PUBLIC SESSION

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COMMISSIONERS PRESENT:

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TRICIA BROOKS, MBA
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AGENDA PAGE

AGENDA PAGE

P R O C E E D I N G S

[10:35 a.m.]

CHAIR VERLON JOHNSON: Good morning, everyone. Welcome to our February 2025 MACPAC public meeting. We do have a full agenda today -- over the next two days, actually. We're going to be covering a number of critical topics, and we are very excited to have you join us today.

And so, with that, let me kick it over to Bob, who will actually start our first two sessions. Bob?

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman, and I'm excited to have Linn and Ava join us today for, hopefully, the final draft of looking at the recommendations made on the transition of care for children and youth with special health care needs.

And so they've gone through the four policy options with the recommendations we've made from the last meetings, and we look forward to hearing what you've got for us. So, with that, I'll turn it over to Linn.

DRAFT POLICY RECOMMENDATIONS TO IMPROVE TRANSITIONS OF CARE FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

* LINN JENNINGS: Thank you very much, and good

morning, Commissioners.

So today, Ava and I will present the draft recommendation language for our work on transitions from pediatric to adult care for children and youth with special health care needs.

So I'll start by summarizing our high-level findings from this work, and then Ava will go through our four draft recommendations and the modifications that we made to the recommendations based on your feedback at the January meeting, and then we'll end with next steps.

And just before getting into the findings, just as a reminder, the objective for this work was to examine how state Medicaid programs and MCOs operationalize their transition of care policies for children and youth with special health care needs, how beneficiaries and their families experience transitions, and to identify whether there are barriers to transitions that can be addressed in federal policy.

And as a reminder of our study population definition, we defined them as children enrolled in Medicaid through SSI-related eligibility pathways, those eligible for Medicaid under TEFRA and Katie Beckett

authorities, and our definition is also inclusive of children who qualify to receive institutional level of care. And this population is reflected as a minimum population in our draft recommendations.

So the findings from this work indicate that there are five primary challenges to children and youth with special health care needs transitioning to adult care.

And so, first, findings from the family advocate interviews and beneficiaries and caregiver focus groups indicated that beneficiaries and their families often had difficulties finding -- or having been given clear expectations about their transition to the adult care system and for understanding who is responsible for supporting them during this process.

Second, our findings indicate that often children and youth with special health care needs don't receive a transition of care plan, and findings from the literature reviews, stakeholder interviews, and focus groups indicate that having a structured transition of care strategy that includes individualized transition of care plans improves the outcomes for these children.

And third, there's a lack of guidance to states

on coverage of services to support transitions of care, and through our work, we found that some states do cover transition-related services using existing authorities, but in many cases, states were unaware of how to use these existing authorities to cover transition-related services.

And there's also a lack of data collection on transitions of care. Our findings from the state policy scan and stakeholder interviews indicate that states aren't required to and, in general, are not collecting information related to children and youth with special health care needs and their transitions. And so this is a barrier to stakeholders understanding this population and their needs on whether -- needs and then also whether the existing transition of care state strategies are effective.

And then, finally, there's a lack of cross-agency coordination between state Medicaid and Title V agencies. State Medicaid and Title V agencies are not required to coordinate specifically on the transitions of care for this population or to include the roles and responsibilities related to these transitions in their interagency agreements, and so few state agencies coordinate on these transitions. And there aren't always clear expectations

around which agencies are responsible for supporting them during that transition to adult care.

We also want to highlight some of the additional contextual factors that can affect their experience with transitions of care and why this transition process can be so challenging. These include the termination of the EPSDT benefit at age 21, and this can result in loss or reduced coverage of certain services if they aren't covered in the state plan.

They may also lose access to services and supports obtained through state Title V programs when they transition to adult care.

And another contributing factor is that health care transitions often occur concurrently with other types of transitions, and so these transitions can also lead to a loss of supports such as education and career counseling, workplace readiness, self-advocacy training, and an individualized education plan.

Children and youth with special health care needs also interact with and are supported by multiple agencies at the federal, state, and local level, and there is a need for increased interagency collaboration and coordination at

all levels and between multiple agencies that go beyond Medicaid and Title V.

And so I'll hand it over to Ava to present the draft policy recommendations.

* AVA WILLIAMS: Thanks, Linn.

Now I'm going to go over the draft recommendations and rationale based on Commissioner comments from the January meeting.

This slide should look familiar, but as a reminder, it shows the challenges identified in our work, policy objectives, and possible recommendations for addressing these challenges.

The first recommendation states that Congress should require states to develop a strategy for transitions of care for children and youth with special health care needs that includes an individualized transition of care plan, the entity responsible for developing and implementing the individualized transition plan, time frames for the transition, and making the state's strategy publicly available.

Additionally, based on Commissioner feedback, staff updated the minimum population to include children

and youth who qualify to receive an institutional level of care.

Under this recommendation, states have the flexibility to determine their transition strategy, including what services to cover based on their children and youth with special health care needs, population, delivery system, and program design.

Commissioners also identified several considerations for states when developing their strategies, such as including children and youth with special health care needs outside of the minimum population detailed in the recommendation; leveraging existing frameworks for transitions as a foundation for their strategies; engaging and soliciting feedback from stakeholders, beneficiaries, and families when developing their strategies; and the importance of engaging adult providers in the transition process.

The Congressional Budget Office does not estimate there will be a direct effect on federal spending for any of the four recommendations.

States would need to allocate resources to develop and document their transition strategies as well as

establish parameters for individualized transition plans. Beneficiaries and their families would have a better understanding of their state's transition strategy and expectations for their own transitions. Similarly, plans would have a better understanding of the state's transition strategy and expectations for how they should support this population during their transitions. And lastly, providers may be involved in developing individualized transition plans.

Our second recommendation states that the Secretary of HHS should direct CMS to issue guidance to the states on existing authorities to cover transition of care-related services for children and youth with special health care needs.

Some states already cover and pay for transition of care services, but our analysis found that other states were not aware of the authorities for doing so or the CPT codes for claiming.

Stakeholders indicated a need for guidance on claiming for transition-related services, capitation rate setting that accounts for these services, and opportunities to cover interprofessional consultation, as well as

information about opportunities for providing transition-related services under targeted case management and the EPSDT benefit.

Commissioners also noted that CMS should consider addressing how states can cover warm handoffs and same-day visits between pediatric and adult providers.

There would be no direct effect on federal spending. States would have a better understanding of how to use existing authorities to pay for transition-related services. Beneficiaries, their families, and caregivers may experience increased access to transition-related services and supports. Plans may need to implement provider payment changes, and providers may receive payment for services they previously have not been.

The third recommendation states that the Secretary of HHS should direct CMS to require states to collect and report data related to if beneficiaries receive transition-related services, including the receipt of an individualized transition of care plan.

Additionally, states should collect and report data related to beneficiary and caregiver experiences with transitions of care.

This recommendation is focused on improving data collection related to establishing a baseline about the number of children and youth with special health care needs receiving transition-related services, what services they receive, and if they have an individualized transition of care plan.

In response to Commissioner feedback, we have included considerations for CMS in implementing this recommendation.

States should solicit input from stakeholders, including beneficiaries, their families, and their families on what information would be most meaningful to collect to better understand this population and their transitions of care.

States should also leverage existing data collection activities to prevent duplicative efforts to consider collecting and consider collecting information related to the adult system after beneficiaries transition.

There would be no direct effect on federal spending. Depending on the extent which states leverage existing data collection efforts, they may not have to collect additional data to meet the reporting requirements.

Stakeholders would have a better understanding of beneficiaries, their families, and caregivers' experience with transitions and, in turn, how to improve transitions.

Similar to the state implications, depending on the extent current data collection is leveraged, plans may not have to change their collection efforts.

And lastly, providers may have new reporting requirements related to the receipt of an individualized transition plan.

The last recommendation states that the Secretary of HHS should direct CMS to require state Medicaid agencies' IAAs with state Title V agencies specify roles and responsibilities for supporting children and youth with special health care needs, transitions from pediatric to adult care.

In response to Commissioner feedback, staff added language to ensure that state Medicaid agencies' roles described in the IAAs reflect the state's transition strategy.

