raised as well.

But I think what we're seeing is that we have people with lots of questions and some need for assistance. Some of our staff are just spread thin.

JANICE LLANOS-VELAZQUEZ: Thanks, Amy.

And this question is for Audrey. Adela, you spoke earlier to Colorado's collaboration with community organizations. But, Audrey, do you want to speak more about your collaboration with community orgs and health centers or MCOs to get the message out?

AUDREY FRENZEL: Yeah, I appreciate that.

So for us and similar to what was mentioned before, we came up with a provider toolkit that we shared with providers, you know, in the community, but also for, you know, hospitals, doctor's offices. And the reason that I made that distinction is because I went to my own doctor's office a couple weeks ago, and I was sitting on that little crinkly paper table. And I looked over at the wall, and I said, "Oh, my goodness, that's our Healthy Indiana Plan work requirements flyer." So I'm excited to see that at least Dr. Cynthia Kizer in Indianapolis, Indiana is utilizing our provider toolkit. So I'm very excited about that.

The thing that I think is going to be really helpful for us and instrumental -- and I'm not sure whether, you know, other states have their own policies or

whatnot -- it's going to be our data sharing, I think, with our MCOs when it comes to medical frailty is going to be a big thing. I think that we are going to likely experience a lot of churn in our Medicaid population.

We did unwind delayed here. So we're seeing people -- we're seeing our enrollment numbers drop right now. I think work requirements is going to add to that.

But, you know, the MCO history of claims for a person who may have been enrolled in Indiana Medicaid prior, who might not be and is in the future, that will be very helpful for us kind of putting together a picture of that person.

And then I think outside of that, really, there is one thing that Indiana is not doing yet, but we are exploring how we can do this. And I think Kentucky is doing it. I said this last week, and I regret that I have not followed up with Kentucky yet. But I think what they have done is they have put on the Provider 271 forms, what an individual's next redetermination date is, and so that way, if a person who is subject to work requirements comes in and sees their doctor and they pull up the form, it says, very clearly listed, hey, this person is subject to

their next redetermination date, July 1. And I think it's incorporating those pieces of information at every opportunity, because we're limited on the number of people that we can really work with to get out and spread the news unless you are a good Samaritan, which I will take.

If anybody wants to come out and share the news with me, I'd love that. But in terms of people who are contractually, you know, working with us, there's only so many things that we can do to give them -- or places where we can give information that makes it easier.

So MCOs with medical frailty and then providers, hopefully, with just keeping people aware of what their "redet" date is and the types of things that they need to do to be able to maintain the coverage is going to be critical.

JANICE LLANOS-VELAZQUEZ: Thanks, Audrey.

And, Adela, is there anything you'd like to add about Colorado's work with MCOs or providers?

ADELA FLORES-BRENNAN: Yeah. So I didn't really mention the MCOs and providers before, but we are meeting with them on a regular basis; the MCOs, that is.

And then I have a couple of roundtables that we

are in the process of getting scheduled to meet with, especially our primary care workforce, so that we can both make sure they understand what's happening and what to expect, but also to start getting some feedback from them on how it will look moving forward to verify the medical frailty component of the work requirements. So that's something that we're working on developing right now.

And I was just looking at my notes to see if there was anything else. I think I covered most of it, though.

JANICE LLANOS-VELAZQUEZ: Thanks.

And, Amy, from a health center perspective, I know you already mentioned you meet with the state regularly. Is there anything else you'd like to share about how you've been collaborating with the state and other organizations on work requirements?

AMY BEHNKE: Yeah. I mean, I think I talked a lot about the state. I'll touch briefly on the MCOs.

So, from the provider perspective and how we're able to work with them, we have three Medicaid MCOs in the state, and two of them who are working with our health centers -- not with us directly, obviously, from a

confidentiality perspective, but working with the health centers to provide some additional data and information on the health center's attributed patients.

And the goal is that they'll be more able to proactively reach out to their patients, whether it's through their texting service or through phone calls or, you know, at an upcoming visit, to help educate them.

I think that that has been a heavy lift for our MCOs to kind of sort through that data and figure out how to get it to the health center in the best format.

So now that we are really kind of into the thick of implementation of work requirements, we're also figuring out how we might be able to access denial data through the MCOs, so we can do some follow-up with patients if their coverage has been denied to see if it is something procedural or administrative where we can help them and they are, in fact, eligible, and we can help them follow up with the resources that they need.

So it's complex, and Audrey and Adele know that better than I do, but we are certainly working through that process.

JANICE LLANOS-VELAZQUEZ: Thank you.

AUDREY FRENZEL: What do they say, Amy? If you know one Medicaid program, you know one Medicaid program. I'd say you've got it worse going first.

My chief of staff in the governor's office keeps looking at me asking why we can't be like Nebraska, our big older brother.

JANICE LLANOS-VELAZQUEZ: Well, thank you, and those are the questions we had. So, Verlon, I can pitch it back to you.

CHAIR VERLON JOHNSON: All right. And I will have Carolyn ask the question.

COMMISSIONER CAROLYN INGRAM: Thank you.

I wanted to know from all three of you, actually, if you had a magic wand and you could get help either from us or CMS, what would be the help you -- or I guess somebody else, too, but what would be the help you'd ask for?

ADELA FLORES-BRENNAN: I can't think of much beyond time.

COMMISSIONER CAROLYN INGRAM: Time is a good one.

ADELA FLORES-BRENNAN: I mean, if I really had a magic wand, I would say making this whole thing optional

would be fantastic, and then I might maybe take the option to not do it at all. But to the extent that that magic doesn't exist, then perhaps more time to execute it with fidelity and intentionality and do all of these things that we're hoping we're doing to make it less impactful on our members.

But it is challenging and confusing, and even when we were presenting on Monday at our webinar, I couldn't help but think, I hear the words, I see the words, but I only know what the heck we're talking about because I've been in it for a long time. I can't imagine that this even makes sense to anyone else. So that was kind of a harsh real-time realization to have in the middle of a webinar for 4,000 people. Yeah, I guess time would be the biggest thing

COMMISSIONER CAROLYN INGRAM: I appreciate that.

Audrey and Amy?

AMY BEHNKE: Gosh, I'm trying to think how to answer that.

I think if there was any way to simplify and ease the burden on an individual and going back to what people understand and what they don't understand -- you know, an

individual walks into a health center and they may have -- their insurance card is from UnitedHealthcare or it's from Centene. It doesn't say, "Congratulations. You're enrolled in Medicaid and you happen to be part of the expansion population." And so for a lot of our patients, they may understand that they have health insurance coverage, but not all the detail behind it. And so now when we're asked to do these additional steps, it's challenging for individuals, and it can be frustrating.

And some of what we've started to hear is if you're a young, relatively healthy individual, you may just walk away from the chaos altogether, and what we don't want is for people to not have health insurance. And so simplification, I guess, would be my magic wand.

AUDREY FRENZEL: Gosh, I think mine is really in line with the both of you, honestly.

From a philosophical standpoint, I think that for ABAWDs, work requirements is a good thing, and I think that it has come to show, it builds resilience, strive for achievement, reduction of social isolation, things like that. So from that standpoint -- and I guess maybe it's not necessarily work requirements, but somebody having

something that they feel a purpose towards.

So I'm hopeful that individuals are able to find that where they're at in their job level, whether or not it's them needing training to get to the workforce or being able to come into the workforce. But I think if I had a magic wand, it would be to have people understand the math of Medicaid.

A person who is disenrolled from the Medicaid program doesn't save Indiana State General on any money, and that is going to have an impact when they show up as an uninsured person in our hospital.

And we have additional challenges with the hospital assessment fee and the state-directed payments and provider taxes and challenges within our state of having highest hospital payments for the commercial population.

And I say all these things, and it's like, well, that doesn't sound like it's related to Medicaid, but it really is. And so if I had a magic wand, it wouldn't be to necessarily make work requirements go away or anything like that. It would be to have the people that were going along with me, whether it's my legislature or my administration or just community members, understand the math of Medicaid.

COMMISSIONER CAROLYN INGRAM: Very helpful. Thank you. Very thoughtful comments. Appreciate all of you for sharing today.

CHAIR VERLON JOHNSON: Yeah, absolutely. I love that question. I love the answers. And I love that all of your names start with an A. I think that that means something for us, for sure, but very helpful.

Again, we want to thank you for your time. Thank you for your knowledge. Thank you for your insights, and I hope people out there in the world heard your wishes, too, as well. So thanks again. We appreciate it. Have a great day.

And to Janice and Linn, thank you all for organizing the panel. Do you want to just pause for a moment and see if there's any additional reflections from our Commissioners out here as we close out this section?

Sonja.

COMMISSIONER SONJA BJORK: It might be too early for anyone to tell yet, but I'm very interested in the lookback period for establishing the compliance with work requirements. So when someone's just finding out they had cancer, they might have been sick. So they didn't work or

do community engagement the month before. I just am curious of how are we going to figure out the impacts of that, because they might have a delay in getting eligible. Now they are sick, and they have to start treatment. So it might be even harder to meet the requirements.

And I think it is too soon, because it's all just starting. But I'm just curious of how can we track that. How can we keep an eye on that? Because it can't just be anecdotal, but maybe it will be.

So I'm sorry I'm just wondering aloud, but I was just wondering from our expert staff, do you have any ideas about how to keep an eye on that?

JANICE LLANOS-VELAZQUEZ: It's something we will brainstorm.

CHAIR VERLON JOHNSON: Good points, though.

Heidi.

COMMISSIONER HEIDI ALLEN: Yeah, thank you so much for the panel -- it was really excellent -- and for all of this work. It's so much to think about.

I am curious to see if anybody's tracking work, to see if there's -- actually how many people will get jobs related to this process, because that seems like if that

was the intent, that should be a really important metric.

And I still keep coming back to this idea of mental health care and particularly that the symptoms that would keep you home and unable to work could also be what keeps you from accessing care, and that even if you wanted to access care, we just know it's really difficult.

And yet I am sensitive to the issue that was raised about the fact that so many people have depression, and so many people are on antidepressants. So that doesn't mean that you can't work, and if we said, well, you're on an antidepressant, so you can't work, that that's not the specificity that they're looking for.

But there just really is a problem with the thinking of using a claims-based approach for something like major depressive disorder, where people do have trouble getting out of bed, and we don't want to make the claim necessary.

I'm a social worker, right? So if I were a social worker in Indiana, what I'd be telling people is, well, go to the emergency department, because you need a track record of acuity. But the criteria for hospitalization or what you think the criteria for

emergency department should be is imminent danger to self or others, right?

When I would assess people in the ED, that's what I would determine for a hospitalization, and yet now there's this perverse incentive that you have to generate a claim that shows acuity. And the easiest and the quickest way to do that is not to find a behavioral health care provider who will see you, because even then, the question is, how do they document in a claims-based system, your acuity? Because you can't, right?

So the only thing you can do is say, "Go to the emergency department. You're going to spend a day there, and they're going to tell you to go home, because you don't meet criteria for hospitalization. But then you'll have something in your record that shows that you are sick enough for Medicaid." That's not what we want. And so I'm very concerned about that particular subset of people, because mental health disability is one of the leading causes of disability in America, and depression is one of the most significant, and PTSD, one of the most significant parts of that.

And so I think we just need to watch that very

closely, particularly in states that aren't allowing self-attestation. If you were able to say that you're that depressed, then I feel like there's a mechanism, but if that doesn't exist, then I'm really very concerned about that population.

CHAIR VERLON JOHNSON: Thank you, Heidi.

April and then Carolyn.

COMMISSIONER APRIL HARTMAN: I'm glad I'm speaking right after Heidi, because this kind of piggybacks on that.

I think it concerns me that physician documentation of medical frailty is going to play a part in this, just because we know historically that there's all kind of bias and your politics and ideology and everything else comes to play, and a lot of disability is invisible. So the ones that are obviously disabled are no problem, but the ones that have significant disability that is not obviously visible right away, I worry that we're going to see a lot of disparities and people being told, "Oh, yeah, you could go to work. It'll help you get over that depression or that anxiety or whatever to go to work," without really taking into consideration and having an

understanding of how disabling some of these conditions can be. And so I just have a lot of concerns around that.

And I hope that if we look at people who it gets to the point where the physician has to document just what kind of framework, what criteria, what are they putting out that says this is how you do it, d they have to go through any kind of trauma-informed care training? How are they trained to be able to look at this as objectively as possible so that the people who need it are getting it, even if their disability is not readily apparent just by looking at them?

CHAIR VERLON JOHNSON: Thank you, April.

Carolyn?

COMMISSIONER CAROLYN INGRAM: I found the comments at the end really insightful, I think, from each one of the folks and kind of reiterated that we're seeing all this action now and things, but we haven't even seen what's going to happen next when the people end up without insurance that we're talking about, the people with mental health or substance abuse issues or otherwise, at a local hospital or in a rural community, and they can't get care.

And that coupled back together with the changes

that are coming on the state directed payment side and all the other challenges that we just heard about in terms of costs for hospitals, small providers, I think there has to be something done to look again at the rate process and what's going to be done to support these small providers in rural communities and maybe not even just the small ones, but all the providers in those communities. So really concerned about that and hope that we will continue to think about that or look at what states are starting to think about and doing in those areas to make sure that people who have these hidden disabilities keep access to care.

CHAIR VERLON JOHNSON: I agree. Thank you.

Tim?

COMMISSIONER TIMOTHY HILL: Thanks.

Just a couple points and to riff on some of what's already been said first. Just like filled with kind of gratitude, right, just to all the work that's going on? And this is like a really complicated, hard thing to do, and even to the comments of the presenters, if they had to do it over again, if they had a magic wand, maybe they wouldn't do it. But they're being creative and vendors are

being creative, and people are trying to do this in a way that's going to make it least disruptive to folks as they can, which is gratifying to hear.

Having said that, I kind of echo Heidi's point. It's like, where's the evaluation of this? Is this working? And this is a theme that we've kind of talked about, and I think it's kind of the same notion, which is what is the real impact here? And it's not just work requirements, but it's the culmination of everything that is kind of coming through the system as we head into January, reductions in state-directed payments, the changes to the financing rules, the payment rate changes. Are people -- you know, there's just a lot to understand, and we are very focused appropriately on like what has to happen in the next six months to make this work.

And it's very micro and implementation-oriented, but at some point, either we or somebody needs to step back and say, what is the impact? What is the cumulative impact here? And how do we evaluate it to be sure that we're not actually hurting people by implementing these things, which we all thought were a good idea to make the financial footing of the program better?

CHAIR VERLON JOHNSON: Thank you.

Anyone else?

[No response.]

CHAIR VERLON JOHNSON: Okay. So, once again, thank you, Linn. Thank you, Janice. We appreciate all your efforts on this for sure.

All right. So now we're going to open the floor for public comments. We do invite everyone in the audience to raise their hand if you'd like to offer comments. Please make sure, though, you introduce yourself and the organization you represent, and as always, we ask that you keep your comments to three minutes or less.

The floor is open.

PUBLIC COMMENT

* [Pause.]

CHAIR VERLON JOHNSON: All right. Seeing no comments. If you do have comments later, please feel free to submit those through our website, MACPAC.gov.

And with that, we will go to break, and we will return at 3:15 Eastern time. Thank you.

* [Recess.]

CHAIR VERLON JOHNSON: All right. Welcome back.

Our next session continues our work on utilization management for medications for opioid use disorder. With that I'll turn it to Sheila and Anu.

UTILIZATION MANAGEMENT FOR MEDICATIONS FOR OPIOID USE DISORDER (MOUD) IN MEDICAID

* SHEILA SHAHEED: All right. Thank you, Madam Chairwoman. Today Anu and I will be presenting our claims analysis findings from our work on utilization management for medications for opioid use disorder, or MOUD, in Medicaid. As you will recall, last month we presented findings from our literature review and our interviews.

Today we'll start with our policy and research questions, and I'll provide a high-level summary of our findings from September, before I explain our claims analysis methodology. Then Anu will dive into the key findings from our claims analysis. We'll finish with our next steps and questions for Commissioner discussion.

Our key policy questions for this project was: do utilization management strategies, such as prior authorization, or PA, and daily dosage limits, enable states and managed care organizations, or MCOs, to ensure appropriate and timely access to MOUD while also managing

costs.

Our research questions for the quantitative analysis centered around the effects of removing PA for buprenorphine/naloxone and the effects of raising the oral buprenorphine daily dosage limit to at least 32 milligrams per day on MOUD use and other clinical outcomes.

So I'll briefly go over our background. As you all may recall, the first phase of this work examined federal policies and funding that affected access to MOUD, such as the 2018 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities, or SUPPORT, Act, and the 2024 Consolidated Appropriations Act, in addition to providing an overview of MOUD coverage, including estimates of use and barriers to access. Additional information on other barriers that we found in our first phase of work can be found in our June 2025 chapter, but notably, MACPAC found persistent barriers impacting access, including but not limited to, prior authorization and daily dosage limits.

The second phase of work examines the impact of these utilization management strategies on access to MOUD for Medicaid enrollees, and our claims analysis, in

particular, compares the outcomes in states that changed their policies (i.e., removed prior authorization, increased their daily dosage limit) to states that did not change their policies.

As a quick reminder and as additional context to some of our claims analysis findings that Anu will share later, in our first phase of work we found that in fiscal year 2022, approximately 1.4 million Medicaid beneficiaries, age 18 to 64, with opioid use disorder, or OUD, received some form of MOUD. We also found that nationally the share of beneficiaries receiving MOUD increased from 63 percent in fiscal year 2017 to 71 percent in fiscal year 2022.

State Medicaid agencies and MCOs have flexibility to apply PA to health care services, including MOUD and related treatments. But federal statute and rules that some general requirements, including a required response time of 24 hours for PA requests.

States and MCOs implement PA requirements on medications to control costs and ensure MOUD is prescribed appropriately, but overall findings are mixed when it comes to these outcomes, as we reported in September.

We also found that PA can cause delays and disruptions in care at multiple points during treatments, and that these delays can inhibit a patient's ability to start or continue MOUD. Several states that we spoke to during our interviews indicated that they have flexibility in designing PA policies, and that decisions on which drugs are preferred, which typically means that PA is not required for these drugs, are primarily cost-based and depend on supplemental rebates.

As we reported in September, daily dosage limits typically follow FDA labeling and clinical trial findings, but may fail to keep up with changes in clinical practice. In December 2024, the FDA asked manufacturers to update their oral buprenorphine product labels to clarify that neither 16 nor 24 milligrams per day should be interpreted as maximum dosage for these medications, and that although dosages higher than 24 milligrams per day have not been investigated in randomized clinical trials, they may be appropriate for some patients.

Daily dosage limits are intended to ensure that prescriptions align with clinical standards, but as we have shared, can pose barriers to access to treatment. The new

FDA guidance may make it clearer to clinicians and payers that doses above the 24 milligram amount may be appropriate and should not automatically be considered off-label use. However, as of fiscal year 2023, 38 states still had daily dosage limits of 24 milligrams per day or lower. These states may be concerned about budgetary considerations or the risk of diversion with higher doses. Additionally, some states have also implemented dose tapering policies, requiring that dose limits be lowered after a specific period, which may be misaligned with FDA guidance.

The objective of our claims analysis today was to better understand how states and MCOs use utilization management strategies for MOUD, specifically oral buprenorphine, and the impacts on Medicaid and CHIP enrollees. We used a synthetic difference-in-differences analytic design to compare changes in outcomes in states before and after a policy change, to changes in outcomes in similar states that did not make that policy change. Our sample included full-benefit, non-dually eligible Medicaid and CHIP enrollees, age 16 to 64, with OUD, between calendar years 2019 through 2023.

In our first model, we compared changes in

outcomes in states that removed PA requirements for at least one oral buprenorphine/naloxone product, also referred to as the combination product, to states that did not remove PA for the combination product. We looked at state fee-for-service DUR reports to assess these changes in PA policies.

In a second model, we compared states that increased their daily dosage limit to at least 32 milligrams per day to states that did not increase their limit to at least 32 milligrams per day. We examined three outcomes related to oral buprenorphine utilization as well as opioid-related overdoses, and ED visits.

Now I'll pass it to Anu to discuss the findings from our claims analysis.

* ANUPAMA WARRIER: Thanks, Sheila. I'll start with presenting some descriptive trends from the claims analysis to set the stage, before diving into the results of the difference-in-differences analysis.

On this slide we show the percentage of individuals enrolled in Medicaid and CHIP with OUD who had at least one oral buprenorphine prescription in that year. We see that between 2019 and 2023 this share increased from

35.5 percent to 39 percent, which is an increase of around 3.5 percentage points.

However, over the same time period, the share of enrollees that experienced at least 180 days of continuous treatment with any type of MOUD dropped by 3 percentage points. Conditional on having at least one oral buprenorphine fill in the year, the share with treatment continuity declined from 58 percent to 55 percent. This contrast suggests that improvements in treatment initiation may not have been sustained into improvements in treatment continuity.

We then examined the share of enrollees that experienced an opioid-related overdose in a health care setting, with and without at least one oral buprenorphine prescription in that year. The upper trend line shows that the share of all enrollees with OUD that had an overdose increased temporarily in 2020 to 2022, but returned to 2019 levels by 2023, and the lower trend line follows that same pattern. We also see that the rate among enrollees with at least one fill was lower than the overall rate by about 2 to 3 percentage points in all years.

Here we have the share of enrollees that

experienced an opioid-related ED visit, with and without at least one oral buprenorphine prescription in that year. The upper trend line shows that the share of enrollees with OUD with at least one opioid-related ED visit decreased by around 2 percentage points between 2019 and 2023. Similar to the last slide, rates are lower for those who had at least one oral buprenorphine fill, and we see that for both groups the decline happened more recently, between 2021 and 2023.

Now we'll move on to the findings from the difference-in-differences analysis, starting with the PA model.

In this model there were five treated states that removed PA requirements for at least one combination product according to their fee-for-service DUR reports. We compared them to a synthetic control group made up of states that did not remove PA, meaning that they had no policy change or added PA between 2019 and 2023. Here, the five treated states are colored in green.

In the PA model, we looked at four outcomes, which are listed in the left-most column. There was only one statistically significant finding at the 5 percent

level in this part of the analysis, which we have called out in red here. In states that removed PA for the combination product during the study period the policy was associated with a statistically significant 13 percent increase in the adjusted rate of oral buprenorphine fills relative to the control group.

We then conducted a lagged analysis to assess how effects may have changed year over year. We were able to include three of the five treated states in this analysis, as these three states removed PA in 2020, and gave us a three-year follow-up period.

This figure shows us the size and significance of the year-over-year treatment effects. In the three early implementer states we see that by the end of year 3 post-implementation, which is 2023, the volume of oral buprenorphine fills significantly increased by 18 percent. And visually you can tell this is statistically significant because the confidence interval does not cross the horizontal line at zero, as it does in the previous years.

Starting in 2022, we see that opioid-related overdoses significantly declined by 1 to 2 percentage points, with the treatment effect growing stronger by 2023.

And then looking at opioid-related ED visits, we see that ED visits significantly declined by 1 percentage point by 2023.

Now moving on to the daily dosage limit model. In this model there were 11 treated states that increased their daily dosage limit to oral buprenorphine by at least 32 milligrams per day, between 2019 and 2023, based on claims. The treated states are colored in green. We compared them to a synthetic control group made up of the dark gray states that stayed the same or decreased their limits. We excluded the states that are colored in dark blue and light blue, because they made other changes that did not provide a clean comparison for the treated states.

We looked at three outcomes, which are listed in the left-most column. In treated states, the policy was associated with a 1 percentage point decrease in opioid-related ED visits relative to the control group.

This analysis had several limitations. In our PA analysis we had to solely rely on the DUR reports because claims data do not record use of PA. However, the question on PA in the DUR reports does not represent the totality of PA requirements for MOUD in a state Medicaid program. For

example, states could have PA policies in place for other combination products, the mono product, or extended-release forms. States could also have additional restrictions for a specific situation, such as a higher dose or an early refill.

Second, we only reviewed fee-for-service DUR reports in this analysis and not managed care DUR reports.

Third, and this is somewhat related to the first limitation, we do not have data on baseline PA rates in each state. Having that information would help us understand how effective removing PA would be in a given state. For example, if a state had strict requirements and a high denial rate, we would expect the effect of removing PA to be greater than in a state with loose PA criteria and a low denial rate.

Fourth, states may still be in the process of increasing their daily dosage limit, given December 2024 FDA labeling guidance, and as such these changes would not be reflected in the 2023 DUR reports or claims data.

Finally, these models are policy-specific and did not account for overlapping policy changes. For example, the PA model does not control for states that made changes

to their daily dosage limit during the same time period.

Now for some key takeaways and next steps on this project. From the PA analysis we found that removing PA for at least one combination product was associated with an increase in oral buprenorphine fills and decreases in opioid-related overdoses and ED visits over time. In fiscal year 2023, three states do not have any combination products available without PA.

Our findings on removing PA are consistent with a state-specific study and another study on Medicare Part D.

And then to tie it back to what we learned from our interviews, many interviewees reported that PA can cause several days' worth of delays in getting access to medication, and some interviewees shared that they consider PA to be an ineffective utilization management policy compared to other policies like retrospective reviews of claims or other data, and point-of-sale safety edits used at the pharmacy.

With the daily dosage limit analysis, we found that increasing daily dosage limit for oral buprenorphine to at least 32 milligrams per day was associated with a decrease in ED visits. And just like in the PA analysis,

we did not find any evidence that increasing the daily dosage limit to at least 32 milligrams per day had increased the rate of opioid-related overdoses, speaking to concerns about patient safety with the availability of higher doses.

Our interviews with several providers also indicated that dosage limits may be a barrier for populations that need higher doses to stabilize, such as those who have used fentanyl or who have been on opioids for a long time. They shared that inadequate doses of buprenorphine can destabilize patients and put them at risk of relapses or overdose.

And finally, according to our review of both the fee-for-service DUR reports and claims data, we found that in 2023 two states still limit daily dosages to 16 milligrams per day, both in policy and in practice, while most states are around the 24 milligram amount, according to both DUR and claims.

For our next steps we welcome your reactions to the findings and any questions from the Commission based on the evidence presented. This slide notes some particular areas where we would appreciate your feedback. And based

on Commissioner input, staff may return with draft policy options in January. We will synthesize the qualitative and quantitative findings for a chapter in the June 2027 Report to Congress.

Thank you.

CHAIR VERLON JOHNSON: All right. Thank you so much. That was very helpful. Can we maybe stay on this slide just to give Commissioners things to think about. We'll start off with Patti.

COMMISSIONER PATTI KILLINGSWORTH: Fascinating work. Thank you both. And I'm going to defer almost everything to Doug. But I have a couple of questions. It's very intuitive to me if you remove the PA that you're going to see higher utilization. I mean, that's sort of the purpose of prior authorization. So all of that made a ton of sense to me. I was a little bit more interested in the reductions in overdoses and ED visits. I thought that was a little bit more compelling.

Here is what concerns me, is the time frame and the ability to control for other things that were happening during that time frame. So it doesn't surprise me at all that we see these upward trends during COVID time and

during a time when I think we were doing less with respect to MOUD. And then now, I think states have a lot of different things that they're doing. It's not my area of expertise, but when I think back to my time in state government, there was a lot of activity going on.

So it's really hard to point to one thing and say, "Oh, that was the thing that reduced trips to the ED or an overdose," or "That was the thing that reduced overdoses," because there were a lot of interventions that were happening simultaneously. Add to that then the impacts of COVID and what we saw happen with respect to mental health and substance abuse during that period of time, and it's just really hard for me, with that dataset, to draw conclusions.

The other thing I would just say, and this is where I start to defer to Doug, is this makes me so anxious. When I think about the struggles that we have faced as a country and all of the lives that have been lost to opioid use disorder, lifting what feel like reasonable controls just makes me a little bit anxious, unless it's just so clinically sound, to make sure that people have appropriate access and that there are still ways to

mitigate risk.

So with all of that I'll be quiet and defer to Doug.

CHAIR VERLON JOHNSON: I'm going to officially say Doug.

COMMISSIONER DOUG BROWN: Thank you. I do not have all the answers, Patti, but I was also thinking along the same lines for some of the same comments.

I want to start with kind of going back to where we kind of started today. Many states don't have prior authorization on at least one of these types of drugs, the combo product, so that doesn't require prior authorization in most all states, 47, 48 states.

You also mentioned towards the end that some people that you interviewed talked about an extended period of time to get a prior authorization. So I want to make sure that we're talking about pharmacy prior authorization, which in the notes here, 24 hours. My experience has always been pharmacy authorizations are done in 24 hours. Medical authorizations for behavioral health, in this case, could take longer. I don't know what the law says around that.

So those prior authorizations where you're referencing longer periods of time and patients could decompensate during that time, is that for a medical prior authorization or is that a pharmacy prior authorization?

ANUPAMA WARRIER: So the interviews that we were referencing were with the providers who are speaking about the time from prescription to when their patients report receiving the medication. Then we spoke to one individual with lived experience who said the same. So their perspectives may be speaking to the process from kind of prescribing to receipt of medication.

COMMISSIONER DOUG BROWN: Okay.

ANUPAMA WARRIER: So there obviously could be some nuance in there about how each individual part of the prior authorization, how long each part took. So that's where we don't have that information from the interviews. We didn't go into that detail. But we can double-check the interviews.

COMMISSIONER DOUG BROWN: The other information that I would want, if we're going another step here, is I don't know what the rate of relapse is for people who are on an MOUD product and how often or how frequently they

would relapse and end up in the ED. It's a long journey, right, for this treatment.

After COVID we had the law change in 2020, which is between the two time periods that you looked at, 2019 to 2023, the law changed, which is why you see some of those states relaxing their criteria. Is telehealth playing a role in better access, which would increase the number of patients that are able to use it? Are there more prescribers today than there were in 2019; to increase the number of prescribers so the patients don't have to wait as long to see a physician for scripts? Those are some of the things that I think would help us round out some of the data that you saw here.

I'm going to stop there. I know there are other Commissioners that have comments, and I want to make sure we hear all of them. Thank you.

CHAIR VERLON JOHNSON: Thank you, Doug. Heidi, and then April.

COMMISSIONER HEIDI ALLEN: Thank you for this work. It's super cool.

I am not as worried as some of my fellow Commissioners about these other things, because you did a

synthetic control difference-in-differences, correct, which is meant to try to address all of the confounding other things that could be explanatory variables. I mean, I think that's the kind of rigor that you really need in these policy analyses to know whether or not you're looking -- it's the best you can do, okay. I mean, I guess that's what I have to say. You never can randomize people to these kinds of conditions, and the best that you can do is to try to use rigorous empirical methods to isolate your explanatory variable, and you did it in this case, so I feel like you can have confidence in the results.

One question that I had is it wasn't clear to me in the written materials how you defined an overdose. Was that from a specific code or claim? Can you speak to that?

ANUPAMA WARRIER: Yes. You know, I have the codes available in the methodology, which I can send later. But it was based off of claims, and they looked for those, that set of claims that indicated an opioid-related overdose in any health care setting. It's not restricted to a hospital.

COMMISSIONER HEIDI ALLEN: Okay. That's great to know. I figured it was that. So what I would say is that

this is a signal. I think it's a really important signal, and it would make me want to look into the mortality data. Because an overdose that makes it to a care site is a good overdose. An overdose that doesn't make it to a care site is not in that dataset. And so if you're seeing a statistically significant reduction in overdoses I think you want to look and see if you see if it saves lives, because that would be a very compelling story for reducing or eliminating prior authorization in MOUD.

And that's all I wanted to say. Great work. Thanks.

CHAIR VERLON JOHNSON: Thank you. April, and then Adrienne.

COMMISSIONER APRIL HARTMAN: Around 2023, naloxone became a whole lot more available, even without a prescription. And I just wonder if you looked at the number of pills. If you have Medicaid and even though you can get naloxone without a prescription it will be covered if you have a prescription. So I just wonder if you looked at naloxone prescriptions also as part of that preventing overdoses, if the number of prescriptions helped decrease overdose, if you saw any information on that. That was

just a side.

The one thing that I really was interested in is seeing your information broken out by age group. I'm just wondering if some things might have been more effective for different age groups, especially the younger, maybe the 16- to 18-year-olds, if a lot of these interventions really work to keep them out of the ED, if they were more or less likely to follow the treatment. I just think it would be helpful to see it broken out a little bit by age group also. Thank you.

CHAIR VERLON JOHNSON: Adrienne.