This recommendation addresses challenges with cross-agency coordination and focuses on requiring state Medicaid agencies to specify in their IAAs which agency is

responsible for providing transition services, developing pertinent training and educational resources, and providing other supports to facilitate transitions for this population.

Additionally, although this recommendation is specific to state Medicaid and Title V agencies, states should consider engaging in collaborating with other agencies that provide services and supports to children and youth with special health care needs, such as departments of developmental disabilities and education agencies. There would be no direct effect on federal spending.

State Medicaid and Title V agencies would need to update their IAAs to meet the new requirements. Beneficiaries, their families, and caregivers may experience more coordination and support from both agencies.

And finally, providers may experience changes to their roles in supporting children and youth with special health care needs during their transitions.

Now I'm going to go over next steps.

We welcome feedback on the draft recommendation, rationale, and implications, and we will return in April

with the draft chapter and for a vote on these recommendations.

Thank you, and I'll turn over to the Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Ava. Thank you, Linn. I appreciate you taking the feedback, both from our last couple of conversations as well as those that were written and submitted to MACPAC.

So, with that, Commissioners, thoughts on the language and the draft that's been presented?

Angelo.

COMMISSIONER ANGELO GIARDINO: Linn and Ava, I really wanted to thank you for your hard work on this over these many months.

I see this as part of a journey where we are recognizing the importance of health care transition to children and youth as they mature.

And I speak in strong support of the four recommendations. You know, alchemy is where you take lead and turn it into gold. Reverse alchemy is where you take gold. In this case, that would be kids that we have invested in to get them healthy. And then we convert it into lead, because we follow a disorganized, non-systematic

transition of them from the pediatric to the adult setting. So all that work we did to create gold is converted to lead by letting them have a random, unmanaged, fragmented experience to transition.

And we know from the literature -- and again, Dr. White, Dr. Antonelli from last meeting, gave us some really good information. We know from the literature that if you do not manage that transition, kids experience fragmented care, and their chronic illnesses worsen. And then we have to pick up the pieces in their late 20s. And if we're all about reducing waste in this system, we should organize and be systematic around that transition.

So I support alchemy. So let's take the lead and turn it into gold and then keep it gold.

So thank you for your work.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo, for your comments and the chemistry lesson.

With that, Sonja.

COMMISSIONER SONJA BJORK: Thank you.

I echo the comments of the Commissioner before me about how important this work is, and it really highlights how important Medicaid is in so many people's lives. It's

just a crucial benefit for families with children with special needs and these young people as they become adults.

I used to be an attorney for children who were involved in the foster care system. This was years ago, before California had some of these organized ways of dealing with transitions to adulthood. And one of my clients had sickle cell, and her care just dropped off when she became an adult.

And just as Angelo said, she ended up in the hospital multiple times, and that is just a complete waste for her, for her life, for her well-being, losing her apartment because she was in the hospital so long, and then also for the system. If she could have simply had a good transition to adult care, then this wouldn't have happened.

And so I also am in favor of all four of the recommendations, and I just love how this shines a spotlight on the important role that Medicaid itself plays for so many people.

VICE CHAIR ROBERT DUNCAN: Thank you, Sonja.

Heidi.

COMMISSIONER HEIDI ALLEN: Thank you so much for this work. Like the fellow Commissioners, I'm in support

of all four options.

And I just wanted to reference some feedback that we got from the public after our last meeting from GotTransition, which is part of the National Alliance to Advance Adolescent Health, and from Dr. Richard Antonelli. And I feel like they had good language that we could enter into our -- if not necessarily the recommendations, but in our framing of them about the importance of actually assisting children to find that adult provider and facilitating the exchange of medical records, the exchange of personalized health plans. I thought that there was -- both of them remarked on the need to think about coverage, and I know that that's something that we plan on taking up next.

And I think -- I also really appreciated some of the granularity of thinking about what outcome measures could look like, which would be things like date of last pediatric appointment and then date of first adult appointment and then looking at sub-conditions and populations to understand where the disparities might be.

That's it for me. Thanks.

VICE CHAIR ROBERT DUNCAN: Thanks, Heidi.

Dennis, then Patti.

[Pause.]

VICE CHAIR ROBERT DUNCAN: You're on mute, Dennis.

[Pause.]

COMMISSIONER DENNIS HEAPHY: Sorry about that.

I want to echo comments made by Heidi and others about this important -- I endorse all the recommendations -- the importance of this, because parents will say that graduation from high school when kids transition is both the best and the worst day of their lives. And it's because they go from a very well-organized wrap around set of services, medical, social, and so many other services that support and keep these kids really alive and going, and those services just disappear.

And so we focused in this round on medical services. I'd love to see, in the future, us to look at the social, like the day -- the day services folks receive, because oftentimes these kids, once they graduate, they languish at home. They become depressed and isolated, and we know that depression and isolation have a direct impact on health outcomes.

And so at some point, it would be wonderful to see -- to look directly at what happens to all the social services, all the interactions these folks have and support they have once they turn 22, because they all but disappear as well. So I think it's really important for us to look at in the future.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Patti, then Carolyn.

COMMISSIONER PATTI KILLINGSWORTH: Ava and Linn, thank you for all of your work on this project. It's such an important topic.

It has been over 20 years ago since my son was in the middle of this process of transitioning from the pediatric to the adult system and actually went to heaven in the middle of that process. But I distinctly remember begging his pediatric physicians, his neurologist, his pulmonologist, his orthopedist to continue to see him even as an adult, because there really was no support to make that transition.

And while it disappoints me that we're decades later and still struggling with the same issues, it

encourages me greatly to see us taking important steps to make the system better. So thank you.

And I also fully support all of these recommendations.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

Carolyn.

COMMISSIONER CAROLYN INGRAM: Thank you, and thanks for this work.

I want to echo Sonja's comments about how important this shows, you know, how many people rely on Medicaid and especially our vulnerable populations for accessing care.

I do have a couple of questions that I still am struggling with, and one is towards the outcomes. Heidi even spoke a little bit about that. But we're saying in here, we're going to put in place -- or want to put in place these plans, and so people can write up these great plans in a state about how they're going to work together and how they're going to set up transition time frames and adhere to those plans, I suppose. This all, I guess, makes us hope that somebody will go back and check to make sure that those are good plans that were written or strategic

plans that were written.

But I struggle still a little bit about how it gets to outcomes for the individual, and what we're trying to do is really make sure that the person has better quality of care and also eventually keeping the cost curve down, right, by making sure they don't have these hospitalizations. And I know that's what we're trying to get to, but we don't really say that in the recommendations, and so I struggle a little bit with how we can get to some of those outcomes with what we've got written here.

So maybe there's a way to go back and add something that looks at outcomes of care or we go back and look at the plan to be adjusted because of the outcomes not being successful or being successful or that the strategy needs to include what the outcomes are of these changes. Otherwise, we're just adding more administrative layers onto Medicaid, and anybody can sit down and write up some kind of strategic plan about helping people transition, and then it doesn't result in what we really want.

So I think we've talked a lot about the process here, but what we're trying to get to is the outcomes. I

struggle with that.

The only other thing I have is kind of a nitpicky thing, but there are states without Katie Beckett waivers or authorities, and so I'm wondering about the language we use in some of these recommendations referring back to those Katie Beckett authorities. I don't think that's what it's actually called in state -- or in federal statute. I don't know what all of the waivers are called, but I don't think they're called "Katie Beckett authorities." So I could be totally wrong, but we either need to add the proper language or just change that out.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn.

John.

Oh, excuse me. Go ahead, Linn.

LINN JENNINGS: Yeah. Well, on the outcomes, we can definitely, I think, strengthen that. Maybe also in Recommendation 3, I think we try to link it back to kind of like, in the end, we do want improvements related to that strategy of care, and I think we can look at strengthening some of that language and the rationale.

And we can also do some work to just double-check

on Katie Beckett. I think we've used kind of "Katie Beckett" as kind of like a little bit of an umbrella term. A lot of states have HCBS waivers that are similar to Katie Beckett.

COMMISSIONER CAROLYN INGRAM: Yeah. And that's why I think if we're making a formal recommendation, we want to use the formal legal language, so home and community-based waiver services or programs.

VICE CHAIR ROBERT DUNCAN: Okay. All right. John, then Michael, then back to Patti.

COMMISSIONER JOHN McCARTHY: I just want to say, you know, great work. It's hard to not agree with these. It's like baseball and apple pie on this one. So I think we're all in agreement that, obviously, working with transitions is really important. Many of us have either, you know, experienced it, lived through it, or helped people go through it. So that's all good.

But I want to go back to what Carolyn said, and I agree. I had brought this up at one of our other meetings, is tying this to outcomes. So I really would have liked to have seen a recommendation in here that would be a recommendation to Congress that would also put in an

incentive around FMAPs tied to the outcomes on these programs. So either an FMAP increase or an FMAP reduction, depending on the outcomes measured across the various states.

VICE CHAIR ROBERT DUNCAN: Thank you, John.

Mike?

COMMISSIONER MICHAEL NARDONE: Yeah, I agree.

I wholeheartedly endorse these recommendations.

The one question I had -- and it kind of dovetails with what Carolyn was saying -- on the Recommendation No. 3, you know, the last sentence in there is kind of a catch-all about experience and outcomes. And one of the questions -- one of the things I would not want to see is that CMS directs states to assess and report the CMS beneficiary experience, but there's no standardization of that information and -- because otherwise then states are just reporting stuff that -- you know, I don't know if it's usable. So I think there has to be -- and I, you know -- Carolyn, I think, was pointing to, like, what are the right outcomes, and I just wonder if there's, like, kind of another step that needs to be built in here about exploring, like, what are the measures that, you know, CMS

should be exploring what the measures are and directing, or there needs to be some standardization, because otherwise we have a situation where people are maybe reporting things, but it might not be meaningful information.

VICE CHAIR ROBERT DUNCAN: Thank you, Michael.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Just a quick follow-up on the recommendations of the three previous Commissioners. I do think that outcomes are really important.

I think that the purpose of sort of process measures, if you will, should always be directed toward the outcomes that we are seeking to achieve with the recommendations that we're making. So, you know, reporting on process is not unimportant if you align the measures, the things that you're measuring, with what ultimately those processes are intended to achieve.

So I think measuring whether or not someone had a transition care plan is important. People should have one. I think measuring whether or not that care plan actually got executed is a really good measure. But I do think outcomes are going to be difficult.

And by the way, fully support every opportunity that we can to measure outcomes. I do think avoiding unnecessary hospitalizations or ED visits is important, but as a practical reality, these are individuals with really complex medical needs, medical needs that oftentimes do tend to increase over time. And so, even with the best coordination of care, there still could be hospitalizations. I just think we have to be really careful about recommending outcomes without really allowing those to be thought through with a group of experts, including physicians and families and the individuals themselves, right, to really think through what are the outcomes that we're trying to achieve, and then are the processes that we're recommending really the right ones to measure to make sure that we're doing our best to ultimately support those outcomes and happening?

VICE CHAIR ROBERT DUNCAN: Thanks, Patti.

Madam Chairwoman?

CHAIR VERLON JOHNSON: like when you say that, Bob.

All right. Thank you, Linn and Ava, so much for this work.

I totally support all the recommendations that we have out here. It's obviously a very important issue, and I do love all the passion I'm hearing from my fellow Commissioners.

I echo many of the comments that they made, particularly around outcomes, and Mike's comments about generalizations. I think that's important as well.

And I also just want to put a pin in the idea of making sure that we're getting beneficiary feedback, particularly in all the designs we have.

I really like the recommendation, as a former Fed, of providing guidance. I think that that is key, but I do think that sometimes we mistakenly think that guidance is just enough. And I'm not sure if it's going to be in the actual chapter or if we need to write it into the recommendation, but there are going to be states that are going to have varying levels of capacity in terms of implementing this. And so I think it's important for us to really call out that guidance. Written guidance is wonderful, but also making sure there's going to be technical assistance available, too, from the federal government, I think is really important as well.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you.

All right. Linn, Ava, you both know, much like Patti, how personal this has been to me and how much I appreciate this from being a father of a child with special health care needs and dealing through those transitions and/or their lack of. So I've appreciated this work.

I, too, stand in support of the four recommendations and have appreciated the thought that's gone into it.

Do you feel like you have enough to come back for us in April?

LINN JENNINGS: Yeah. Thank you for all your comments.

VICE CHAIR ROBERT DUNCAN: Thank you.

All right. Well, speaking of transition, now the transition to our continued efforts of Medicaid financing, specifically taking a deeper dive and look into hospital non-disproportionate share, otherwise known as DSH, supplemental payments as well as directed payments and targeting analysis.

We have Asher and Chris joining us. And who is

taking the lead? Asher. All right. Thank you.

HOSPITAL NON-DISPROPORTIONATE SHARE HOSPITAL (DSH) SUPPLEMENTAL PAYMENT AND DIRECTED PAYMENT TARGETING ANALYSES

* ASHER WANG: Good morning, Commissioners. Today I will be reviewing our hospital targeting analyses of non-DSH supplemental payments and directed payments. This work is part of our long-term work plan on hospital payment and financing. In recent sessions we have presented our work on our hospital payment index and our analyses of the growth in directed payments. And for today's session we are going to be looking more specifically at the characteristics of hospitals targeted by non-DSH supplemental payments and directed payments.

I'm going to start by discussing some background about the different types of supplemental payments and their respective goals and characteristics. Next, I will review our previous analyses of supplemental payment data, using the provider-level, non-DSH supplemental payment dataset. Then, I'll discuss our findings from our targeting analyses, based on descriptive information on non-DSH supplemental payments and directed payments. And

finally, I will raise some considerations to help guide our ongoing work, and conclude with next steps.

First, I will start off with some background. There are multiple different types of Medicaid supplemental payments to hospitals, and each of them are subject to different rules and are trying to address different goals. Starting at the top of the table are DSH payments, which are statutorily required payments intended to offset the unpaid costs of care for Medicaid enrollees, or the Medicaid shortfall, and the unpaid costs of care for uninsured individuals.

Congress established state-specific DSH limits, called DSH allotments, and DSH payments to an individual hospital are limited to its amount of uncompensated care costs. Non-DSH supplemental payments include upper payment limit, or UPL, payments, graduate medical education, or GME, payments, and various supplemental payment programs from Section 1115 demonstrations.

The next type of payment here are UPL supplemental payments. These are fee-for-service payments intended to offset the difference between fee-for-service base rates and an estimate of what Medicare would pay. One

of the limits with UPL payments is that they can only be made for services provided in fee-for-service, and so as states have moved from fee-for-service to managed care their ability to make UPL payments had diminished.

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

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

In recent years, CMS has encouraged states to move away from these 1115 supplemental payments and move towards directed payments. CMS introduced the directed payment option in 2016, and it allows states to direct how managed care organizations pay providers. Many directed

payment arrangements are intended to help offset the Medicaid shortfall through uniform rate increases, but some of them are also tied to quality improvement goals.

CMS has recently codified a limit on directed payments based on the average commercial rate, which is much higher than what Medicare would pay.

As shown in the chart above, Medicaid supplemental payments are a large share of Medicaid payments to hospitals. In fiscal year 2022, supplemental payments accounted for more than half of fee-for-service payments to hospitals, and in managed care, directed payments accounted for about one-third of payments, based on annualized estimates.

This table lists some of the different types of payments and how they are used, based on the intent of the payment implied from federal rules. For example, most supplemental payments pay for Medicaid-enrolled patients, but disproportionate share hospitals or DSH payments and uncompensated care pool payments can pay for uninsured individuals.

Now I will review some of our previous analyses of non-DSH supplemental payment data that we presented back

in April 2024. Beginning October 1, 2021, the Consolidated Appropriations Act, or CAA, required states to begin reporting provider-level data on non-DSH supplemental payments. This includes information on payment amounts for UPL payments, GME payments, and some Section 1115 supplemental payments, but they don't include information on directed payments.

This dataset also includes narrative information about payment methods and targeting criteria, which we will discuss in later slides.

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

In addition, we were missing data on provider contributions to the non-federal share. Because a lot of these supplemental payments are financed by providers, we were unable to calculate net payments to providers without that financing data.