COMMISSIONER ADRIENNE McFADDEN: Yeah. I'd like to just echo a couple of things that I think my co-Commissioners were alluding to, that this is likely signaling just increased activity policy-wise in some of these states. So it's hard for me to immediately draw the conclusion that the prior authorization lifting is really what drove these results.

I would love to see, to Doug's point, understanding more about the number of prescribers for MOUD as part of this dataset. Additionally, actually the setting of the prescriber. There has been a big push for

the last 10, 15 years in emergency medicine -- I'm a recovering ED doc -- to have emergency providers actually prescribe the first dose of MOUD when somebody comes in for an SUD-related overdose. And so I'd love to just see ED-related prescriptions versus primary care-related prescriptions, et cetera.

CHAIR VERLON JOHNSON: Thank you. And Jenny.

COMMISSIONER JENNIFER GERSTORFF: I had a methodology question, maybe questions. If you go back to Slide 11, just as an example, I'm particularly interested in this metric with the treatment continuity and how that's decreasing. But what I wanted to understand is the methodology for the analysis here. Is it continuous over the period, or is it individual years?

ANUPAMA WARRIER: So this is slightly tricky. So 180 days was kind of the requirement for continuity for the treatment, so that means they should also be continuously enrolled, and sometimes that had to bridge multiple years. So this population is slightly smaller than the population with other measures that we presented, just because of that slightly additional restriction of actual enrollment continuity, in addition to the treatment continuity.

COMMISSIONER JENNIFER GERSTORFF: That makes sense. So is it truncated at the end with people who would initiate treatment but you wouldn't be able to measure 180 days? Are they taken out of the sample?

ANUPAMA WARRIER: You mean by 2023?

COMMISSIONER JENNIFER GERSTORFF: Mm-hmm.

ANUPAMA WARRIER: I'd have to go back and look and consider that.

COMMISSIONER JENNIFER GERSTORFF: Okay. And then also along these same lines I would be interested in the average gaps in treatment, so if that's changing over time.

ANUPAMA WARRIER: I think there's a lot to dig into, potentially, with treatment continuity, potentially looking at, like you said, the gaps, the average number of days in that gap, and then also were there certain types of dosages that were more continuous than others, maybe higher dosages have less continuity, things like that. I think there are a lot of interesting things to dig into, but we'll have to take it back and consider that for future work.

COMMISSIONER JENNIFER GERSTORFF: That sounds great. Thank you.

ANUPAMA WARRIER: Thank you.

CHAIR VERLON JOHNSON: Great questions. All right, Mike.

COMMISSIONER MICHAEL NARDONE: I just had a methodological question. I noted that there was this discrepancy between characterization of a state raising its daily dosage limit to 32, based on whether or not you used the DUR or reports versus claims. So I was trying to understand, when you looked at claims how did you determine that they had raised the limit? Because elsewhere, I think maybe in one of the charts you note that, in Pennsylvania, it's limited at 24, but you can get a higher dosage. So I wonder, I guess because you submit appropriate paperwork, the provider says, "this is the dose that this person needs." So I'm wondering, was it just the presence of a claim that was higher than, or up to 32, that demonstrated that they had raised their daily dosage limit?

I'm just curious about that and kind of the discrepancies between the DUR report and the claims data. Because it makes it hard to, I think, then -- I'm just a little concerned about the data and what is it telling us, and can we really get to a conclusion based on that data.

ANUPAMA WARRIER: Yeah, that's a good question. So I guess one potential reason for the discrepancy could be that -- so DUR reports what's on paper, you know, policy on paper. Claims is kind of what's happening in practice. So potentially, again, like I mentioned, you can't see prior authorizations in the claims, so we could imagine that maybe there would be states that have a policy that for a higher dose over the DUR limit you have to institute a prior authorization for those higher doses. But we're not going to see that in the claims, so on the whole, in the distribution, you might see a slightly higher daily dosage limit in the claims compared to what we see in the DUR. And so there could be additional restrictions that we're just not able to see in the claims. So that could be one reason for the discrepancy.

And then in Pennsylvania I think it says they were both 24 milligrams per day.

COMMISSIONER MICHAEL NARDONE: But it sounded like that there would be people in the claims history that would be at a higher limit, because the way I read that was that if a doctor recommended a higher dosage they could get it. And so in the claims it might be you had dosages up to

32.

I was having a problem understanding how you were able to make the determination just based on the claims.

ANUPAMA WARRIER: Sure.

COMMISSIONER MICHAEL NARDONE: I'm just trying to understand that.

ANUPAMA WARRIER: It's a complicated methodology to calculate the daily dosage limit. It's in the memo, but, yeah.

CHAIR VERLON JOHNSON: All right. Thank you. Heidi, did you have a follow-up?

COMMISSIONER HEIDI ALLEN: Yeah. I was just going to ask about this Slide 11, because it says share of enrollees with OUD who have at least one oral buprenorphine fill. But then in the notes it says including oral or injectable. And so I was wondering which it was, and it sounds like the way that you defined it -- I'm trying to understand if the way that you defined it as injectables would look like people aren't getting care because they're like a month, or the time limit is --

ANUPAMA WARRIER: That's an interesting point. I think the confusion is the denominator includes all

enrollees with OUD who have had at least one oral buprenorphine fill, to kind of set the expectation that these are people who we expect would have some type of MOUD treatment. And then among those, who had any type of MOUD treatment continuity. So they potentially could have switched to a different type of MOUD in that 180 days.

So we're allowing for that and almost trying to make it a less restrictive definition of treatment continuity in case they did switch forms.

COMMISSIONER HEIDI ALLEN: And it says the gaps no longer than seven days. So if somebody is on a 30-day injection would they be considered of having discontinuity?

ANUPAMA WARRIER: I don't believe so, no.

COMMISSIONER HEIDI ALLEN: Okay.

CHAIR VERLON JOHNSON: Thank you. Any other questions? All right. Do you have what you need then? Anu?

ANUPAMA WARRIER: Yes.

CHAIR VERLON JOHNSON: All right. Well, thank you so much for your work. We appreciate it.

CHAIR VERLON JOHNSON: All right. We're going to switch to our last session of today.

We're going to examine intensive community-based behavioral health services for children and youth, and so we'll give Linn and Holly an opportunity to come.

All right. Welcome, Linn and Holly. The floor is yours.

INTENSIVE COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES: FINDINGS FROM STAKEHOLDER INTERVIEWS AND ADMINISTRATIVE CLAIMS ANALYSIS

* LINN JENNINGS: Thank you.

Good afternoon, Commissioners. All right. So today, Holly and I are going to present on our analysis of the Transformed Medicaid Statistical Information System, or T-MSIS, and our stakeholder interview findings on access to intensive community-based behavioral health services for Medicaid-covered children and youth.

So we'll start with a project overview and some background on children and youth with behavioral health needs and how this project fits into MACPAC's broader work on this topic, and then I'll recap our federal and state findings that we presented last April, and then present findings on our T-MSIS analysis on BH service use. And then I'll hand it over to Holly to present our interview

findings and next steps for this work.

So, as a reminder, in 2024, MACPAC initiated a multi-phase work plan to continue its work examining access to behavioral health services for children and youth with behavioral health and co-occurring health needs.

The first phase of work examined appropriate access to residential care, residential treatment services for Medicaid-covered children and youth who require this level of treatment, and resulted in a chapter in MACPAC's June 2025 report to Congress and a chapter and recommendation in MACPAC's June 2026 report to Congress.

So, for the second phase of work, we're examining access to intensive community-based BH services for children and youth with behavioral and co-occurring health needs using MACPAC's access framework, which considers availability of services, beneficiary experience in accessing services, and utilization of services.

And we're focusing on these intensive community-based BH services based on findings from MACPAC's prior work that demonstrates that intensive community-based BH services can help children and adolescents with significant mental health conditions remain in their communities and

avoid unnecessary residential treatment.

So, for this phase of work, we reviewed existing federal Medicaid authorities and state approaches to covering intensive community-based BH services, and our stakeholder interviews and T-MSIS analysis allowed us to examine each of the three access framework dimensions, to assess whether there are policy barriers to states covering these services, or to children and youth accessing them that could be addressed through federal policy.

Additionally, for this work and given the breadth of intensive community-based BH services, we decided to focus in on five of these services, which were chosen based on findings from the 2013 joint Centers for Medicare and Medicaid Services, or CMS, and the Substance Abuse and Mental Health Services Administration's SAMHSA guidance. It was also informed by our literature review and background interviews with experts.

So, on this slide, we include the definitions for each of these services, which draw from CMS and SAMHSA guidance and our literature review. Because federal Medicaid statute does not explicitly define these five services, states maintain flexibility in defining them and

may use different terms for the same types of services.

As a reminder, last fall, we conducted a literature review, federal policy scan, and state policy review of 14 states that cover one or more of these five services through one or more federal Medicaid authorities, and findings of the scan informed our state interview selection. So I'll present some key findings and just recap what we covered in April.

So, although the Social Security Act broadly authorizes Medicaid behavioral health services for children and youth, federal Medicaid statute does not explicitly define these five benefits for these five specific intensive community-based BH services in our study, and instead, states make policy decisions regarding their program's behavioral health benefits within federal requirements to meet their state-specific needs.

States can use optional state plan and waiver authorities to cover these services, depending on their policy goals, population needs, and program structures. And findings from our state policy scan demonstrate that states use this extensive flexibility to determine which intensive community-based BH services to cover, and there

are many state approaches to covering these services.

For example, some states cover a wide range of these intensive community-based services, including all the five services that we have focused on through an 1115 demonstration, a combination of SPAs and waivers, or concurrent 1915(b) and (c) waivers. Others cover a narrower scope through one waiver or one SPA.

Although states can cover these services through many waivers and SPA authorities, findings from the MACPAC's June 2021 chapter indicate that Medicaid-covered children and youth with significant mental health conditions often experience challenges with accessing behavioral health services, including these intensive community-based BH services.

Some factors that can affect access to intensive community-based BH services include Medicaid coverage policies, Medicaid authorities used to design these benefits, understaffing and workforce constraints, and coordination among multiple agencies involved in supporting this population.

And findings from our literature demonstrate that insufficient access to intensive community-based BH

services can lead to foregone care and higher acuity needs, increased BH-related ED use, and unnecessary or inappropriate use of residential treatment.

Additionally, research indicates an increasing rate of children and youth are being referred to the ED for BH-related care or conditions that could have been provided in outpatient settings, and this type of service use is considered an important indicator to understand whether individuals have unmet BH need.

All right. So now I'll move on to our findings from our T-MSIS analysis on BH service use.

We used calendar year 2024 enrollment claims and encounter data from T-MSIS to examine how Medicaid-covered children and youth use intensive community-based BH services. Although our project focuses on individuals with an SMI or SED diagnosis, under the Early and Periodic Screening, Diagnostic, and Treatment, EPSDT requirement, children and youth can access BH services without a diagnosis. So, for the purposes of this claims analysis, we included all children, regardless of whether they had a diagnosis.

In our analysis, we measured BH-related service

use and use of four specific services that we were able to identify consistently across states in T-MSIS, which are targeted case management, crisis intervention and stabilization services, BH-related ED services resulting in outpatient care, and BH-related ED services resulting in inpatient or IP admission.

So, in addition to targeted case management and crisis, we chose to include these BH-related ED services because it's often used as an indicator of unmet need.

And then due to limitations, our analysis does not include mobile crisis services, high-fidelity wrap, or respite. We also disaggregated our measures by several demographic characteristics, including age, race, and ethnicity and geography.

So, in this first figure, we show the percentage of Medicaid-covered children and youth, ages 1 to 20, with at least one BH-related service claim. And so, in the far left columns, you see the total Medicaid covered children and youth with at least one BH-related service claim. So 83.1 percent of those with an SMI or SED diagnosis and 15.1 percent of those without one of these diagnoses had at least one BH-related service claim. In the other two

columns, you see this disaggregated by those who are enrolled in an HCBS program or an 1115 demonstration.

So, overall, you see that the majority of those with an SMI or SED diagnosis received at least one BH-related service claim if they were in the SMI or SED diagnosis group.

All right. So, in this next figure, we show BH-related service utilization among those who had at least one BH service claim. So, looking at the full 100 percent of BH use, we see that in each of these columns, we've broken it up by the percent of each of the services that we looked at, so crisis intervention and stabilization in the dark blue, then targeted case management, then moving up, BH-related ED services resulting in outpatient care, the light blue being BH-related ED services resulting in inpatient admission, and then the gray is any other BH-related services. So, for those without an SMI or SED, the majority of the BH claims were related to services other than those that we focused on, whereas those who had an SMI or SED diagnosis, the majority were related to these four services that we focused on. And about a third of BH-related utilization were these BH-related services that

resulted in outpatient care.

So, in this next figure, we show the percentage of Medicaid-covered children and youth with an SMI or SED diagnosis who received either crisis intervention and stabilization services or targeted case management. On the x-axis, you see this broken up by age group, and then we've disaggregated those data by race and ethnicity.

So, for crisis intervention and stabilization, we see generally a similar trend across race and ethnicity groups with the highest utilization among 12- to 18-year-olds. For targeted case management, the trend is generally similar, with the exception of Black, non-Hispanic, where we see the highest utilization among 4- to 5-year-olds. Otherwise, for the other groups, it's the 12- to 18-year-old group that has the highest utilization.

And then this figure shows the same type of information, but then instead looking at BH-related ED services resulting in outpatient care, and then those resulting in IP admission. So, for the ED services resulting in outpatient care, we see a similar trend across race and ethnicity groups, with utilization being highest among the 12- to 18-year-olds, and then ranging for the

race and ethnicity groups between about 30 percent and 40 percent being the greatest for Black, non-Hispanic. For those resulting in inpatient admission, a very similar trend across race and ethnicity groups and overall low utilization.

So, overall, our findings demonstrate that the use of BH services was greater among children and youth under age 21 who had an SMI or SED diagnosis compared to those without a diagnosis, and then use of services among those with a diagnosis was high, regardless of whether they were enrolled in an HCBS program or 1115 demonstration.

There were also differences in specific BH-related service utilization, and as I pointed out, about a third of BH-related ED services resulting in outpatient care -- or sorry -- about a third of BH-related service utilization was for BH-related ED services resulting in outpatient care.

Now I'll hand it off to Holly.

* HOLLY SALTRELLI: Great. Thanks, Linn.

I'll now go over our findings from our stakeholder interviews.

With the assistance of a contractor, we

interviewed federal officials from CMS and SAMHSA, state Medicaid officials, managed care organizations, state advocates, provider associations, and national experts. We designed the interviews to build on the federal and state policy scans we presented in April by examining how coverage decisions operate in practice, which the scans alone could not show.

We focused on six of the 14 states from the state policy scan. We selected them for variation in geographic region, population density, delivery system, and the authorities they use to cover these services.

Interviewed stakeholders reported that most intensive community-based BH services can be covered under existing federal authorities. States often layer and combine multiple federal authorities to cover the full range of these services.

When cost considerations constrain coverage decisions, states often look to authorities that allow them to establish guardrails. For example, states often select Section 1915(c) waivers because the authority allows them to cap enrollment, limit services to certain beneficiaries, and thereby control costs.

The administrative effort and time required to seek approval also influence state decisions on authorities. Compared to SPAs, the 1915(c) waiver approval and amendment process can be lengthy and difficult.

Additionally, in one state, any new waiver or SPA requires state legislative approval, which affects both the timing and the feasibility of adding services.

States and national experts said states would benefit from clearer guidance on using waiver authorities to cover community-based BH services. They also said recent CMS and SAMHSA guidance, while valuable, needs companion implementation guidance to be most useful.

National experts and state-level advocates shared that targeting coverage to those with the highest level of need could inadvertently make it harder for children with mid-acuity needs to obtain services. These children's conditions can deteriorate until they reach a level of acuity that qualifies them for more intensive services. One state advocate described this as, "having to fail the system" before qualifying for needed services.

National experts and state representatives identified respite as a challenging service to cover under

current Medicaid authorities. Respite is not a Section 1905(a) benefit, so states cannot cover it as a standard state-planned service, and it is not included under the EPSDT requirement.

States may instead cover respite under a 1915(c) HCBS waiver, a 1915(i) HCBS state plan benefit, or another authority that permits HCBS coverage.

1915(c) requires enrollees to meet an institutional level of care and allows enrollment caps and waitlists. 1915(i) permits states to waive the comparability requirement and target the benefit to one or more subgroups, but caps and waitlists are not allowed. Interviewees reported that this can make states hesitant to use the authority because of the cost of having to provide the service to all who qualify.