Using this non-DSH supplemental payment data, we

found that in fiscal year 2022, 62 percent of non-DSH supplemental payments were made to hospitals that already received DSH payments. This suggests that some states may also be using non-DSH supplemental payments to make up for low DSH allotments.

Compared to DSH payments, a smaller proportion of non-DSH payments were made to deemed DSH hospitals and rural hospitals. It is also important to note that national averages masked considerable state variation in the use of non-DSH supplemental payments.

Now we will discuss our findings from our hospital targeting analyses.

Our previous analyses of non-DSH supplemental payments could not discern how states targeted these payments because we didn't have the base data to show the extent to which these payments were specifically targeted to a subclass of providers. To better understand the characteristics of hospitals targeted by non-DSH supplemental payments we reviewed the narrative reports for fiscal year 2022, non-DSH supplemental payments collected by CMS.

The CAA requires states to submit a narrative

describing the intended goals of each payment, the targeting criteria, and the payment methodology. However, our review of the narrative information found that many states have submitted incomplete information, so we also reviewed the accompanying components of the Medicaid state plan that describe a state's supplemental payment methods in more detail.

Our narrative analysis included only UPL and GME supplemental payments, and for each type of non-DSH supplemental payment we analyzed the type of hospitals targeted and the payment distribution method. We found wide variation in how states targeted UPL payments. This targeting criteria varied based on hospital ownership, hospital type, patient case mix, geographic factors, and other state-defined criteria, which we will review more in the following slide. GME payments primarily targeted teaching hospitals, but some states adjusted their GME payment methods to target specific services, like primary care or high-need specialty care.

In total, 38 states provided narrative information on their UPL supplemental payments to CMS or described their UPL supplemental payments in their Medicaid

state plan. We found that UPL payments often targeted government-owned hospitals, rural hospitals, and teaching hospitals. Several states also targeted UPL payments based on state-defined criteria for safety net hospitals that serve a high share of Medicaid and low-income patients, which may include rural hospitals.

Other targeted hospitals not shown in the table above included rehab hospitals, cancer hospitals, urban hospitals, and trauma centers.

Rural hospitals are a critical source of care for rural communities, but they may often face financial instability. So we also analyzed how states are implementing non-DSH supplemental payments to support rural hospitals. In total, we identified 15 states that explicated targeted UPL or GME payments to rural hospitals based on the narrative information reported to CMS or their Medicaid state plan. Eleven of these states explicitly targeted critical access hospitals, which are small rural hospitals that receive a special payment designation from Medicaid because they are often the sole provider in their community.

Using provider-level data on non-DSH supplemental

payment amounts we found that states that explicitly targeted rural and critical access hospitals spent more and a higher share of non-DSH dollars on rural hospitals than states with no rural targeting criteria. States that explicitly targeted rural hospitals were about twice as likely to allocate non-DSH dollars towards rural hospitals than states that did not target rural hospitals. And states that explicitly targeted critical access hospitals distributed the highest share of non-DSH spending towards rural hospitals.

We also found wide state variation in the payment methods states used to distribute UPL payments, which may be attributed to factors such as differences in state delivery systems, financing methods, and local hospital market characteristics. Because upper payment limits are calculated in the aggregate for a broad class of providers, states have considerable flexibility to allocate UPL payments for a more narrow subclass of providers.

The most common payment method related to hospital was Medicaid shortfall. Specifically, states determined UPL payment based on the difference between the hospital's Medicaid payments or costs and what Medicare

would pay for the same services.

The volume of Medicaid utilization and the payment for hospital charges were also common factors in states' UPL payment methods.

Although UPL supplemental payments are not intended to cover the cost of uncompensated care, like DSH payments, some states still use UPL payment methods that accounted for deemed DSH status or the provision of uncompensated care.

Other payment methods included distributing fixed dollar amounts and tying payments to the achievement of quality goals or metrics.

We found that states may often use a combination of payment methods for different types of providers. For example, some states distributed fixed, lump-sum payments for rural hospitals and paid other hospitals based on their relative share of Medicaid volume or payment.

In addition to narrative information in a non-DSH supplemental payment dataset we also examined descriptive information from directed payment preprints. In our most recent directed payment issue brief we found that states are increasingly using directed payments to make uniform

rate increases for hospitals. And as mentioned earlier, states can use directed payments to make uniform rate increases up to the average commercial rate, which is much higher than the Medicare-equivalent rate limits used for UPL supplemental payments.

To better understand how states are targeting directed payment spending across hospitals, we reviewed 129 distinct directed payment arrangements in 2022, across 33 states. This analysis excludes a minimum fee structure set at state plan rates because CMS does not require preprint submissions for those types of directed payments.

We found that states use varying levels of detail to describe the targeted providers. Most preprints included information on the types of participating hospitals, but several preprints were missing information on the hospitals targeted or applied to a broad range of hospitals with no specific targeting criteria. Because of this incomplete preprint information, our analysis might not reflect all the states that had targeted the selected types of hospitals.

We found that the most common type of hospital targeted was general acute hospitals. Other targeted

hospitals included teaching hospitals, rural hospitals, psychiatric hospitals, children's hospitals, and state-defined safety net hospitals. Out of the 10 states identified that explicitly targeted rural hospitals in their directed payment preprints, four of these states also explicitly targeted rural hospitals using non-DSH supplemental payments.

The make-up of state delivery systems might affect how states use supplemental payments. For example, states with a high proportion of managed care may rely more on directed payments to target hospitals because UPL supplemental payments only apply for fee-for-service.

It is also important to note that CMS finalized a number of changes in its 2024 managed care rule that may impact how states use directed payments to target hospitals. For example, CMS will eliminate separate payment terms, effective July 2027, and states will be required to report provider-level directed payment data once CMS release the reporting instructions.

Finally, we will move on to considerations and next steps.

Our targeting analysis of non-DSH supplemental

payments and directed payments highlights how states use a variety of targeting methods and payment methods to advance different goals. This targeting information can provide additional context on specific policy goals, certain payments they are supporting, and the extent that they may overlap with other types of supplemental payments.

As we continue work in this area it would be helpful for the Commission to discuss the extent to which these payment authorities should remain distinct or whether there should be greater alignment across authorities. We have listed some specific areas of consideration above. Compared to non-DSH payments, directed payments have more rigorous evaluation requirements under the 2024 managed care rule. These additional evaluation requirements will go into effect July 2027.

Should non-DSH supplemental payments have similar evaluation requirements to monitor whether these payments are achieving specific policy goals?

To what extent should the Commission consider the economy and efficiency of specific supplemental payment arrangements versus the overall effect of supplemental payments combined?

Finally, should there be different considerations for supplemental payments that are targeted more specifically to a subclass of hospitals versus those that support hospitals more uniformly?

For next steps, staff will continue monitoring non-DSH supplemental payments and directed payments to better understand how states are using and targeting these supplemental payments to advance their intended goals. We plan to use our analysis to inform sub-analyses of the updated hospital payment index, which will compare Medicaid fee-for-service and managed care hospital payments across states and to Medicaid payments.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, and if you would, take it back to that last slide, the slide before the last one, on the areas for consideration. Thank you very much. Again, I appreciated the work that went into this and the deeper dive, particularly in that subclass of hospitals and impact.

I will open it up for comments to my fellow Commissioners. Angelo.

COMMISSIONER ANGELO GIARDINO: I just wanted to

say how much I appreciate the work that has gone into this, and I know this has been a several-year process for the team to help explain how hospitals get their funding through Medicaid.

Just a couple of things I would like to say, Bob. One, I don't think anybody is doing anything wrong. I know this looks like a spaghetti bowl, but these are the mechanisms that we have provided to states to develop and construct mechanisms to fund the care of people in their states who need hospital care. So I think this is admirable that they are coming up with ways to develop the funding base for this.

So I think, as a quality improvement professional, I tend to want to have no variation, but we have asked this to be a joint federal-state program, and we want states to respond to their local context and do things that are important in their state, for their populations, and for the ecology of hospitals that they have to contend with.

So I don't see the variation as a problem. I do think it's important for us to understand, and I really appreciate the way that you illuminate these issues for us.

And it is very complicated.

I used to think of this as a spaghetti bowl, but now I think of it as a lasagna. And there are layers that people are putting together so that the individuals in their state who have health needs can acquire the care they need, and then the provider system needs to sustain itself. So I think the work you're doing is really important.

I guess what I would like to see is obviously since there is a lot of variation, there should be a way of determining best practices. So like, for example, you've talked about how some states target the rural hospitals, which are under so much pressure, and those critical access hospitals are fundamentally important to the health and well-being of people in those states.

So I just wonder if some of this work could then be targeting, maybe through panels or focus groups, like what are some of the best practices. I'm not critical of the variation, but I assume that in a system that has a lot of variation there would be some ways of doing targeting that's better than others.

So I just want to thank you for your work, and I really feel like I always learn something when you present.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thanks, Angelo. First to chemistry class and now cooking class. This is great.

All right. Jami, Heidi, then Tim.

COMMISSIONER JAMI SNYDER: Thanks so much, Chris and Asher, for your continued work on this important topic. You mentioned during your presentation that there are supplemental payments that really support goals such as improvements in access and quality. Can you provide a little bit more detail in terms of what types of metrics are included in those sorts of supplemental payment programs that are focused on access and quality?

ASHER WANG: Yeah. A lot of the metrics and goals are more qualitative information that states release. CMS, as part of the CAA, requires that states report for their non-DSH supplemental payments the intended goals and effects of their supplemental payment, the payment method, and also the different targeting criteria. So a lot of it is up to the states for deciding how they are going to be meeting the goals for access.

But some examples that come off the top of my head for directed payments, for example, they might think

about the network that managed care organizations are using to serve Medicaid beneficiaries. Some of it might also be related to Medicaid utilization, so if Medicaid utilization is going down for areas like primary care. And also some other examples of access could be the average distance that people or patients need to travel to see a beneficiary.

But a lot of it, again, has to do with the state variation that we mentioned before. Many of it is state-specific goals. And there is a lack of standardization across these supplemental payments.

COMMISSIONER JAMI SNYDER: I think that was kind of one of my follow-up questions. To what degree is CMS tracking performance against the metrics that are included in the supplemental payment programs? Do you have a sense?

ASHER WANG: Yeah. My sense is that for UPL demonstrations, they are reporting on some of the effects, but there is not a standardized metric that CMS is using. And then for directed payments, CMS recently added, in the managed care rule, a lot more evaluation requirements. For example, states must now submit an evaluation plan, and at least one of the metrics that states use has to be a performance-based metric.

CHRIS PARK: And also with the managed care rule, if the state-directed payments are above 1.5 percent of the total capitation rate they do need to submit a formal evaluation report on that.

VICE CHAIR ROBERT DUNCAN: All right. Heidi, Tim, then Dennis.

COMMISSIONER HEIDI ALLEN: Thank you, Chris and Asher. Like Angelo, I am always learning, and I am always still confused because this is so complicated. And what I'm really always just longing to understand is how much hospitals get paid for their Medicaid patients. And I know it's so complicated when you take into consideration provider taxes.

So I just feel like our North Star, as a Commission, should always be to be thinking of this long-term goal of being able to wrap our minds around the relationship between provider taxes and supplemental payments and what this means for Medicaid as a payer and how they compare to other payers. And then what kind of quality are they seeing and what kind of access are they getting for that payment amount.

I think just one of the very simple questions

that we would like to answer is are hospitals receiving much less from Medicaid than they are from Medicare, or even commercial insurance. And I think it's just really hard to answer, and yet it seems like such a simple question.

So I know that there are different sources of data that we go to, to try to eke out information, that we compare, and I know how much work this body of work has been, to even get us to where we are today. But I'm always in the mood for recommendations, for thinking about how we could cogently collect the data or align the sources of data in a way that we could have an easy to understand and actionable assessment of how much money is being paid.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi. Tim, Dennis, then Carolyn.

COMMISSIONER TIMOTHY HILL: I am going to align myself with Angelo's comment on there's nothing going wrong here, although as somebody who missed breakfast, I would say please don't make any more food analogies because I'm hungry.

The way the supplemental payment programs and directed payments are set up they are important sources of

support, particularly for safety net facilities, rural facilities. It's something we want to continue to support and understand, as Heidi is articulating.

But particularly to your areas of consideration, while, in general, nothing is going on around here, nothing bad is going on around here, sometimes folks push the envelope, right. So the notion that there are different considerations for approval of supplemental payments and evaluation of non-DSH UPL payments and the directed payments is a source of worry to me, so the more that they can be aligned. And I think given that the focus in the managed care rule has put some more rigorous criteria around the evaluation approval of the directed payments, it would be nice for CMS to think about how that could roll into the UPL supplemental payments, as well.

But also considering how they are paid for and where the financing is coming from, because I think in addition to are they driving economy and efficiency for a particular facility, it is also the case that sometimes, from whence the money comes and how it's financing, how it's being financed is driving some of the payment, and I think that has to be a consideration for whether or not you

think the particular payment arrangement is appropriate or not.

VICE CHAIR ROBERT DUNCAN: Thank you, Tim. Dennis.

COMMISSIONER DENNIS HEAPHY: When I think about this, I think of hospitals that have high numbers of folks who are either underinsured or uninsured, and without these Medicaid payments covering the cost of folks who are on Medicaid in these hospitals, the hospital might actually go under. So how do we actually protect all these hospitals that have high numbers of folks that really aren't able to cover the costs, and without Medicaid paying for folks who are on Medicaid the hospitals would really go under.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

COMMISSIONER DENNIS HEAPHY: I don't know if you have anything to say to that, Chris or Asher.

CHRIS PARK: Yeah, certainly this is why we are also trying to look at some of the subclasses of hospitals, because we have done some work that looked at hospital payment broadly across the state, and that work, in our 2017 hospital payment index issue brief, kind of demonstrated that in a lot of places Medicaid may pay

similarly, or even more, than Medicare, on average, on a market basket of services.

But it wasn't clear. We didn't have as good of information on specific types of hospitals. So does that apply broadly to all hospitals? Part of this work was trying to figure out how narrowly focused states could be in terms of saying we really want to support rural hospitals or teaching hospitals, and maybe target more money there versus just spreading it broadly.

So that is one area we are going to try to improve as we are doing this updated hospital payment index work, is that now that more information is available at the hospital level, can we tease apart that a little bit more, about are they really just spreading money around broadly or how strategic they may be in terms of really focusing on hospitals with high Medicaid utilization, or how does that tie to hospital financing, maybe for like rural hospitals or anything, where maybe they could focus the dollars a little bit more to support specific goals.

VICE CHAIR ROBERT DUNCAN: Thank you, Chris. Dennis, did that get your answer?

COMMISSIONER DENNIS HEAPHY: Yes.

VICE CHAIR ROBERT DUNCAN: All right. Thank you. Carolyn, then Michael.

COMMISSIONER CAROLYN INGRAM: Thank you. I really appreciate the work you all are doing on this, and especially your charts. I love when you guys give us charts, on Slide 4.

So one of my questions was around do all of these types of supplemental payments or directed payments require some type of quality outcome? I'm familiar with the DSRIP and some of the others, but would it be possible on your chart on Slide 4, when it's in the document, to list which ones actually require some type of outcomes and quality? Okay.

And then the other question I had for you is, there are rules around how these can be set up in states, right. There are rules in the federal regulations around things like you can't hold an entity harmless, you can't pay them back, things like that.

CHRIS PARK: Yes, certainly some of those financing rules and regulations were highlighted in our financing chapter last year. There are current lawsuits going through the court system about what hold harmless

maybe means, so that was acknowledged in the managed care rule, that they had put into place some requirements on attestation about the financial arrangements on the providers.

But it's also kind of on hold until some of those court cases go through the system. So it remains to be seen what that breadth is of what is allowable in terms of those financial arrangement.

COMMISSIONER CAROLYN INGRAM: Of how far it goes?

CHRIS PARK: Yeah.

COMMISSIONER CAROLYN INGRAM: Could we at least, though, in this chapter, and when we're doing this, include what the current regulations are and the current guidance we know they do give?

CHRIS PARK: Yeah.