To be compliant with the 2014 HCBS conflict-free case management requirements, states covering respite under 1915(i) or 1915(c) must ensure that the decisions about a beneficiary's services are made independently of the organizations that deliver them.

Section 1915(i) extends these conflict-free case management requirements to the determination of eligibility

itself. A state covering respite under 1915(i) must therefore complete two separate determinations before services begin: an evaluation of eligibility against the state's needs-based criteria and an independent assessment of needs.

Interviewed stakeholders noted this can add significant administrative burden and delay needed care. In one state, it can take up to 30 days before a child is approved to receive respite, when families requesting respite often need relief within a day or two of making the request.

Coverage of a service establishes that a child is entitled to receive it. Whether the child is able to access and use the service depends on the entities responsible for screening, referral, authorization, and service delivery. In most states, these are not the same organization.

National experts told us that access can improve when there are multiple entry points into the system, but no state has a true no-wrong-door approach, as described by SAMHSA, that facilitates individuals accessing or connecting with BH crisis services regardless of where they

initially seek help.

States have taken different steps to address this issue. For example, one state employs a contracted system administrator as a centralized entry point for all referrals from families, schools, child welfare agencies, and providers.

Breakdowns in referral and handoff processes can shift responsibility to families. In one state, a Medicaid official explained that the independent organization conducting eligibility screening does not always send referrals reliably and sometimes refers children to adult providers. In those cases, families must contact Medicaid directly for a pediatric referral.

Experts in advocacy organizations also reported that coordination across schools, child welfare, juvenile justice, BH providers, and managed care organizations remains inconsistent in practice. Because these systems can operate under separate authorities and funding streams, Medicaid coverage alone does not establish the communication pathways that timely referrals depend on.

Federal officials reported that states most frequently attribute access challenges to workforce

shortages and provider capacity rather than to limitations in federal Medicaid authorities. National experts and state advocates noted that provider payment rates are often viewed as inadequate to sustain the workforce. However, provider payment increases alone may not resolve capacity problems. One state reported that despite, "substantially" increasing reimbursement rates for these services, the increase was not sufficient to increase capacity given its provider shortages and rural and frontier geography.

Coverage establishes that Medicaid will pay for a service. It does not ensure that a state can deliver the service, especially if no qualified provider is enrolled and available. For example, one state has a state plan pathway and billing methodology for mobile response and stabilization services. However, the service model is not yet operational because the state has not built the training infrastructure needed for crisis providers.

Several national experts and state-level advocates raised that workforce shortages and provider availability, especially in rural areas, are the primary barriers to providing mobile crisis services specifically

tailored to children.

States also identified financing as a recurring concern. They cited their reliance on one-time limited funding sources, such as the American Rescue Plan Act of 2021, or ARPA, along with upcoming changes to state-directed payments as adding uncertainty.

Stakeholders emphasized that inadequate community-based infrastructure often results in children entering residential treatment or using emergency departments when less restrictive alternatives would be otherwise appropriate. Several experts noted that community-based capacity must exist before residential diversion can occur.

Limited step-down services may also reinforce reliance on residential treatment. As highlighted in an earlier phase of MACPAC's work on this project, lack of intensive community-based services and step-down services can also prevent residential treatment facilities from being able to discharge residents when appropriate, which can limit bed availability for individuals in seek of residential care.

State advocates described families seeking

residential care after extended periods without community-based services. During that time, children's needs can escalate beyond what community-based services can meet. Advocates in two states described youth being placed in out-of-state treatment due to limited community-based infrastructure and a shortage of providers.

We also found that data to actually assess access and diversion are limited. None of the states we interviewed are monitoring the use of these services or how that use relates to residential treatment. Inconsistent service definitions and billing codes also make it difficult to evaluate outcomes or compare across states.

To summarize, existing authorities give states flexibility to cover intensive community-based BH services, but the authority a state chooses shapes who can access them and how quickly.

Respite is particularly constrained because it falls outside EPSDT and can be covered only through HCBS authorities. Across our findings and services, coverage alone does not ensure access. Access also depends on care coordination, provider capacity, and stable financing. This finding was echoed by our T-MSIS analysis. About one-

third of BH service use among those with an SMI or SED diagnosis was for ED services resulting in outpatient care, as Linn highlighted, which showed that there might be unmet BH-related need for this population, as we heard from stakeholders.

Finally, limited community-based capacity contributes to reliance on residential treatment, and limited data make it difficult to assess whether these services help children avoid it.

At this meeting, we would appreciate Commissioners' questions and feedback on the findings we presented. We identified three potential areas that may yield potential policy options, but additional research and analysis are likely needed. Those areas are the requirement under 1915(i) for two separate independent assessments before beneficiaries receive services, the limited BH service-specific data available to assess access, and the lack of federal standards for child- and adolescent-focused mobile crisis services.

Thank you for your time, and with that, I'll turn it back to the Chair.

CHAIR VERLON JOHNSON: All right. Thank you so

much, Linn and Holly. Very helpful.

I'm opening up the floor, then, for our Commissioners. We'll start off with Heidi and then go to Patti.

COMMISSIONER HEIDI ALLEN: Thank you for this work.

I mean, obviously, it seems like respite is a -- if you have to get -- like, when you're in crisis, you can't get those independent evaluations. So that makes -- like, that seems like a very, you know, no-brainer.

But the other thing that I think is really ripe for policy discussion is this idea of not enough community providers engaging in Medicaid, and I think this is a problem in children and adolescents. It's a problem for adults, too. But maybe, you know, going about addressing it in children and adolescents would be a good starting point.

I think that, you know, for one, nobody really knows how much Medicaid pays behavioral health care providers relative to the commercial rates in their area. At least, I haven't been able to find that out. When I ask people who say they don't take Medicaid, why they don't

take Medicaid, they say reimbursement is so low. And then I say, well, how much does Medicaid pay? And they say I don't know, because they don't know. And sometimes I think Medicaid does pay as much as commercial insurance, but they're not aware of it.

But there's some real significant challenges that I think that we could address from a policy perspective, and that is that, like, Medicaid delays payment. And so, if you are -- in many cases, in many states, if you are a small-group practice or an individual practice, particularly if you're small-group practice and you have rent to pay and you have employees to pay, you can't afford to have this delay in meeting payroll. So, unless you have some kind of financial reserves at hand, you know, that allow you to make payroll and wait 30, 60 days to get paid, you just simply can't do it.

And then I've heard a lot of people express concern about clawbacks, because small clinics can't afford to have Medicaid to come back and say, oh, by the way, we overpaid you this amount, and now we're going to take that money back. So it just doesn't make a lot of sense for the business model of small providers, and that takes a lot of

people that could potentially be in the enrolled Medicaid behavioral workforce out of play.

So I would like us to do more research in this area of really figuring out why behavioral health care providers aren't enrolling, what they know about pay. I mean, we've tried, I think, in the past to get it, like, whether we can assess pay parity, and I think the answer is no. But if something has changed in the last however many months since I asked about it, that would be great, because I think that -- or what states are doing to advertise how much they do pay, like, how are they communicating to a behavioral health care provider? Like, it's worth enrolling in Medicaid because, you know, we pay as much as you might make if you were in Blue Cross Blue Shield.

So those are my comments, and thank you for this work.

CHAIR VERLON JOHNSON: Thank you.

So, Patti, John, and then Bob.

COMMISSIONER PATTI KILLINGSWORTH: I echo the appreciation for the work.

For 30 years, I have been perplexed why, on the physical health side, there is this well-defined package of

benefits that states are obligated to cover, and on the behavioral health side, it's a lot more ambiguous than that. There's probably some -- a few things and then some broad categories and lots of flexibility in terms of what you cover and what authorities you cover it under, which means there may or may not be legitimate access.

So it's not that I disagree with any of your potential policy options, but it seems to me the problem is just so much bigger than that, which is we have an EPSDT benefit that is not well defined for kids with behavioral health needs.

I'll tell you my experience is the same with respect to crisis-driven -- and by that I don't just mean crisis services, but ED utilization, inpatient utilization, all those things. High, high, high percentages of Medicaid costs.

We talked earlier about the math of Medicaid. Oh, my goodness, this is an area where we need to do the math of Medicaid and realize that by not having appropriate community-based services available, we are paying a lot more money, not to mention the non-monetary costs to these kids and their families that result from not having timely

appropriate access.

So I would like -- if I get to just wave my magic wand, which I don't have one, but I would love to see us -- we have 2013 recommendations from CMS and SAMHSA right around these five categories of service that we say are proven to improve outcomes for the population. Maybe those aren't the right five, but what are the right services? There ought to be a minimum package of benefits, specifically defined and consistently coded, that we could identify and actually know what people are getting, and then be able to better understand the outcomes that it is producing for those children and their families.

So I would love for us to go back to that. Like, if it's not those five, what is it? What does the data tell us? Has there ever been any effort to kind of -- I know we hate the word "standardize" or "prescribe," but standardize or prescribe at least a minimum set of behavioral health benefits that must be provided for children and must be provided not through Section 1915(c) waivers, where you might or might not be able to get into them, but through a state plan or 1115 authority where they're absolutely available and accessible.

And then we still have to address the workforce and payment issues. But right now, we don't even have a standard set of benefits to hold -- and I'm going to say ourselves -- accountable to as the Medicaid program writ large. That's needed. It's so desperately needed. I'm astounded by some of that data, especially for like that 12- to 18-year-old population. Really, we have to do better, and I think it starts at least with making sure that we're at least making available the things that we know to be critically important to better outcomes for these kids.

Thank you.

CHAIR VERLON JOHNSON: Thank you.

John?

COMMISSIONER JOHN McCARTHY: I just saw some really scary data when it comes to this, where the rate of suicide for kids between the ages of like 8 and 14 has been going up the last however many years, which is super scary to think about for kids that young.

You know, based on some of the data I've seen -- and I just want to reiterate what Patty's saying. Like, this is one of those areas, being a former Medicaid

director, Medicaid agencies don't understand mental health services and benefits.

I mean, I know like in Arizona where the behavioral health agency was brought in, but usually it's a sister agency. You know, the understanding is not there, and you just get confused, just like Patti was talking about, as Medicaid director of like, well, I thought we'd cover everything under EPSDT. And then these services aren't there. Well, what should we cover, and what are some of those different pieces?

So, I really want to push us as MACPAC on doing the things that Patti said. What services should we be saying? Maybe we should relook at 1905? Should respite be in there? Or having something to say, here's those things that we need to be adding in there.

Crisis services, there's another example. States are just having a struggle doing crisis services. And one of the issues -- I do want to bring this up, and it's tough for us -- is that for crisis services, there's a whole bunch of kids not on Medicaid that need crisis services. And then in commercial insurance doesn't pay for it. So we've got to address that.

Lastly, I would also like to push us and, you know, again, beyond these three here. And then how do we pay for that? I mean, the Congress has said, you know, this last time through, looking at H.R. 1, that they are committed to the Medicaid program, especially for kids, right? We heard that, the kids and disabled.

So I think we should be looking at things that we've done in the past, which is if we're going to add these services to it, tie higher FMAP to it and then phase it down. So it's like we do 100 -- we've done this before -- 100 percent coverage for certain codes for some period of time, and it gets phased down, or 90/10 for some time, it gets phased down.

I really would like to see us on this one, really kind of push on this one because of some of the crises we're seeing with kids in this area.

CHAIR VERLON JOHNSON: Thank you, John.

Vice Chair?

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman.

I, too, want to give Patti and John a high-five because you spoke exactly the notes that I'd written down.

So just to go on record, I would like to see pediatric mobile guidelines specific, a little more defined.

To John's point and Patti's point, you know, measuring the outcomes, not just the utilization, so the services, are they impactful, and do that.

But, again, I stated that this morning in hospital cost, address the economic benefits of community-based care. I think if you look at it, it's going to be a whole lot less expensive than what you're paying me to keep a child [unintelligible] in a place. They're not getting the services they need. So, therefore, they're utilizing a service, but not getting the outcome we're looking for. It's not what's best for the beneficiary.

If there's any way possible -- and I need Patti's magic wand -- to create a policy where you can coordinate among Medicaid agencies within states of wrapping services and coordinating for these kids, I think that would be wonderful.

CHAIR VERLON JOHNSON: I love it.

All right. April?

COMMISSIONER APRIL HARTMAN: I think everyone

knows this is like one of those things that just makes me cringe.

I agree with everything that everyone's saying. My thing is we really, really need to focus on prevention. We talk a lot about crisis. If we can catch these kids before they go into crisis, we're going to have a lot more impact.

There are a lot of programs. Like the schools are doing a lot of things around school climate, and all these other things are happening, but it's extremely fractured. I can't tell you how often I've had a kid come into my office, and maybe they're staying with the aunt or they just got placed in foster care, and nobody knows anything about them. They have no history, no nothing, and yeah, they're going to be in crisis because nobody knows anything about them.

We got to have prevention, but we also have to have communication. It's not just within Medicaid. It's within the school system. There's got to be some -- if we could do a policy that would force these agencies to talk to each other and to create -- I don't know -- a task force or something that deals with this, figures out a way to

make sure that these kids have medical records that follow them wherever they go, it would be so helpful.

And then the other thing is, you know, you get a kid that's in crisis, you stabilize them, and you send them back into the family where they get triggered. because nobody knows what you did to stabilize them or how to continue that. This has got to be family-based treatment.

Patti, you kept saying children and families, but so often the families are left out of it. These kids are treated in school, through telehealth. They're treated wherever, and the parents are nowhere around. They don't know what's being said or how to implement these things in the home setting, and so you might see a kid for an hour, but then they go home, and the rest of the week they're with that family who has no idea what you did, how to handle it, how to keep them stable.

So we need more things that incorporate the family and teach them the skills they need to keep these kids out of crisis once they get stabilized. If their kid is depressed, how do they recognize it? How do they make the home safe? There's got to be some parenting things involved in that.

There are some codes that do -- as a pediatrician, I can't just meet with a parent without the child being there and get reimbursed for that. There are codes like that, but most states don't cover those codes that would allow me just to talk to the parent, train the parent, get the parent knowing what's happening. Most agencies, most Medicaids don't cover those codes. They exist. They're just not available to me as a provider. And so maybe something that allows more of that family interaction with or without the child would be especially helpful for providers like me who do spend a lot of time talking to families to just help them be prepared to receive that stabilized child and keep them from having a problem again.

Those are the kind of things that really stand out to me. Thank you.

CHAIR VERLON JOHNSON: Thank you. That insight is very helpful.

Jami.

COMMISSIONER JAMI SNYDER: Thanks so much for this work.

I was just going to comment on the third policy

option that you have listed around the lack of federal standards for child-focused mobile crisis services. I would really encourage us to look beyond just mobile crisis care and look at the three components -- the call center, the mobile crisis, and stabilization -- because I feel like there's a real opportunity for additional guidance in all three areas.

There's been a lot of focus on crisis more generally in recent years, which is great, but I think community stakeholders and providers in particular really still struggle to understand best practices when it comes to the continuum of crisis services for children and youth.

CHAIR VERLON JOHNSON: Thank you, Jami.

Anyone else?

[No response.]

CHAIR VERLON JOHNSON: I think you all have got a lot of good feedback, and I think we are building a magic wand that we can maybe actually use, right? So this has been a really good conversation. So thank you both for your work and for your continued dedication. We appreciate you.

Okay. So, with that, we are now going to turn to

the floor for public comments again. Again, we invite everyone in the audience to raise your hand if you would like to make a comment. Please make sure that you introduce yourself and, of course, the organization that you represent. And then, as usual, we ask that you keep your comments to three minutes or less.

PUBLIC COMMENT

* [Pause.]

CHAIR VERLON JOHNSON: All right. Seeing no comments, that's okay. If you have comments later, please feel free to visit our website and submit your comments there.

And with that, we are now adjourned, and we will hopefully see you all tomorrow at 10 a.m. Thank you so much.

* [Whereupon, at 4:28 p.m., the meeting was recessed, to reconvene at 10:00 a.m., Friday, October 30, 2026.]



PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, October 30, 2026
10:04 a.m.

COMMISSIONERS PRESENT:

VERLON JOHNSON, MPA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
DOUG BROWN, RPH, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
APRIL HARTMAN, MD, FAAP
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
ANNE KARL, JD
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
MICHAEL NARDONE, MPA
JAMI SNYDER, MA

KATHERINE MASSEY, MPA, Executive Director

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P R O C E E D I N G S

[10:04 a.m.]