COMMISSIONER CAROLYN INGRAM: Even though it's being challenged in the court, I think we could mention that, just because I think one thing that's misunderstood by the public or folks, back to Dennis' point and others is our rural communities really rely a lot on having successful hospitals. In some states, especially my state, it is the only lifeline for people to get access to care,

deliver a baby, if there's an accident in some of these rural communities for miles and miles. And there are rules set up around how these payments can operate.

So I think it's important for people to remember that, what the rules are in the current regulation. It's just another example, you know, it seems like we're hitting these today, another example of how much our communities rely on Medicaid and how many people rely on Medicaid to be successful, and increasing access to care and having actual access to care in rural communities, and this is just another example of that.

So I think if we can explain the rules around it, it will help people understand it's not just some program that's out there willy-nilly, as Angelo said, a big bowl of spaghetti. It's not just a willy-nilly program. It does actually have rules around it. So thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn. Michael, then John.

COMMISSIONER MICHAEL NARDONE: Thank you for this great work. This is an incredibly complex topic, and every time we talk about it my head feels like it's going to explode, I think, a little bit.

I wanted to ask just a couple of really basic questions. When we're looking at directed payments, those aren't just for hospitals, though. So I'm wondering, is it the overwhelming majority? Like I'm just wondering, because previous work you provided information on directed payments, and I didn't go back to that. But I was wondering, were we able to tease that out in terms of how much was for hospitals versus --

ASHER WANG: Yeah. In our previous directed payment issue brief we analyzed all directed payments including those that didn't go to hospitals. The majority of directed payments do go to hospitals, and that's why we isolated them for this analysis. But they also are going to other providers too, and we showcase all of that in our directed payment issue brief.

COMMISSIONER MICHAEL NARDONE: And I just want to make sure I understand this too, myself. When we talk about the UPL payments versus the directed payments, as states go more to managed care there is less room on the UPL. So I don't know that we've looked at this information long-term enough to understand, are the directed payments going up at the same time that the UPL payments are going

down. I would think that there would be some relationship there.

CHRIS PARK: Yeah, certainly our early work on directed payments we interviewed some states, and they did indicate that directed payments were kind of taking place of the UPL payments as they moved to managed care, as a way to kind of keep in place the additional funding that would be available through UPL in the managed care system.

We haven't looked at that correlation specifically, but this is another place where -- like directed payments may be going up even though UPL payments are kind of staying the same, because there is more room under directed payments with the average commercial rate ceiling than there was under the UPL program.

COMMISSIONER MICHAEL NARDONE: I think it just speaks to the complexity of this. You know, when we're looking at directed payment numbers going up, there are all these other factors that are kind of in the background, like what's happening with managed care in the state. You mentioned the fact that we really don't have a good way of getting at the net amount that's actually being distributed to hospitals.

I just want to kind of echo, I guess, that given the complexity of it, I think we have to always be cognizant of when we're presenting information around directed payments that there is this larger context. And I think just a couple of points that Carolyn and Tim made, I mean, I think we always have to be cognizant of finding the right balance there. I know you guys do a good job of that, but I think it's also important for people, when we're thinking about this topic, because it's an incredibly complex topic.

And I would also just add that even though when we're talking about that the targeted group might be general acute care hospitals, there is actually targeting that is going on if the formula that's being used for distributing the resources under directed payments is tied to utilization. Because if you have high Medicaid hospitals, they're getting more money than those hospitals that maybe don't have as much Medicaid utilization.

So I think it's just an added point around the targeting question, and it's hard because I don't know how you get at these various categorizations. But I think it's also part of the discussion with respect to when you're

looking at just a general acute care group. And we could probably talk about this topic for hours, but those are my comments that I wanted to make.

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

COMMISSIONER JOHN MCCARTHY: I have a couple of questions for you, Asher, based on what was just said. When we're talking about directed payments, and let's say there is a hospital system that is going after a physician directed payment, are you saying that is included in these numbers, or would that be excluded from these numbers?

ASHER WANG: So if it was going for physician services, that would be excluded from the data that we presented today.

COMMISSIONER JOHN MCCARTHY: Okay. So this would be just focused on inpatient and outpatient at hospitals?

ASHER WANG: Yes.

COMMISSIONER JOHN MCCARTHY: Okay. I think it's really important, because then the directed payment conversations that have been going on, physician directed payments are also part of those numbers that are going up. So they would be excluded from here, so that's good.

I think the other thing is, two points. One is, and I've said this before, to me we do this as one big supplemental payment chapter. I really wish we would just break these out as each one having its own chapter to go through, and some of these topics, because they are so complex and have different rules around them. You talk about this a little bit in there. DSH, for example, you hit on some of the rules of DSH, and this is back when me and Mike and Carolyn and Tim and Jami were younger, and lived through the DSH days of how the program started and how the changes happened to it and why we have DSH caps today and why states aren't all equal on those things. A little unfair.

So I just bring that up because it's being talked about on these directed payments, things like putting caps on them or things like that. You know, some states benefit; some states won't. That's one issue. So I'd like to see these, like, each chapter for each one of these.

The other one is you guys did amazing work, I don't know, it must have been like five meetings ago, where you went and looked at the Texas data, and you specifically were looking at cost coverage. I think that's the one

thing that we keep missing on these things, is that we see these huge increases.

My point of it is, having been Medicaid director two times over, and then Ohio, when I was looking at inpatient and outpatient cost coverage, this is cost coverage off the cost report on the Medicaid side. Our goals was to get 85 percent cost coverage on the inpatient side. When you included DSH on that, we didn't really have too many supplemental payments at that time. We had a hospital tax that was adding a little bit. I think we got to about 90 percent average cost coverage. So for every person somebody saw on the inpatient side, they lost 10 percent. So that was one issue.

But on the outpatient side, we were at 35 percent cost coverage. I got that up, I think, by the time I left, to 50 percent cost coverage. And we were trying to get more people to use outpatient services rather than inpatient. But that cost coverage number, you know, that's very low.

So, of course, they are subsidizing it through commercial rates and things like that. The state has done more since then. They have been able to do it through

things like provider taxes and other directed payments and things like that.

I think that's a really important point that we look at, because if you look at the numbers and you look at these huge increases, and you just look at it as a percentage increase it looks really big. But if cost coverage was running really, really low, then you could also argue, well, those people are being drastically underpaid, and so that's what you're coming up with.

And again, it's within the rules of the program, and people could push back and say, well then, states should be putting in more state share for these things. Mike didn't bring it up this time. He brought it up every other meeting, and the same thing for me. In the Great Recession, states turned to provider taxes and other things in order to keep benefits and programs afloat and providers afloat.

I really wish we would get back to that. But keep pushing on that analysis of cost coverage for hospitals, just to be able to point some of these things out and how these different mechanisms impact that.

CHRIS PARK: Yeah. We didn't mention it

specifically in terms of the hospital payment, the next work that's currently going on, but we will try to link up the information to hospital cost reports, where available, but also use that as a potential benchmark to compare where state payment rates are.

VICE CHAIR ROBERT DUNCAN: Thank you, John. Thank you, Chris. All right, in the essence of time, Carolyn, Jami. Jami, you will be the last. I ask that you move very quickly, please.

COMMISSIONER CAROLYN INGRAM: I'm sorry, you said, "Move quickly, Jami," and I thought you were going to let her speak first.

One other quick comment. In the rules, when we're looking at that, I believe it's true and accurate that MCOs can't take a cut off the top for these directed payments, and I'm not sure if we have that in the data, so it's worth including in the rules when you're putting that together. I just wanted to add that. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you. Jami.

COMMISSIONER JAMI SNYDER: And I just simply wanted to go back to your first consideration and echo some of the sentiments expressed by Tim. I am also in favor of

applying similar evaluation requirements to non-DSH supplemental payments, so I'd like to see us explore that further as we continue to talk about supplemental payments and directed payments across states.

VICE CHAIR ROBERT DUNCAN: Thank you. And I'll close by the third point about the different considerations for the supplemental part targeted subclass. I think we have mentioned many of those. Dennis made the statement of the number of hospitals that would close. I appreciated our Commissioner John's comments about how they are tied to cost reports. I can just speak for children's hospitals alone.

But with supplemental payments, those that receive it, only 80 percent of cost is actually covered through that. So I think when we look at teaching hospitals, safety net hospitals, public hospitals, particularly rural hospitals and children's hospitals, it is something we need to take a hard look at. If not, I think we'll see the closure, and as Carolyn said, many of our constituents will not be able to receive services.

So again, thank you for the great work. And with that, Madam Chairwoman, I apologize for running over.

Great discussion, but it's all yours.

CHAIR VERLON JOHNSON: All right. Thank you so much. Give us a couple of seconds to switch over. I really appreciate your work, Asher and Chris, on this, and of course, thank you, Vice Chair Duncan, for your leadership on the first two topics. We appreciate that, as well.

[Pause.]

CHAIR VERLON JOHNSON: All right. Now we are going to turn our attention to self-directed within the Medicaid home and community-based services. Gabby and Brian will first lead us through an overview of self-direction, particularly focusing on the roles and responsibilities. They are going to really help us to level-set our understanding before we move on after lunch, with a more focused discussion on learning about their interview findings, as well.

With that, Gabby and Brian.

OVERVIEW OF THE SELF-DIRECTED MODEL

* BRIAN O'GARA: Right. I ran up here like a longshoreman because I know we all want to get to lunch.

Good morning, Commissioners. Today we will be

giving a brief overview on some key actors in self-direction. We will begin with background, we'll discuss the key actors in program administration for self-direction programs, and we'll end with next steps.

Just a brief refresh from the December meeting, self-direction is a Medicaid home and community-based services delivery model that allows individuals to choose their workers and have control over the amount, duration, and scope of services and supports in the person-centered plan.

Self-direction largely differs from agency-directed HCBS in the sense that an agency or health care provider takes ownership of the care process in agency-directed care. However, it's important to note that self-direction programs do operate within the existing framework of Medicaid HCBS. Self-direction does not fundamentally change the level of care determination process or what the state or third-party administrator determines is the appropriate level of support in the community for an individual.

Federal statute outlines several components that all self-direction programs must include. These are the

person-centered planning process and person-centered service plan, information and assistance supports, financial management services, quality assurance and continuous improvement systems, and individualized budget. And we will be discussing these elements in further detail today.

Self-direction is available in all 50 states and the District of Columbia. In 2023, just over 1.5 million individuals were served through these programs, primarily funded by Medicaid. And states have broad discretion to select which populations self-direct their care. Some common populations include older adults and individuals with physical disabilities, intellectual and development disabilities, and HIV/AIDS. States can offer self-direction through an array of Medicaid HCBS authorities and may choose an authority based on flexibility, such as the ability to select certain populations, services, and geographic areas of the state. States may also choose to offer beneficiaries in self-direction employer authority, budget authority, or both, which we will discuss shortly.

Now I'll be discussing some of the key actors and their broad responsibilities within a self-direction model.

Of course, central to self-direction is the beneficiary. This is the individual who is eligible for and enrolled in the Medicaid program. Beneficiaries have the ability and the responsibility to oversee all aspects of service delivery, depending on which authorities they are granted. When a beneficiary is granted employer authority responsibilities, they are responsible for tasks such as recruiting, hiring, training, and supervising workers, while budget authority allows beneficiaries to manage the Medicaid budget allocation across approved service and determine the wage for their HCBS workers.

Beneficiaries must be able to receive support from the state in developing a person-centered service plan and individualized budget, managing and executing services, and carrying out employer and budget responsibilities if they wish.

Next, the representative. If a beneficiary in self-direction is unable or unwilling to self-direct their HCBS, they can choose a representative to assist them with the decision-making process. Representatives may provide support with tasks that the individuals find challenging, such as reviewing and approving time sheets.

Representatives cannot be paid or serve as the HCBS worker while assisting the beneficiary in directing their care.

HCBS workers are, of course, the individuals hired by the beneficiary to provide the services outlined in the person-centered service plan. We use the term "HCBS workers" in our work to include a broad array of professionals. These include direct support professionals, personal care aides, home health aides, certified nursing assistants, and that term may include other providers, as well. States may require background checks and establish education, certification, or licensing requirements for these individuals, and states can allow family members to also serve as the HCBS worker, including legally responsible individuals.

A legally responsible individual is any person who has a duty, under state law, to care for another individual, such as the parent of a minor child or a spouse. Legally responsible individuals must offer care that goes beyond what is typically expected from a spouse or parent in self-direction, and this is referred to as providing “extraordinary care”. An example of that would be a legally responsible individual supporting a teenage

child enrolled in the waiver, with activities of daily living such as bathing and dressing, and this would constitute extraordinary care, and this is because a teenage child with a disability or a chronic illness typically would not require such supports.

And finally, the states. Of course, self-direction programs must exist within the framework developed by the state Medicaid agency, and they are primarily responsible for maintaining systems of quality assurance and improvement. All states are responsible for monitoring performance and outcomes to ensure that services delivered through self-direction are appropriate and adequate.

States may take on some of the information and assistance supports and fiscal intermediary duties, which Gabby is going to discuss next, or they may contract with non-governmental entities to provide these supports. State Medicaid agencies can also delegate the task of operationalizing the self-direction program to other state operating agencies, such as agencies focused on aging or developmental disabilities.

Some states utilize beneficiary advisory boards

that help inform state policymakers on various HCBS policy topics, and of course, all state Medicaid agencies are required to have a Medicaid Fraud Control Unit to investigate any cases of potential fraud, waste, or abuse within the program, and that applies to self-direction, as well.

And now I will hand it over to Gabby.

* GABBY BALLWEG: Thanks, Brian. Now I'm going to go ahead and get started talking about some of the information and assistance supports and the different entities that can provide those supports in self-direction.

Information and assistance support in self-direction must be made available to beneficiaries, but they can generally choose how much support they would like. Some examples of information and assistance could include support in developing the PCSP, managing the budget, as well as managing services and HCBS workers and performing some of their employer-related responsibilities like training and paying HCBS workers.

In the following slides, I am going to discuss the information and assistance entities that a state may make available in self-direction.

Beginning with case managers, they share information about self-direction options and may help an individual enroll in self-directed HCBS. Case managers assist with care planning coordination and assessment, they support beneficiaries with resources and counseling, and they train them in their employer responsibilities. They complete paperwork for or in coordinate with the beneficiary, and may have regular check-ins with them. It is important to note that the case manager function is also provided to support HCBS users in a traditional, agency-directed model, so this isn't exclusive to self-direction.

In contrast, we have the support broker role, which is specific to self-direction. A support broker, which we may also hear referred to as a counselor or a consultant or a coach, are generally selected by the beneficiary and they take direction from the beneficiary, acting as an agent of the beneficiary. They coach them in navigating day-to-day processes, from identifying personnel needs to ensuring services are properly managed. Support brokers may monitor service delivery and also help address concerns regarding quality or safety or any payment and time sheet issues, generally liaising between the FMS

agency and the beneficiary.

In some states they also have what's called an independent facilitator. This can be in addition to the support broker, and they may take on some of the support broker functions.

There can be some overlap in the roles of the case manager and support broker, and both of these functions generally work closely together if they are both available in a state.

In addition to the primary role of the financial management services agency, or FMS agency, acting as fiscal intermediary, which we will discuss shortly, FMS agencies can also provide information and assistance in support of self-direction. For example, they may share budget tracking reports with beneficiaries, and they can provide training on things like timesheet entry and any other skills that are necessary for a beneficiary to successful self-direct their services.

Area Agencies on Aging, or AAAs, and beneficiary advocacy organizations can also support beneficiaries who are self-directing their HCBS. As a reminder, AAAs are actually funded outside of Title XIX. However, they can be

funded by Medicaid in support of self-direction through a contractual agreement with the states or any of the third-party administrators like MCOs. AAAs can provide options counseling and referrals for prospective self-direction beneficiaries, or they can also provide case management and service coordination supports.

Beneficiary advocacy organizations provide resources and education on self-direction options. It could support beneficiaries as issues arise when they are self-directing. Generally a lot of the supports from a beneficiary advocacy organization are more informal.