CHAIR VERLON JOHNSON: Welcome to Day 2 of our October MACPAC meeting. Yesterday was a very good meeting, and so we expect the same today.

I'm going to turn it over to our Vice Chair to kick us off.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman. We are excited to have Michelle and Josh here today to talk about adult enrollees with IDD and access to behavioral health. So with that I'll turn it over to Michelle.

ADULT MEDICAID ENROLLEES WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD): ACCESS TO BEHAVIORAL HEALTH SERVICES

* MICHELLE CONWAY: Thank you. Good morning, Commissioners. As Bob said, today we'll be discussing adult Medicaid enrollees with intellectual and developmental disabilities and their access to behavioral health services.

First we'll walk through some background information. Then we'll summarize findings from our

literature review, including key data sources on this population, information about their health conditions expenditures, and access challenges. Then we'll move to findings from our federal policy scan, including findings related to Medicaid and LTSS eligibility, evaluation and coverage of behavioral health in Medicaid, and then care coordination for co-occurring IDD and behavioral health conditions. And finally we'll discuss next steps.

During the last analytic cycle MACPAC conducted an analysis of behavioral health spending and utilization using calendar year 2023 data from the Transformed Medicaid Statistical System, or T-MSIS. This analysis uncovered several notable findings specific to people with IDD, including that behavioral health services accounted for the majority of Medicaid funding for adults with IDD condition and adults with co-occurring mental health and IDD conditions.

This cycle we're continuing this work. We will conduct a quantitative and qualitative analysis to understand how adults age 19 to 64 with IDD use behavioral health services in Medicaid and the barriers they may face to accessing those services.

This project is beginning with our literature review and federal policy scan, for which we'll share our findings today.

We'll begin with definitions. IDD are conditions that are typically present at birth and affect a person's physical, intellectual, or emotional development. Examples include cerebral palsy, Down syndrome, and autism spectrum disorders. However, definitions of IDD may differ depending on the source or program.

Estimates of the number of people in the United States who have IDD also vary. A recent analysis from the national Residential Information Systems Project, or RISP, estimates that in 2021, about 8.6 million people in the U.S. had an IDD, including about 2.2 million adults.

Behavioral health is an umbrella term that includes mental health and substance use disorders. Mental health conditions may include anxiety disorders, mood disorders, personality disorders, and schizophrenia. Substance use disorders include opioid use disorder, alcohol use disorder, and other drug use disorders.

Next we'll move to findings from our literature review. Data sources on adults with IDD are limited.

Health surveys often exclude information about IDD or do not include demographic data on people with IDD, and data collection can vary widely across and even within states. Here we outline several existing data sources and selected findings on demographics and living arrangements of people with IDD from each source.

One source is the National Core Indicators Intellectual and Development Disabilities, or NCI-IDD. NCI-IDD is a set of national surveys that collect data on adults receiving at least one paid service from a state, family members of people with IDD, and provider agencies supporting adults with IDD. These surveys were designed as performance measurement and quality improvement tools.

Key demographic takeaways from the 2024-2025 NCI-IDD survey of about 30,000 adults in 39 states with IDD, receiving at least one service from a state, include 81 percent of survey respondents lived in a metropolitan area; 82 percent had an intellectual disability diagnosis; 30 percent had an autism spectrum disorder diagnosis, and those diagnoses are not mutually exclusive; 60 percent were male; 65 percent were white; 23 percent were age 55 and older; about half had Medicare coverage; and about half

lived in a parent or relative's home.

Another source of data on people with IDD is the National Survey on Health and Disability. MACPAC conducted an analysis of data from this survey in 2025, looking at responses compared across insurance coverage type. The survey's small sample size limited our ability to present detailed findings, but a couple of key takeaways included about 55 percent of survey respondents with IDD, between the ages of 18 and 64, reported having some Medicaid coverage, while one-third were enrolled in private-only coverage. About two-thirds of those with Medicaid coverage needed help at home due to health or disability, compared to fewer than half with private-only coverage.

And finally, as I mentioned on the previous slide, RISP, the National Residential Information Systems Project, RISP annual surveys of state IDD agencies and state-operated IDD facilities include data on the prevalence of IDD, number of people receiving LTSS from IDD agencies, living arrangements of people who receive those LTSS expenditures, and related terms. The most recent analysis estimates that in 2021, 1.4 million people in the U.S. received LTSS from state IDD agencies, and most of

these LTSS recipients lived outside of institutions. Sixty-three percent, for example, lived in the home of a family member.

Here we'll walk through some high-level takeaways from our literature review about health conditions and expenditures for adults with IDD.

Adults with IDD experience higher rates of chronic conditions than those without. Among Medicaid enrollees age 19 to 64 with IDD, 67 percent have a chronic condition compared to 42 percent of enrollees without IDD.

Adults with IDD also have higher rates of behavioral health conditions. MACPAC's recent analysis of 2023 T-MSIS data that I mentioned earlier found that adult Medicaid enrollees age 19 to 64 with IDD were 1.6 times more likely to be diagnosed with a behavioral health condition than those without.

Survey data from the U.S. National Health Interview Survey found that adults with IDD have a higher prevalence of anxiety and depression, more frequent and severe symptoms, more psychiatric medication use, and more cost-related barriers to IDD than adults without, more cost-related barriers to therapy than adults without IDD.

Adults with IDD also have higher health care spending. MACPAC analysis of 2023 T-MSIS data found that per enrollee Medicaid spending for people with IDD is almost four times higher than per enrollee spending among all Medicaid enrollees, and for people with both IDD and a behavioral health diagnosis, the gap was even wider.

Despite having a higher prevalence of behavioral health conditions, people with IDD face barriers to accessing behavioral health care. Delivery systems for IDD services and for behavioral health services are often separate, with different eligibility, funding, and regulatory frameworks.

Adults with IDD may face barriers like inadequate transportation, long wait times and provider shortages, and inaccessible telehealth platforms that may delay or interrupt their care. They are also unlikely to refer themselves to behavioral health services and may rely on caregivers who often don't have specialized training to recognize signs of mental health conditions and seek treatment.

In addition to these more structural factors, challenges at the provider level can also prevent people

with IDD from accessing behavioral health services. For example, behavioral health conditions in people with IDD can be difficult to diagnose, particularly for people with limited verbal communication. Standard psychiatric diagnostic tools rely on self-reporting and communicating complex thoughts, for example.

Many behavioral health providers also have limited training or expertise on IDD, and providers may ascribe behaviors or symptoms to an individual's IDD rather than to a potential behavioral health condition, a practice referred to in the literature as diagnostic overshadowing.

Mental health care for people with IDD has also historically relied heavily on pharmacological treatments. Psychotherapies like cognitive behavior therapy can be effective for this population, but most therapists are not trained in appropriately modifying these treatments for individuals with IDD or autism.

Now I'll turn it over to Josh to walk us through findings from our federal policy scan.

* JOSH VARCIE: Great. Thank you, Michelle. Our federal policy scan sought to understand the multiple ways in which adults with IDD may access and receive behavioral

health services in Medicaid, including through state plan coverage as well as through LTSS.

To begin, we'll discuss eligibility for Medicaid and LTSS. Federal law does not provide a single IDD-specific Medicaid eligibility pathway that is applicable for all adults with IDD. Instead, adults with IDD use a variety of Medicaid eligibility pathways, including some pathways that are provided at state option.

In 2021, KFF estimated that 76 percent of non-elderly adult Medicaid enrollees with IDD qualified through a disability-related pathway, meaning that 1 in 4 of these adults qualified based on low income alone. Many adults with IDD who are enrolled in Medicaid are also eligible for LTSS, either in an institution or in a home and community-based setting or receiving HCBS services.

In 2021, KFF estimated that 56 percent of non-elderly adults with IDD used LTSS and that about 92 percent of these LTSS users used HCBS.

States can offer a variety of services in their HCBS programs for adults with IDD. These services may include residential and rehabilitation services, which help adults with IDD develop skills for daily living and

independence in the community. They may also include case management services, which help patients and their families identify care needs and navigate care systems. Finally, they may include other services such as employment supports, transportation, and assistive technology or other medical equipment.

Federal policy allows states to establish state-specific eligible criteria for LTSS. For this reason, adults with IDD may face different eligibility rules for LTSS across states.

Moving along to evaluating behavioral health needs, an adult with IDD in Medicaid may have their behavioral health needs evaluated at different times and for different purposes. For example, an evaluation may occur to determine if an individual is eligible for Medicaid or LTSS. It may also occur when a provider assesses whether an enrollee has a certain behavioral health condition or needs a certain treatment.

When an individual applies for Medicaid, federal policy generally requires the state to evaluate their behavioral health needs only if they are qualifying through a disability-related pathway or applying for LTSS. Once an

individual enrolls in Medicaid there are few broad federal requirements to provide behavioral health evaluations for those not enrolled through a disability-related pathway or receiving LTSS.

Even so, adults with IDD may still receive behavioral health evaluations if other provisions cover these services. For example, these evaluations may be covered through the Early and Periodic Screening, Diagnostic, and Treatment benefit, or EPSDT, for individuals under age 21, or through an Alternative Benefit Plan. Additionally, several states cover behavioral health evaluations in their state plans at state option. For example, in 2022, 45 states covered psychiatric evaluations, and 43 states covered psychiatric testing in their state plans, according to a survey of states conducted by KFF.

Additional federal requirements govern whether adults with IDD who receive LTSS also receive behavioral health evaluations. Given that most adults with IDD receiving LTSS use HCBS, this slide focuses on federal requirements for evaluating behavioral health needs in HCBS programs.

Before an individual enrolls in HCBS, states must administer a functional needs assessment for that individual. This assessment must be updated at least annually, and may evaluate certain psychosocial and behavioral issues.

However, the extent to which these assessments evaluate behavioral health needs may vary for two reasons. First, federal requirements for assessments vary by HCBS authority. While Section 1915(i) regulations explicitly require assessments to evaluate behavioral health care and support needs, regulations for Sections 1915(c) and 1915(k) do not.

Second, federal policy allows states to develop their own assessment tools, and prior MACPAC work has identified variation in these tools, both within and across states.

Next we'll discuss coverage of behavioral health services. Federal policy requires mandatory coverage of certain behavioral health services in Medicaid, such as inpatient and outpatient hospital services, services delivered through a federally qualified health center, or FQHC, and physician services. States can also cover many

behavioral health services that adults with IDD use at state option. These services can include case management, clinic visits, and prescription drugs.

Adults with IDD who are receiving HCBS may receive additional behavioral health or behavioral support services that are included in their person-centered service plan. Behavioral support services are designed to help individuals develop, maintain, or improve behaviors or skills that support participation in the community. These can include services such as applied behavioral analysis, positive behavior supports, or other evidence-based approaches.

Notably, receiving HCBS does not preclude an individual from also receiving services through the state plan.

Federal policy allows states flexibility to develop tailored HCBS programs to cover behavioral health or support services for adults with IDD. Existing research suggests that HCBS services for adults with IDD are most often provided through Section 1915(c) waivers. However, some people with IDD apply for but do not receive HCBS services because they are on a waiting list. A 2026 KFF

survey found that about 468,000 people with IDD were on HCBS waiting lists, making up 72 percent of the total number of people on these lists.

Finally, we will discuss care coordination for adults with IDD and co-occurring and behavioral health conditions. Adults with co-occurring conditions often receive care from multiple providers and through multiple delivery systems. Care coordination can make it easier for these adults to navigate their care by streamlining the delivery of services or providing additional resources such as case managers.

Federal policy does not create broadly applicable requirements to coordinate care for adults with a co-occurring condition. Even so, certain federal models that may be used by adults with IDD do contain requirements for care coordination. For example, FQHCs must provide basic physical health services and patient case management services and, at a minimum, offer referrals to behavioral health services.

Furthermore, several states have used federal policy flexibility to coordinate care for adults with co-occurring conditions. For example, Arkansas coordinates

care for those with complex co-occurring behavioral health needs through a managed care model.

The next steps for our analysis will include qualitative stakeholder interviews, a review of select state waivers, and a claims analysis. We appreciate the Commission's ongoing interest in this topic, and look forward to the discussion. We have provided a few questions to guide the conversation. Specifically, we hope to learn, in your experience to what extent are adults with IDD evaluated for behavioral health needs, and could states benefit from additional federal requirements for guidance? What elements of care coordination do you think are most important for adults with IDD who need behavioral health services? And finally, we would be curious to know if there are any topics that we have identified today that we should prioritize in our future work.

Thank you, and I'll turn it back to Verlon.

VICE CHAIR ROBERT DUNCAN: Thank you, Josh. Thank you, Michelle. All right, Commissioners, Patti.

COMMISSIONER PATTI KILLINGSWORTH: It will probably surprise no one that this area is a particular passion for me. Thank you all so much for bringing it

forward.

Can you go back to Slide 8 for just a minute? I have a question. And specifically it is about when you talk about health care spending, can I presume that's Medicaid spending, not inclusive of long-term services and supports? Because that number would be really low, I think, if it were.

MICHELLE CONWAY: I think you're correct, but I would have to go back and double-check that analysis.

COMMISSIONER PATTI KILLINGSWORTH: Okay. That would be helpful. I think it would also be helpful if you could then look at the data and add to, but separately, that analysis that LTSS spend, because I think what you're going to find is that it's not just the health care spending that is significantly higher. You're going to find that the LTSS spending is also significantly higher, particularly when there is a behavioral health diagnosis.

We did an analysis of Medicaid data many, many years ago in a single state and found that 3 percent of Medicaid beneficiaries were driving 50 percent of Medicaid program costs. Out of that 3 percent -- well, let me say it this way -- 75 percent of people with intellectual and

development disabilities who were receiving long-term services and supports were in that 3 percent, driving 50 percent of the Medicaid program costs.

So it's a really high-cost population, and I say all of that to say that my new favorite term may become "Medicaid math." We need to start doing Medicaid math and realize that by not making the right behavioral health services available to this population we are driving extraordinary expenditures in other areas of the program.

I'd love for us to break down that health care spending for this population and look at -- we know there are access barriers. We talk about those. So what are they getting? And my guess is that what they're getting is ED utilization, crisis supports, and inpatient psychiatric care. We're using all of the more acute, higher cost services because we don't have an adequate system of behavioral health services that are, I'm going to use the word "tailored" to the needs of this population. The community behavioral health infrastructure, by and large, doesn't know how to serve this population well. And so they tend to access the system at those higher cost points. So I would love for that to be a part of our analysis going

forward.

I would love for us to look at models that have been successful, and not just in reducing costs but more importantly in improving outcomes for people so that they're able to work, so that they're able to stay in community, so that they have fewer out-of-home placements and those sorts of things, and think about whether there's any opportunity there with respect to policy recommendations.

But I do think the additional data will also be really powerful as we go forward. Thank you again.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti. I don't know what it is but you and I are on the same brain wavelengths today. Angelo, I'll get to you next, but since you brought it up, the questions I had after reading is do individuals waiting for the home and community-based services utilize the ED more? My hypothesis is that it does, and understanding that.

Because also I said getting the right service, in the right setting, by the right clinical professional should lead to better outcomes versus utilization. So I was going to ask if there is anyone that does this

extremely well that we could look at. So, Patti, thank you for echoing my thoughts. Angelo.

COMMISSIONER ANGELO GIARDINO: Okay. I don't have a shared brain with you and Patti, but I'll put my comments out.

I really appreciate this work. This group almost defines a vulnerable population and in need of a safety net, and your data has really supported that.

I'd be interested in a couple of things. One, obviously the adults with IDD started out as children with IDD, so I'd be really interested in more information on how systematized the health care transition from the pediatric to adult setting is.

As these folks get older, their traditional caregivers get older, and then they depend more and more on the blended and braided network of services that we provide through a variety of different agencies. So I'd really like to understand what other agencies adults with IDD need to rely upon and what that ecology is, and are there ways that we could have policies that facilitate that, much like we did in some of the other work we did, where we talked a lot about how the agencies really need to have those

agreements so that they make this as streamlined as possible.

And I'm going to keep beating this drum, but I really believe in simplification. So I would really like to hear what do the agencies and what do the individuals that are caregivers for the adults with IDD and then also what do the adults with IDD say are barriers, and what policies could we explore that would decrease barriers, because you don't outgrow IDD. So these folks need our support. The safety net needs to be tight and can't have holes in the weaving. So I'd really like to understand what we could do at a policy level to help them not fall through the cracks. So thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo. We have April, Mike, then John.

COMMISSIONER APRIL HARTMAN: Thank you guys for this work. Angelo, I think you said a lot of what I wanted to say. One thing that stood out to me was assessments, because like Angelo said, a lot of these people are diagnosed in childhood. But the way we assess children is focused on their ability to learn, and the way adults are assessed is their ability to work. So there's a

significant transition, and someone who may be disabled as a child because they have problems with learning may be able to work and keep a job just fine.

So I think how it's assessed and that transition from childhood to adult is going to be really important. And I don't know really the best way to capture that, but I do think it's something that needs to be thought about and looked at. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, April. Mike, then John.

COMMISSIONER MICHAEL NARDONE: Thanks, Michelle and Josh, for this work. I have to begin by saying that I want to congratulate my two fellow alum from the Princeton School of Public and International Affairs, so it's great to see you on this panel presenting this work.

The thing that I was interested in, and maybe this kind of ties back to some of the things Patti was saying, is many of these individuals will be in, I guess for lack of a better word, traditional managed care organizations. And one of the things that we would like to see in those organizations is care management and care coordination around some of the higher-need populations.

So it sounds like maybe 50 percent, more than 50 percent, could -- I don't know if I can do the percentages based on the data you have here, but I think a fairly high number would be in traditional managed care programs. I know that's the case in Pennsylvania until they become LTSS eligible.

So I think maybe if we can look at whether or not there are care models there that have been adopted, or not. I think understanding that a little bit better.

The other thing I was really struck by in the numbers is that it would also appear that there is a fairly significant subset of people who are dual eligible, 50 percent on Medicare, and I don't know what percentage of that is on Medicaid. So it seems to me that that might merit a little deeper look in terms of -- I don't know if we can get to a number around that, but understanding kind of the intersection of the Medicare and Medicaid I would think could present some really unique challenges for this population. So thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike. John.

COMMISSIONER JOHN McCARTHY: I know it seems to

be that one person brings us back to what questions you asked, because specifically you guys are just focused, right, this chapter is on access to behavioral health services, not just IDD services, in general. Correct? So it's really focused on that. And when you were talking about this earlier in there, like on Slide 8, you were talking about different barriers to access and things like that.

One of the things I would like you to get back to us, and this is where Patti and I think Bob were going, is there are many individuals with IDD who need behavioral health services, but there just aren't providers out there that will see individuals with IDD, whether they're kids or adults, because they don't think they're equipped to provide services to them. That's what I feel we need a deeper dive on, and picking a state to tell us, like, is that true? Is that not true? What does that look like? Or is it that there are providers but all those providers are employed by the children's hospital, and there's only one children's hospital in that state, so is it really access? Is it a telemedicine access?

That's the part I'm trying to get at from you

guys is how do we get that data to see is that the barrier, that there's just no providers? Because we could do all the care coordination in the world, and if we just don't have providers. Or is it that providers actually are qualified and they just don't know it. Like what are those levels in there?

I'm just bringing this up because in my experience it's just been there are a lot of providers who say they're not qualified or can't do it.

And then outside of that, then the next level of that is, is the payment rates for those, is that really the barrier? Because seeing an adult or a child who isn't DD coming into your office, you know, let's say you get paid $50, but then the person does have DD, is there disruptions in the office, like all those things, so the payment rate doesn't match what it is, or all those different pieces. So I think that's kind of the deeper dive information I would need to be able to look forward, because one of the questions on here is federal requirements. Well, where is the barrier on this one?

VICE CHAIR ROBERT DUNCAN: Thank you, John. Any other Commissioners with thoughts, feedback, or

suggestions?

[No response.]

VICE CHAIR ROBERT DUNCAN: Michelle and Josh, do you feel like you've got enough information for next steps?

MICHELLE CONWAY: Yes.

VICE CHAIR ROBERT DUNCAN: All right. I thank you very much. Again, great job, excellent work. And I pass it over to our Chair.

CHAIR VERLON JOHNSON: All right. Thank you, and I agree, great work, Michelle and Josh. I appreciate you.

And I think, Josh, at least this is your first time presenting. Is that right? You did a very fine job.

Michelle, this is your -- you've been up there a couple of times, right? Yes, exactly.

I just want to acknowledge when we do things for the first time when we do them very well. So thank you so much.

All right. So we are going to go on to our next session. We've looked before at ways states can support better integration, of course, for people who are dually eligible over and over, because we think that's an important population to consider, and we've also made

recommendations around state strategies and contracts with D-SNPs.

So our next session is really going to take us into a related area. We're going to look at full-benefits duals enrolled in Medicare Advantage special needs plans, or C-SNPs and I-SNPs. I love the SNPs here, and so where we know that that same contract relationship does not exist.

So Michelle and Gabby are going to give us some background and get us started on some key discussions around this. I'll turn it over to both of you. Thank you.

FULL-BENEFIT DUALLY ELIGIBLE INDIVIDUALS ENROLLED IN MEDICARE ADVANTAGE SPECIAL NEEDS PLANS (SNPs)

* MICHELLE CONWAY: Thank you. Good morning, everyone.

Today, we'll be discussing full-benefit dually eligible individuals enrolled in Medicare Advantage special needs plans. We'll begin by providing some background information about all three types of special needs plans or SNPs. Then we'll give a brief refresher on relevant prior MACPAC work on dually eligible individuals. We'll then discuss our project plan and the need for this analysis,

including SNP enrollment trends and state awareness of SNPs. We'll then conclude with next steps.

Dually eligible individuals are eligible for both Medicare and Medicaid. There were about 13.6 million dually eligible individuals in 2022. They are a diverse population that includes individuals with multiple chronic conditions, physical disabilities, and cognitive impairments such as dementia, developmental disabilities, and mental illness, as well as relatively healthy individuals. They account for a disproportionate share of expenditures in both Medicare and Medicaid relative to the size of their population.

Dually eligible individuals may experience fragmented care and poor health outcomes when their benefits are not coordinated. It has long been the Commission's view that integrated care has the potential to improve care for dually eligible individuals, eliminate incentives for cost shifting between Medicare and Medicaid, and reduce spending that may arise from duplication of services or poor care coordination.

Dually eligible individuals may be enrolled in a Medicare Advantage, or MA, SNP for Medicare services.

Depending on the plan, they may also receive Medicaid services through a SNP.

A SNP is an MA plan specifically designed for individuals with special needs, including those who are institutionalized, dually eligible, or have a severe or disabling chronic condition.

Accordingly, there are three types of SNPs: institutional special needs plans, or I-SNPs; dual eligible special needs plans, D-SNPs; or chronic condition special needs plans, C-SNPs.

Prior MACPAC work has focused on D-SNPs, which are designed for dually eligible individuals and offer varying levels of integrated care, but dually eligible individuals can also enroll in C-SNPs or I-SNPs if they choose. Unlike D-SNPs, however, they only cover Medicare services and are not required to coordinate with a state Medicaid agency.

We'll turn now to some background information on SNPs more generally.

The Medicare Modernization Act of 2003 established SNPs as specialized MA plans for special needs individuals defined as institutionalized individuals,

dually eligible individuals, and/or individuals with severe or disabling chronic conditions as specified by the Centers for Medicare and Medicaid Services, or CMS.

SNPs became available beginning in 2006. Legal authority for SNPs was extended several times until they were made permanent by the Bipartisan Budget Act of 2018. As MA plans, SNPs are subject to all Medicare Advantage regulations and must provide Medicare Part D prescription drug coverage.

SNPs submit bids to CMS, and CMS pays them according to the agency's risk adjustment methodology, the same way other MA plans are paid.

A key difference between SNPs and other MA plans, however, is the SNP Model of Care, or MOC, which SNPs are required to develop. Through its MOC, the SNP explains how it will meet enrollee needs with information about the enrollee population, its care coordination approach, its provider network, and quality measurement and performance improvement.

The SNP must also conduct enrollee health risk assessments and use them to create individualized care plans for each enrollee in the plan and describe this

process in its MOC. The National Committee for Quality Assurance, or NCQA, scores the MOC according to CMS guidelines. Plans must meet a minimum score for approval, and higher scores result in longer approval periods for D-SNPs and I-SNPs. For C-SNPs, however, the MOC may only be approved for one-year increments, and NCQA posts MOC scores publicly on its website.

Next, we'll walk through each of the three types of SNPs.

D-SNPs restrict enrollment to individuals who are entitled to both Medicare and Medicaid and coordinate care across both programs. They must have a contract with the state Medicaid agency that meets minimum requirements to coordinate with Medicaid benefits. D-SNPs may also provide coverage of Medicaid services, including long-term services and supports, or LTSS, and/or behavioral health services.

They are the most widely available vehicles for integrating Medicaid and Medicare. They were available in 46 states in the District of Columbia in 2025, and about six million dually eligible individuals were enrolled in D-SNPs in 2025.

There are three types of D-SNPs with varying

levels of integration with Medicaid. Coordination-only D-SNPs must meet minimum requirements for coordinating with Medicaid benefits but are not required to contract with a state to provide Medicaid benefits. Highly integrated D-SNPs, or HIDE D-SNPs, must provide coverage of either LTSS or behavioral health or both under a capitated contract with a state Medicaid agency, and fully integrated dually eligible special needs plans, or FIDE D-SNPs, must provide access to Medicare and Medicaid benefits under a single entity that holds both a contract with CMS and a Medicaid managed care contract with the state.

The FIDE D-SNP's capitated contract with the state must provide a more complete set of Medicaid services, including both LTSS and behavioral health. FIDE D-SNPs must also operate with exclusively aligned enrollment which means limiting enrollment to only full-benefit dually eligible individuals who receive their Medicaid benefits from the same organization.

C-SNPs restrict enrollment to individuals with one or more severe or disabling chronic conditions. They may enroll individuals with one chronic condition or a grouping of chronic commonly comorbid and clinically

related conditions with CMS approval. These conditions and groups of conditions are defined in CMS regulations which include a list of 22 different qualifying conditions. However, nearly all C-SNP enrollees, about 95 percent, are enrolled in plans for people with cardiovascular conditions, chronic heart failure, and diabetes. In 2025, there were about 1.1 million C-SNP enrollees and about 211,000 dually eligible enrollees in C-SNPs.

I-SNPs restrict enrollment to individuals who have had or are expected to need the level of services provided in a long-term care facility for at least 90 days. I-SNPs can enroll individuals living in the community who require an institutional level of care under certain circumstances. And in 2025, there are 121,000 total I-SNP enrollees including about 110,000 dually eligible enrollees, so a much smaller population.

Though C-SNPs and I-SNPs do not provide Medicaid benefits and are not required to coordinate Medicaid benefits for enrollees who are dually eligible, the nature of those two types of C-SNPs, those two types of SNPs, plans for those with chronic conditions and those with long stays in long-term care facilities aligns with the

characteristics of dually eligible individuals.

Dually eligible individuals face a high prevalence of chronic conditions. In 2025, 63 percent full-benefit dually eligible individuals had three or more chronic conditions, for example, and the vast majority of Medicaid-covered nursing facility residents are dually eligible.

As I mentioned in the previous slides, dually eligible individuals make up a notable percentage of enrollment in these two types of plans, about 20 percent of C-SNP enrollees and about 90 percent of I-SNP enrollees.

I'll now turn it over to Gabby to talk more about relevant MACPAC work and more details on our project objectives.

* GABBY BALLWEG: Thank you, Michelle.

As you all may recall, the Commission's extensive work on dually eligible beneficiaries has established that individuals who are dually eligible often experience fragmented care and poor health outcomes due to a lack of coordination across the Medicare and Medicaid programs.

As Michelle discussed, the Commission has an extensive track record ensuring dually individuals have

access to integrated care. To this end, MACPAC's prior work identifies strategies to integrate and coordinate care across the two programs with a focus on opportunities for integration in D-SNP contracting.

We analyzed D-SNP lookalike plans, which may draw beneficiaries away from integrated care, acting at cross-purposes to federal and state efforts to promote integration. D-SNP lookalike plans are MA plans that appear to offer benefits targeted to dually eligible beneficiaries based on their cost-sharing structure and supplemental benefits. A large share of their enrollment is comprised of dually eligible beneficiaries. However, these plans are not subject to the same requirements as D-SNPs, such as having contracts in the states where they operate or an approved model of care, as Michelle just discussed.

Since then, CMS finalized regulatory changes which prevent CMS from entering into or renewing an MA plan contract if 60 percent or more of the projected enrollees in the plan bid are dually eligible beneficiaries. These changes are in line with the Commission's prior comments urging the agency to monitor this issue and take action.

Building on this work in 2022, the Commission recommended that Congress require all states to develop a strategy to integrate Medicare and Medicaid coverage for full-benefit dually eligible beneficiaries. After a further analysis on this topic in 2024, the Commission recommended that states leverage their contracting authority to require that D-SNPs submit care coordination and encounter data, and that CMS update guidance on D-SNP contracting to help states use their contracts to advance their state policy goals.

As I just discussed, the Commission has an extensive body of work on D-SNPs but not on other SNP types. In recent years, the number of C-SNP -- dually eligible beneficiaries enrolled in C-SNPs has grown.

According to CMS, between 2024 and 2025, C-SNP enrollment among dually eligible beneficiaries grew by more than 57 percent. Much of this growth is occurring in plans where dually eligible beneficiaries make up at least 60 percent of C-SNP enrollment, which, as you recall, is the lookalike threshold for D-SNPs.

On this slide, we have charted the percent change in the number of C-SNPs since 2021, according to CMS. When

we include all C-SNPs, which is the blue line, there's been an 86 percent increase in the number of plans since 2021.

When we look only at C-SNPs where dually eligible individuals make up at least 60 percent of the plan's enrollment, which is the green line, those have increased by 313 percent.

For comparison, we can consider the increases in conventional Medicare Advantage plans around the same time period. A recent MedPAC analysis showed conventional MA plans only increased by 14 percent from 2021 to 2024, and that number actually decreased slightly between 2023 and 2024.

In that same analysis, MedPAC observed that as the number of conventional plans with a high share dually eligible individuals decreased with the new restrictions on lookalike plans, the number of C-SNPs with a high share of dually eligible enrollees increased from about 17 plans in 2021 to 43 in 2024. This trend aligns with the increase in the number of C-SNPs described on this slide.

When MedPAC restricted the analysis to C-SNPs with features of lookalike plans and estimated data for 2025 and 2026, they found that the number of C-SNPs that

may be functioning as lookalike plans has grown from five plans in 2021 to 92 in 2026, with a particularly large increase in 2026.

Consistent with other researchers, MedPAC also found that C-SNPs are concentrated in states that limit their participation in the D-SNP market to insurers that also offer a Medicaid managed care plan for dually eligible beneficiaries in their state.

Lastly, MedPAC also found that C-SNPs with a high share of dually eligible beneficiaries had common features. One of the most relevant features to Medicaid is that most of these plans had the highest possible out-of-pocket cost limit for Parts A and B, which Medicaid covers either in part or completely for full-benefit dually eligible individuals, but would disincentivize non-dually eligible individuals from enrolling in that type of plan.

I-SNPs have experienced less growth than C-SNPs but have nonetheless expanded in recent years as well, with an increase in enrollment from about 90,000 in 2021 to 122,000 in 2025, according to the MedPAC analysis of Medicare enrollment data.

The large growth in dually eligible individuals

in C-SNPs, as well as the number of C-SNPs available, suggests additional analysis is warranted. One potential contributor to the increase in dually eligible beneficiaries enrolled in C-SNPs is CMS's regulatory changes related to lookalike plans. With lookalike plans being phased out in D-SNPs, some hypothesize that C-SNPs are stepping into a similar role, marketing to and enrolling dually eligible individuals that might otherwise enroll in an integrated plan such as a HIDE or FIDE SNP.

Stakeholders have raised concerns about the dually eligible population in C-SNPs and to a lesser degree I-SNPs, experiencing more fragmented care or D-SNP enrollees switching plans and losing access to integrated benefits.

From initial conversations with states, we learned that they may not be aware of C-SNPs and I-SNPs operating in their state, but still pay for the Medicaid services among those dually eligible enrollees.

C-SNPs and I-SNPs are not required to contract with the state Medicaid agency, which limits the state's authority to require integration or to coordinate with Medicaid services. States also do not have access to the

models of care for these plans, so they do not have visibility into the population served or how the services are delivered.

Lastly, C-SNPs are designed to provide specialized services for enrollees with specific chronic conditions, yet 95 percent of all enrollment in C-SNPs is targeting cardiovascular disease, chronic heart failure, and diabetes, which are conditions that are very common among Medicare beneficiaries and particularly among dually eligible beneficiaries.

In terms of our next steps, we will be conducting a quantitative analysis that examines the demographics and Medicaid utilization and spending for full-benefit dually eligible individuals in D-SNPs, C-SNPs, and I-SNPs. The analysis will provide some baseline data that establishes states' role in financing the Medicaid services provided to SNP enrollees.

Information about demographic characteristics of enrollees will also better inform our understanding of those who are impacted by the growth in enrollment among dually eligible individuals in C-SNPs and, to a lesser degree, I-SNPs.

At this time, we're happy to answer any outstanding questions about C-SNPs and I-SNPs and are interested in any additional considerations we should contemplate as we get into this work.

So, at this time, I will pass it back to our esteemed Chair, who will facilitate our discussion. Thank you all.

CHAIR VERLON JOHNSON: Thank you. Thank you for that, too, as well. Did you hear that, "esteemed Chair"? Did you hear that, John?

All right. Thank you. Great work. Great work.

Let's go to Patti. Thanks.

COMMISSIONER PATTI KILLINGSWORTH: I echo the great work.

This feels like a game of Whack-a-Mole. So you close one pathway, and they find another. I think this work is incredibly important. I think the work that you've done so far is so insightful and we need to continue to dig deeper.

I realize that we are a ways away from a policy recommendation. I know that. But that's not going to keep me from voicing something that we should be thinking about

as we kind of continue through this exercise of what the right next steps are.

It is striking to me that 90 percent of enrollees in I-SNPs are dually eligible, and yet I-SNPs do not have the same requirements that D-SNPs have. That seems a little nonsensical to me. So I think we should continue to ask ourselves that question.

As we've talked about sort of leading up to this, states have little insight and absolutely no control over these two types of SNPs and how they operate in their state, and yet significant percentages of the beneficiaries they're serving, particularly in I-SNPs, but in this growing subset of C-SNPs, are Medicaid beneficiaries too.

So I think we should ask ourselves the question about I-SNPs. I also think we should ask ourselves the question about C-SNPs that serve 60 percent or more dually eligible. It's the same standard that was applied to the lookalikes. Why would that not be applied to C-SNPs? There need to be expectations for beneficiaries who are dually eligible that their benefits are coordinated, that there is, you know, information that flows to the Medicaid agency, that the Medicaid agency has some ability to impact

how care is delivered in the interest of their own beneficiaries.

So I don't have, you know, specific things with respect to the data. I would say, please continue the good work. Please bring that back to us, and then let us all continue to be thoughtful about what the right policy steps might be.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti.

Carolyn?

COMMISSIONER CAROLYN INGRAM: Thank you.

I have to agree with Commissioner Killingsworth that it's crazy to me that we have entities that are supposed to be integrating care out there that don't follow the same standards that D-SNPs have, and that the states have no control over them. So I have to agree that about applying the lookalike threshold.

I mean, could you imagine to members and consumers and individuals what this looks like when they're trying to figure out what to apply for and what to be in? For families trying to figure out Medicare and Medicaid, it's insane as it is, and then on top of that, we layer D-

SNPs, C-SNPs, I-SNPs, and then a broker who's financially incentivized to get you to move. So I would go further to even say those financial incentives that go to brokers to convince people to move out of an integrated plan into these unintegrated plans should be stopped. They should just be done away with. That just seems like we're financially incentivizing somebody to move them to a product that doesn't really integrate their care. So it's just kind of appalling to me.

I think if our former Commissioner Melanie Bella and Chair, also esteemed Chair, former Chair were here, she'd be echoing some of those comments and reminding us to make sure to take a look at all of these platforms.

So I would say also if you could look at the states where these C-SNPs and I-SNPs are growing, were they states that had integrated D-SNPs in some way? And then those entities that were growing were the ones that lost the contracts for those integrated D-SNPs? Because I have kind of a feeling that may be what we're seeing. So I wonder if you see states where they are prolific, and they happen to be states that did integrated bids, and then those vendors didn't win the bid, and so they just figured

out how to shift their members into a C-SNP or an I-SNP. And maybe you can't dig that far into it, but it'd be interesting to see that.

Thank you.

CHAIR VERLON JOHNSON: Thank you so much. Appreciate that.

John?

COMMISSIONER JOHN McCARTHY: I just have a very basic question. I don't know if somebody in the room can answer it, but it's what was the policy -- how do we end up with so many different types of SNPs? Was it the industry that proposed that? Was it Medicare that proposed it?

MICHELLE CONWAY: I'm not sure of the original intent. I know that those three, as I mentioned, were created by that Medicare Modernization Act in 2003. I'm not sure where the distinction between those three types came from originally. It's a good question.

COMMISSIONER CAROLYN INGRAM: Tim?

COMMISSIONER TIMOTHY HILL: I appreciate the work.

I'm going to echo my colleague, Dr. Giardino, on the simplification theme that we seem to have. I find,

honestly, the duals conversations around how they get their care to be incredibly mind-numbing, and I would really encourage us -- I did some work four or five years ago around trying to do some lived experience and conversations with beneficiaries about what do they think the word "integration" means versus what is it that we all think it means.

I know we have this policy focus that we use on these types of delivery mechanisms that we think we know what we're saying and we think we're integrating care for beneficiaries. I really think it would be helpful as an analytic exercise to talk to members about what is important to them, how they experience any of these delivery models, and are they getting out of it what we think they should be getting out of it? When we say integration, do we all mean the same thing? I worry that we talk past each other a lot on this topic.

CHAIR VERLON JOHNSON: Thank you, Tim.

Mike, Jami, and then Patti.

COMMISSIONER MICHAEL NARDONE: Thank you for this work.

I agree. This seems like something we should

definitely continue to follow and continue to follow to recommendations, even at this early stage.

I just wanted to have a clarifying question, just to confirm my understanding. For the I-SNPs, Medicaid would be the payer for stays in the institution for over 90 days to 100 days -- 120 days. In effect, that's where the big expenditure is going to be, and yet there is no kind of coordination with the Medicaid program. That just seems kind of really crazy to me.

So, anyways, I look forward to your continued work here. Thank you very much. Sorry.

CHAIR VERLON JOHNSON: Thank you, Mike.

COMMISSIONER MICHAEL NARDONE: I have that on airplane mode and mute, so I don't know why it keeps --

CHAIR VERLON JOHNSON: All right. Jami and then Patty.

COMMISSIONER JAMI SNYDER: Thanks so much for your work on this.

I want to echo the sentiment expressed by Carolyn. I really feel like that state-by-state analysis would be helpful, in particular seeing where we've seen dramatic growth in C-SNPs.

And kind of along those lines, I fully support Tim in terms of bringing beneficiaries in, as well as individuals that are responsible for duals programs within state Medicaid programs. It would be great to hear from individuals where we've seen a lot of that growth in C-SNPs and kind of what they feel sort of the root causes of that growth are.

CHAIR VERLON JOHNSON: Thank you.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: I also want to follow up on Carolyn's comments because it gave me a thought related to specific data. Ownership data would be incredibly helpful in the growth, just understanding if there are particular companies that are sort of driving that growth.

Ideally, I would love to have a crosswalk to that and Medicaid procurement processes, but if we at least start with the ownership, I think that would be incredibly helpful.

The other thing that would be interesting and probably more complicated to try to do would be to look at people who are discharged from an institutional setting who

are in an I-SNP relative to people who are not, because my sense is, if you're the I-SNP, you're generally a nursing home, or at least you have some relationship usually with a nursing home provider. You're not incentivized to want that person to leave, and my guess would be that we would see a much lower opportunity for people to return to more integrated community settings. But I think that would be a very complicated analysis to do.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti.

Any other Commissioners?

[No response.]

CHAIR VERLON JOHNSON: I think we heard a lot of great comments. I think a lot of us are echoing those comments in our heads or vocally as well.

I mean, we did a lot of work around really thinking about state integration strategies, and so really thinking about what can states actually see and influence is important. I think we heard that from our Commissioners. As a study, is it possible to see both sides of the coverage from a Medicare and a Medicaid perspective?

I love the conversation around what's driving enrollment change. I think that's really important. Very good point to even think about that, Patti, in terms of ownership as well. I think that's really key as well.

And then I really want to know, what does coordination look like in practice for these plans? Right? I mean, are we seeing, you know, transition issues, access issues? Things like that would be important. But, overall, again, if our stance has always been about the state integration, you know, strategies, how is this really helping that, I think will be important.

Any other last comments?

[No response.]

CHAIR VERLON JOHNSON: All right. Okay. Thank you both for this work. Good work. Looking forward to hearing more.

Our next session is on hospice, and hospice is often discussed through I think the Medicare lens, particularly, right. But many of us have seen, I think, in our own families and communities, just the differences that it can make for a person. So I'm excited to be able to talk about this topic here. There is a lot that we don't

know from Medicaid hospice perspective, and so we've got, oh, Josh is back. Hey, welcome. Two in a row. Awesome. And, of course, Brian, who we always love to hear from, as well. So go ahead and take this one away. Thank you.

MEDICAID HOSPICE: POLICY, UTILIZATION, AND OVERSIGHT

* JOSH VARCIE: All right. Thank you, Verlon. We appreciate the opportunity to speak with the Commission today about the Medicaid hospice benefit.

MACPAC is undertaking descriptive work to better understand how the Medicaid hospice benefit operates. Today's presentation will provide background information about the benefit and discuss next steps for our work.

Our presentation is informed by a review of the literature, federal statutes, regulations, and guidance, and state plan amendments. Throughout the presentation we will share our findings and highlight areas where important gaps in knowledge remain. We will conclude by discussing next steps on the project, which include stakeholder interviews and a claims analysis.

I will begin by providing some background on the Medicaid hospice benefit. The Medicaid hospice benefit

provides interdisciplinary care and support to terminally ill individuals, typically in their final months of life. The benefit serves a unique population that differs from those who receive hospice care in other programs such as Medicare.

Although the Medicaid hospice benefit is an optional state plan benefit, all states currently provide the benefit. Key elements of the benefit are frequently modeled on the Medicare hospice benefit, though states have flexibility over some aspects of policy and administration.

In fiscal year 2024, combined federal and state spending on the Medicaid hospice benefit was about $3 billion. However, comprehensive estimates of the number of Medicaid hospice users and their demographics are not readily available, and we hope to fill this gap in our future work.

Moving along to eligibility and enrollment, Medicaid hospice benefits are available to terminally ill beneficiaries who voluntarily elect to receive hospice care and forego curative treatment. Many states define a terminal illness using the Medicare definition, which requires an individual to have a life expectancy of six

months or less if the illness runs its normal course. However, some states define terminal illness using a longer prognosis period, which federal policy allows.

The provider must first certify that an individual's terminal illness diagnosis is in accordance with the state's definition before an individual can enroll in Medicaid hospice care. Once enrolled, there is no overall limit on how long an eligible beneficiary may receive hospice care, though a provider must recertify the beneficiary's terminal illness in each successive election period. These election periods are defined by the state. Many states adopt Medicare's framework of two initial 90-day election periods followed by an unlimited number of successive 60-day periods, though some states use a different framework.

Since the passage of the Patient Protection and Affordable Care Act, or the ACA, children under the age of 21 have been allowed to continue receiving treatment for their terminal condition while also receiving hospice care, a provision that's known as the "concurrent care" provision. We will return to this provision in a few slides.

Much of the available research on the Medicaid hospice benefit has focused on specific states or populations, which makes it difficult to comprehensively assess patterns of hospice enrollment, access, and care in Medicaid. Even so, existing research highlights some important findings.

First, patients enrolled in Medicaid are less likely to use hospice care than patients with similar diagnoses enrolled in Medicare or who are dully eligible for Medicare and Medicaid. Some research suggests that these differences may be due to differences in the underlying composition of the populations served by each program, with Medicaid hospice users typically being younger and having fewer comorbidities.

Second, several studies have found lower hospice enrollment among Black and Hispanic Medicaid users relative to non-Hispanic white Medicaid users. Some research has attributed these findings to cultural differences such as distrust in the health care system among African-Americans and higher religiosity among Hispanic immigrants.

One area with a growing body of research is access to hospice care for children. Existing research has

shown that historically hospice enrollment for children in Medicaid has been low. For example, one study of children in California Medicaid who died between 2007 and 2010 showed that just over 10 percent of those children used hospice care.

Since the ACA established the concurrent care provisions, research has shown increases in utilization of concurrent care among children receiving Medicaid hospice. Specifically, concurrent care use has increased to 75 percent in the decade following the ACA's passage.

Even so, there are several remaining challenges for children in accessing hospice care. For one thing, a child must have a provider certify that they have a life-limiting, terminal illness according to the state's definition before they can receive hospice care. Making these determinations can be difficult for children because prognoses can be highly variable and many terminal illnesses in children are not well researched or understood.

Second, research has demonstrated that patients, families, and providers may not be fully aware of the concurrent care provisions, and as a result, some patients

and their families may choose not to enroll in hospice care because they believe the child will need to stop receiving curative treatment in order to enroll in that care.

Finally, existing research highlights confusion about how the concurrent care provisions and the Early and Periodic Screening, Diagnostic, and Treatment benefit, or EPSDT, interact. We plan to explore these areas in further detail in the next phase of our work.

Although hospice is an optional state benefit, state Medicaid programs that opt to provide the benefit must cover a broad range of hospice services. Those services generally align with those covered by the Medicare hospice benefit and are shown in the table on this slide. Importantly, these services must be provided under a written plan of care established by the patient's attending physician, the hospice's medical director, and an interdisciplinary group at the hospice. The initial plan of care is established before the beneficiary receives hospice care and is reviewed every 15 days, or more frequently if necessary.

Beneficiaries receive covered hospice services at one of four levels of care. Routine home care is provided

when an individual receiving hospice care is at home and is not receiving continuous home care. Continuous home care is provided at home during brief periods of crisis, which consists predominantly of nursing care and is necessary for the individual to remain at home.

Inpatient respite care is short-term care provided in an approved inpatient facility for respite purposes. Finally, general inpatient care is provided in an inpatient facility for pain control or symptom management that cannot be managed in other settings.

These levels of care are primarily used to determine the per diem reimbursement rate the state Medicaid agency pays the hospice provider, and Brian will discuss this further in a few slides.

Existing research shows that most hospice care is delivered outside of the inpatient setting. Specifically, a study of adolescents ages 15 to 29 who died from cancer in New York found that 81 percent of those hospice patients used outpatient hospice care only. Research also shows that hospice lengths of stay are typically short for most users. Specifically, a study of Connecticut Medicaid decedents with common hospice diagnoses found that between

2017 and 2020 about 40 percent of patients had a hospice stay of less than seven days.

Thank you, and I'll turn it over to Brian.

* BRIAN O'GARA: Thank you and good morning, Commissioners. Turning to provider participation, federal statute and regulations establish requirements that hospice providers must meet to participate in the Medicaid program. These include the hospice federal Conditions of Participation, which establish standards for patient rights, assessments, interdisciplinary care planning, staffing, and organizational operations. These requirements apply to hospice providers participating in either Medicare or Medicaid.

Federal Medicaid provider enrollment and screening requirements also apply to hospice providers, with screening requirements varying according to the provider's assessed risk of fraud, waste, and abuse. In 2024, CMS designated newly enrolling Medicaid hospice providers and those undergoing changes in ownership as high risk under Medicare. But because Medicare screening categories establish minimum requirements for provider types participating in both programs, these changes also

affect Medicaid hospice enrollment. And hospice providers generally undergo a moderate risk screening upon revalidation.

States may establish additional Medicaid participation requirements for providers. Although Medicaid hospice providers must comply with federal Conditions of Participation, federal Medicaid policy does not generally require them to enroll in Medicare. But, for example, we found that three states -- Indiana, New Jersey, and the District of Columbia -- do require Medicare enrollment as a condition of Medicaid participation. Our review of state plan amendments also identified additional examples of state licensing, documentation, and screening requirements for Medicaid providers.

Moving to payment, Medicaid hospice payment generally follows Medicare payment methodology. State Medicaid agencies pay hospice providers a predetermined daily rate based on the level of care furnished to the individual. This figure illustrates how Medicaid hospice payment rates are established.

Starting on the left, each day of hospice falls under one of the four levels of care, which Josh just

discussed. Routine home care, which accounts for most hospice days, has two payment rates, based on the duration of hospice enrollments, and an additional payment may apply for certain nursing and social work visits during the last seven days of life. This is known as the service intensity add-on.

Moving to the right, CMS applies geographic wage adjustments to the labor-related portion of each rate and publishes these resulting minimum Medicaid hospice payment rates annually. For some context, for fiscal year 2027, the routine home care rate is approximately $237 per day for the first 60 days, and then drops to $187 per day beginning on Day 61. By comparison, the general inpatient care rate is approximately $1,232 per day.

States can also establish their own payment methodologies subject to these federal minimums, and the daily rate covers most hospice services, including nursing care, medications, and medical supplies. However, Medicaid reimburses direct physician services separately.

Although Medicaid hospice payment follows the Medicare framework, states do retain flexibility in several areas. First, states may establish payment rates above the

federal minimum, and we found evidence of this in our review of state plan amendments.

And federal policy also establishes limits on inpatient hospice payment. During each annual period, inpatient days may not exceed 20 percent of the total hospice days furnished by a hospice provider. If a provider exceeds this limit the state recovers the applicable overpayment.

States may also establish an optional aggregate cap on Medicaid hospice payments, similar to the mandatory Medicare care. States that adopt an aggregate Medicaid cap must recover payments exceeding that applicable limit.

Medicaid also has a separate payment arrangements for certain nursing facility residents receiving hospice services. The hospice provider manages the beneficiary's hospice care while the nursing facility continues providing room and board. Medicaid pays the hospice provider an additional amount for room and board, which must be at least 95 percent of the applicable nursing facility rate. The hospice provider then passes this room and board payment through to the nursing facility.

States may pay more than that federal 95 percent

minimum, and again, our review found evidence of that. For example, Texas pays 96 percent of the applicable nursing facility rate, and Oregon pays the full 100 percent of the nursing facility rate.

Turning briefly to spending, this figure shows Medicaid hospice expenditures for fiscal years 2020 through 2024, based on state-reported CMS 64 data. Total expenditures increased from approximately $2.4 billion in fiscal year 2020 to $3 billion in fiscal year 2024. CHIP hospice payments were substantially smaller in fiscal year 2024. Twenty-one states and the District of Columbia reported approximately $1.3 million in total CHIP hospice expenditures. And, of course, these expenditure data do not establish how much of the spending growth resulted from changes in enrollment, service utilization, or payment rates.

Turning to oversight, federal and state agencies monitor hospice providers through surveys and enforcement actions, program integrity activities, and provider enrollment controls. Hospice programs undergo initial certification surveys and periodically certification surveys at least every three years.

Survey agencies may also conduct additional surveys in response to complaints or other compliance concerns. State survey agencies or CMS-approved accreditation organizations assess compliance through activities such as patient and caregiver interviews, home visits, and medical record reviews. And although surveys primarily focus on health and safety requirements outlined in the federal Conditions of Participation, CMS, through guidance, has emphasized that survey findings can also identify concerns warranting referrals for potential fraud.

When surveyors identify deficiencies, CMS may pursue enforcement actions such as civil monetary penalties, corrective measures, or termination of the provider agreement. Federal and state program integrity activities also examine the provider documentation of beneficiary eligibility, medical necessity, and the level of care furnished to the individual.

The Health and Human Services Office of the Inspector General, or HHS-OIG, reviews have also identified weaknesses in state Medicaid hospice oversight. For example, they found that Texas overpaid approximately $10.5 million to hospice providers between 2020 and 2022, because

the state lacked procedures to calculate and collect hospice aggregate cap overpayments.

And I'm sure as we all know, in May 2026, CMS imposed a nationwide moratorium on new Medicare hospice provider enrollments, citing concerns about fraud, waste, and abuse. CMS did not extend this moratorium to Medicaid and CHIP providers, but encouraged states to consider whether separate Medicaid enrollment restrictions were appropriate in their jurisdictions. Arkansas, Nevada, Ohio, Pennsylvania, and Rhode Island have implemented temporary Medicaid hospice provider enrollment moratoria this year, and California has maintained a moratorium since 2021, which is supposed to last through 2027.

Quality reporting is another area where Medicaid relies on the Medicare framework. Although state Medicaid agencies are responsible for broadly assessing the quality of Medicaid services, there is no specific federal Medicaid-specific Hospice Quality Reporting Program. Medicare's Quality Hospice Reporting Program collects certain standardized patient-level information, regardless of payer or age. Other quality measures rely specifically on Medicare claims, and therefore do not capture services

furnished to Medicaid-only beneficiaries.

States can establish additional quality requirements or link Medicaid hospice payments to compliance with federal reporting requirements. And we found, again, examples of this in our state plan amendment review. For example, Michigan and Wyoming reduce Medicaid hospice payments to providers that do not comply with federal quality reporting requirements.

CMS does publish some hospice quality information through their Care Compare tool, but it does not separately report these quality measures for Medicaid beneficiaries. So much of the comparable publicly reported information is not specific to Medicaid beneficiaries and remains limited.

To conclude, our initial review identified differences between Medicaid and Medicare hospice policy, variation in state requirements, and gaps in national evidence. Although Medicaid hospice relies extensively on the Medicare framework, states retain flexibility in areas such as eligibility, payment, provider participation, and oversight. And we also have limited national information about Medicaid hospice enrollment, utilization, provider participation, and quality.

Our next phase of work will include stakeholder interviews and analysis of T-MSIS data, and beginning next month we'll be interviewing officials from CMS, state Medicaid agencies, hospice providers, advocates, and other stakeholders to examine how Medicaid hospice policies operate in practice and identify potential challenges. We'll also analyze national Medicaid claims data to examine the characteristics of beneficiaries receiving hospice service and patterns of hospice use.

And at this time we welcome Commissioners' feedback in areas of Medicaid hospice policy and state flexibility that may warrant further examination, gaps in the available evidence, and particular populations or care settings that we should prioritize as we continue to move through this work.

And with that I will turn it back to the Chair.

CHAIR VERLON JOHNSON: All right. Thank you both. Very good work. Any thoughts or insights from the Commissioners? Commissioner Allen.

COMMISSIONER HEIDI ALLEN: Thank you for this work. I think it's really important. I am most interested in the non-duals when it comes to hospice, and particularly

I think it's really interesting that this initial peek into children. I really feel like children and adults are different when it comes to hospice, and just everything about the pathway to hospice. It's hard for me to imagine a child going into a hospice institution, like with older people. That's not where they belong.

So really what you're talking about is hospice that would be provided in home, and that has unique characteristics, and also unique issues related to being willing to say that we're done, that we're not going to pursue treatment anymore. I think with children that's a harder thing to do than it is with somebody who is elderly.

And one population that is of interest to me, from a personal level, is my sister was an RN who decided not to get employer-sponsored insurance one year and then had cancer, and she died very quickly after she was diagnosed. But we were in this scramble of, you know, she's not going to meet criteria for Medicare. Like that's not going to happen. She's not working because she's dying of cancer. How do we get her into Medicaid? How do we arrange hospice? And the only reason that we didn't have to try to figure that out was because she died so quickly

and in a hospital.

So I am interested in when people who are uninsured, even people who may not have qualified for Medicaid but they become really sick quickly, they are unable to work quickly, they don't have the employer support, either through insurance. How do people navigate that? I'm not sure. Because I had everybody in my family saying, "Well, you're the Medicaid expert. What do we do?" and I'm like, I have no idea how to walk this path in such a difficult time to be trying to navigate.

So yeah, for me I think I'm really interested in the interviews, and I hope that you can get enough people in these subgroups of adults, non-elderly adults and non-disabled adults, and children, and that you can get enough in each group to tell their story, that would be ideal for me. Thanks.

CHAIR VERLON JOHNSON: Thank you for those insights and for sharing. April.

COMMISSIONER APRIL HARTMAN: A couple of comments, and Heidi, I have my own personal experience too. With my mother, who was in hospice, she had a massive stroke, and it was a constant disruption in care because if

in 60 days she was unchanged, and she would be kicked off of hospice. We then had to find a physician, go through this whole process. Something would happen and she would end up back in the hospital with a bedsore or something, and then they'd put her back on hospice again. But then she'd be kicked off, and it's still this back-and-forth thing.

Hospice services do make it a lot easier for someone who is caring for someone's total care at home. It really makes a huge difference. But if it's disruptive in that you're constantly playing this game of, oh, we got these 60 days and we got kicked off, and then she's doing too good for hospice, she can't be on hospice, it just creates a problem. So that's just my personal experience.

The other thing I wanted to talk a little bit about is with kids, you know, in reading this information I did not know what concurrent care was. That's not a term that's out there in physician world very much. I don't think we even really know about it. The way we think about it is hospice and palliative care. And so all the kids that are still getting treated, even though they're terminal, are in what's called palliative care. And I know

for that they're billing Medicaid. It's not bundled as hospice would be, because there's still this mindset that if someone is on hospice, that's it. You've given up. There's nothing else to do. You're just going to manage their symptoms and they're going to go, right.

So I think there needs to be some look at the definition of hospice versus palliative care, especially in the pediatric world, because I know that's how we think about it. So I would just encourage us to look at that. We're on the border of Georgia and South Carolina, so I know that palliative care is different in South Carolina than it is in Georgia. So there must be some state plan for palliative care that maybe is different from hospice.

So that's just something. I don't know if you looked at that or if that came up, but I guess we think of it differently. Thank you.

BRIAN O'GARA: Yeah, I will just say that did come up since obviously the topics are very related. I do believe that Hawaii just became the first state with a distinct palliative care benefit in the Medicaid program, and I do know that California requires MCOs to offer palliative care. So I think maybe states are maybe

starting to think about this, but that's certainly something we can look at and flesh out more the difference in the interaction between those two types of services.

CHAIR VERLON JOHNSON: Thank you, April. All right. Next let's have Mike, and then Jami, and then Patti.

COMMISSIONER MICHAEL NARDONE: Thank you, April, for your comments. It's always helpful to see how it looks from the provider perspective, and that was really helpful. And thanks, Brian and Josh, for this work.

I kind of was going to the same place that April was, which is I thought about kids and parents who are trying to make this decision. So the information you provided about concurrent care was something I was really interested in understanding a little bit more about. Particularly where is -- and maybe this is something that could come up in your interviews -- where is the, I don't want to say breakdown, but where is the disconnect in terms of how that information gets down to families? Is it that there is need for guidance from the feds to the states, or is it that the states have the policy and they need to do a better job of informing people who are going through this

very traumatic period of time? I just think it would be helpful to kind of understand a little bit more about that.

And I thought your comments were really helpful, April, in that how, from the provider perspective, do they know about concurrent care, or where is the disconnect there. Thanks.

CHAIR VERLON JOHNSON: Thank you, Mike. Jami.

COMMISSIONER JAMI SNYDER: Yeah. Just a quick recommendation in terms of the stakeholder interviews. You didn't mention managed care organizations specifically, but I just would really encourage us, and I'm sure you're thinking about that, encourage us to incorporate the perspectives of managed care organizations who obviously are responsible for authorizing care and looking at utilization trends and identifying potential fraud, waste, and abuse, and really overseeing the quality of care provided by hospice organizations.

CHAIR VERLON JOHNSON: Thank you, Jami. Patti.

COMMISSIONER PATTI KILLINGSWORTH: I'll be brief. I echo the gratitude for the work. I also echo the comments of my fellow Commissioners. Particularly with respect to kids, it seems like this gap of understanding in

terms of children's ability to concurrently receive treatment, it's consequential, right, your second question. It is very consequential that somewhere along the line things are breaking down.

I also think there's a problem with respect to pediatric hospice care in terms of just hospice providers who will serve children. Many adult providers will not serve children. They don't feel that they have the staff, that they're qualified, their physicians are all geriatricians, whatever. So sometimes finding hospice providers for kids can be really, really difficult. That might be an area that we look at. Are there particular populations that we should focus on? I think even as a subset, I think kids fall into that, in particular, because they're not utilizing it, even when they need it. They're getting a day or two. And there would be such benefit for some of these children and their families to be able to access this care earlier. So I'd really like to look into that. Thank you so much.

CHAIR VERLON JOHNSON: Thank you, Patti. Carolyn.

COMMISSIONER CAROLYN INGRAM: Thank you. I just

wanted to bounce off Commissioner Snyder's comment about quality. Are there any means to measure quality in hospice care outside of managed care or standardized across the states, or I guess standardized even in managed care?

BRIAN O'GARA: That's a great question. I'll have to get back to you on that one. I'll have to dig a little more on the quality side. I do know that there are standard measurements that kind of encapsulate services delivered across hospice beneficiaries, regardless of payer or age. I think a lot of it is related to outcomes measures, but I can get more information to you on that.

COMMISSIONER CAROLYN INGRAM: Yeah, I think it would be helpful to have that as we're looking at these and possible recommendations, to have some of that. Thanks.

CHAIR VERLON JOHNSON: Any other Commissioners?

[No response.]

CHAIR VERLON JOHNSON: All right. Seeing none, thank you both so much. This is very helpful to our understanding of this issue, for sure.

CHAIR VERLON JOHNSON: All right. Now we will go to public comment. We invite you in the audience to raise your hand if you'd like to offer comments. Please make

sure you introduce yourself and the organization you represent. And we do ask that you keep your comments to three minutes or less.

All right. We have one comment from Lynn Lewis. Lynn, go ahead.

PUBLIC COMMENT

* LYNN LEWIS: Yes. In terms of the conversation today, I'm an independent consultant, if you will, like the Commissioner mentioned. I am a broker practicing in 25 different states. So just to talk about palliative care perspective, currently the majority of the palliative care specially provided at a skilled nursing facility is funded by Medicare A and B. And just to integrate the previous conversation in terms of the integrated care, where we have three different types, I heard the Commissioners mentioned the insurance company, if you will, tried to circumvent the enrollment, steering people away from original Medicare enrollment to Medicare Advantage plan. Specifically it's institution plans.

When people are under institution care, the institutions literally took charge of their care, including medical providing services as well as prescription

services. In terms of why the two plans are not coordinating in terms of the benefit is because of the current rules defined on how Medicaid benefits are managed at the state level. So CMS does not have sufficient data to tell us when people are institutionalized, though with a chronic condition how their care is managed.

In terms of the FIDE enrollment, we face a huge challenge for consumers to get sufficient support from the state level. So I totally would disagree with the Commissioners' current assessment in terms of how the insurance company, as well as the brokers, are steering enrollees to these particular plans.

We wish the Commissioners make open and transparent recommendations instead of based on solely how many plans are available. And all the enrollment should be based on the health care needs as well as the consumer's financial affordability. Thank you.

CHAIR VERLON JOHNSON: Thank you for that comment. Any additional comments?

[No response.]

CHAIR VERLON JOHNSON: All right. Seeing none, I do want to thank you all for the comment that we did hear,

and if you have additional comments please make sure that you submit those through our website at MACPAC.gov.

So as tomorrow is Halloween, I would just like to recognize Commissioner McCarthy, if we could spotlight him for a second. He is actually representing the great city of Chicago and the White Sox and the Pope. Would you like to say anything in particular, sir?

COMMISSIONER JOHN McCARTHY: Just, you know, for everyone out there, because of the great world championship win by the Milwaukee Brewers, and the great season the White Sox had this year, and I just have to thank the excellent and unbelievably great Chairperson, who went to the game for me because I couldn't go to get my White Sox Pope hat. Thank you so much for that.

CHAIR VERLON JOHNSON: You're welcome.

COMMISSIONER JOHN McCARTHY: And also for Halloween, everyone, have a safe Halloween if you're trick or treating.

CHAIR VERLON JOHNSON: Thank you. And I would be remiss if I also did not recognize Commissioner Ingram, who is bringing her hometown of Santa Fe to life today.

COMMISSIONER CAROLYN INGRAM: Thank you. I

didn't want to be left out of my cowgirl costume, representing all cowgirls and barrel racers across America who want to dress up for Halloween. You should just do that. Thank you.

CHAIR VERLON JOHNSON: Thank you. All right. So now this does conclude our October meeting. We wish all of you a wonderful weekend. We look forward to seeing you on December 10th and 11th. So thank you again for participating. Have a great day and a great weekend. Bye-bye.

* [Whereupon, at 11:38 a.m., the meeting was adjourned.]