Managed care organizations, or MCOs, may also support information and assistance in self-direction. They can perform functional needs assessments, they can assess a beneficiary's ability to self-direct, and provide case management. In addition to the information and assistance support, MCOs process service authorizations, perform back-end claims payment and encounter filing with the state, and engage in quality monitoring and oversight activities. They work with other information and assistance entities like the FMS agencies to fulfill their role.

As I mentioned earlier, the FMS agency's primary

role is to act as a fiscal intermediary between the beneficiary and the HCBS worker. They do this by fulfilling a range of functions, including payroll processing and performing tax and employment benefit services. There are different FMS agency models that states can choose from, and two of the most common are the Fiscal/Employer Agent model and the Agency with Choice model.

Under the Fiscal/Employer Agent model, the beneficiary is considered the common law employer of the HCBS worker. This means that the beneficiary is directly liable for performing employer-related tasks. In the Agency with Choice model, the beneficiary is a co-employer with that agency. Sometimes this is referred to also as more of a manager. They manage their worker in their day-to-day processes and activities, but the FMS agency is ultimately responsible for the employer-related functions.

Overall, all of the different players that we have discussed today interact in a really complex system to administer self-direction, as you can see in this graphic. At the state level, the state Medicaid agency administers the model. However, the Medicaid agency can designate

program administration to different state operating agencies. States may establish a Beneficiary Advisory Committee to provide input on self-direction to the state Medicaid agency and operating agencies. The state also delegates investigation and prosecution for instances of fraud and abuse to the Medicaid Fraud Control Unit.

The state agencies contract with vendors to provide information and assistance in support of self-direction and FMS, or they can provide these supports in-house. The FMS agency collaborates with information and assistance roles, like MCOs and other information and assistance entities, when operating in a managed care environment, to help the beneficiary self-direct and resolve issues as they arise. The beneficiary interacts with information and assistance professionals, such as case managers and support brokers, so they can effectively and safely self-direct their HCBS. The beneficiary may also select their FMS agency when there is multiple in a state, and interact with FMS agency representatives as needed.

With the support of this network, the beneficiary or their representative is able to hire an HCBS worker, who can be a family caregiver in some cases, to provide the

HCBS outlined in the beneficiary's person-centered service plan. The HCBS worker is enrolled with the FMS agency so that they may receive payment for approved services.

Each self-direction program can establish their own network of supports for a beneficiary. This graphic is considered a general model of how this network could function, but it can vary by state and even by a program within a state.

Now I'm going to move on to our next steps.

At this time, we will be addressing Commissioner questions and feedback around the self-direction model and policy framework. Specifically, we are wondering if there are any areas where the Commission needs clarification around the different roles and responsibilities, or the interaction of these roles in self-direction. After this discussion, we will return to share interview findings.

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

CHAIR VERLON JOHNSON: Thank you so much, Gabby and Brian. This is very helpful. And I will say I love that slide in the diagram. It really puts it into perspective for me, for sure.

I will turn it over to my fellow Commissioners to see if there are any particular questions or clarifications that you need around the roles, or anything else that you heard today. With that I will open up the floor. Carolyn.

COMMISSIONER CAROLYN INGRAM: I will kick things off and get things started. I'm sure that Dennis and others have a lot more to add than I do. I'm just wondering, in your model -- and thank you for doing this work -- if you found any good examples of what states are doing around conflicts of interest. So when somebody doesn't have a family member maybe who has their best interest in mind, what are they doing to try to make sure they protect those individuals?

GABBY BALLWEG: Yeah, that's a really great question. We heard a little bit about the conflict of interest piece in our interviews, which we'll be discussing later.

There's kind of two ways to think about conflict of interest. There's the regulatory piece. For example, the person who is doing the assessment for their care needs, they cannot also act as the caregiver, so that would be a conflict of interest, and that's in regulation. So

there's that piece.

We did hear a little bit about the consideration around sometimes when there is a caregiver that may not have a beneficiary's best interests, and it didn't sound like that was a very common occurrence but it can happen, in terms of what states are doing, we would have to look a little more into that. I think that could be something we could explore further. I appreciate that question.

COMMISSIONER CAROLYN INGRAM: That would be great. I think of when we had a Medicaid Advisory Committee there was a woman who was the grandmother caregiver of her medically fragile granddaughter. But unfortunately, as she got older, she suffered with dementia and wasn't able to do that care, so they had to find somebody, and it didn't always work out the best way. But again, hopefully those cases are few and far between, but I think sometimes it can have detrimental outcomes, so we just need to see what states are doing. Maybe we can figure out a way to put something in our report as a good example. Thank you.

BRIAN O'GARA: And I'll just add to that. We did speak with one Medicaid agency that prohibits family

members from serving, family members who live in the household, as serving as a caregiver. So there is obviously a lot of variability around how states allow or don't allow family caregiving. It seems like a general approach is to try and install guardrails around some certain scenarios. But yeah, we could look more into specific kind of remedial efforts around that.

COMMISSIONER CAROLYN INGRAM: Yeah, and to all those people that are out there that are family caregivers, that was not my intention of looking at that area exactly, but those that end up taking over a legal responsibility when the family caregiver really can't. So like if a grandmother is taking care of their granddaughter but becomes elderly or has dementia and can't, there is often a plan for a legal caregiver. But sometimes those people that take over those cases don't have the best person's interest at heart. And I think I've seen a few examples of that, at least in my state.

Again, it wasn't a family caregiver. I want to make sure I clarify that. It was somebody outside the family who took over that legal authority. So just wanting to know if there are ways that we can, again, like you

said, guardrails that we could take a look at. Thank you.

CHAIR VERLON JOHNSON: Thank you, Carolyn. Let's go with Heidi, then Mike, and then Doug.

COMMISSIONER HEIDI ALLEN: Thank you so much for this. I'm just wondering, I didn't see it in the materials, but the issue related to the ability of beneficiaries to provide benefits to the people that are caring for them. And this seems to me to be kind of a difference between agency care versus self-directed care and what an ask it is of somebody to give up sick leave, parental leave, vacation time, and even health insurance.

So I'm wondering how people navigate that. I'm wondering if some of the agencies that helping with other, you know, background checks, are there any efforts to pool resource to try to provide some kind of benefits? And I'm curious in terms of the allocation of resources why agencies might have the ability to provide those kind of benefits but individuals wouldn't.

GABBY BALLWEG: Yeah, that's a great question. We can look into that a little further. I will think back to our panel we had in December. We did hear that there are ways that the beneficiary can provide some benefits. I

think our panelists had shared that they were allotting a portion of that wage they were paying their caregiver, there was a little bit above what their actual wage was, and that additional cost was supposed to be used by the worker and saved for emergencies and things like that.

COMMISSIONER HEIDI ALLEN: Yeah, that was actually the person I think was thinking about, and then they described one of their people having to leave because they wanted to have a family, and it wasn't the kind of job that you could have a family and do. So, I mean, even setting aside that just made it not possible, and I think when we think of having a high-quality, self-directed workforce, if it's not the kind of job that a person can have a family and do, that's really concerning.

CHAIR VERLON JOHNSON: Thank you. Mike.

COMMISSIONER MICHAEL NARDONE: Yes, thanks for this great work. Obviously, as we try to address the workforce shortage, having a model of self-direction is one of the things we have to continue to work on as a way to expand the workforce, help to deal with some of these challenges.

I was wondering, my questions are really around -

- it doesn't sound like there is any body of information that would tell us how many people, or the numbers of waivers that include self-direction. We have, what, 300 waivers? I would imagine almost every one of those has a self-direction component. And I guess we don't have numbers on how many people are in self-direction.

I'm trying to get my head around the extent of this model in the current framework of HCBS.

GABBY BALLWEG: Yeah, that's a really great point, and you'll hear us talk a little bit more about that in our findings later. But yeah, generally speaking we can't classify the total number of self-directing beneficiaries in Medicaid at a national level. We can try and tease that out a little bit at the state level, with state data, but we don't have a way to access that number nationally right now.

COMMISSIONER MICHAEL NARDONE: And did you find that not only is there variation between states but there's also variation within a state? Because in listening to the prior presentation around the I/DD model, in Pennsylvania I realized the differences between some of the things that were happening in I/DD versus the aging. And I imagine, is

that a theme that kind of emerges as you --

GABBY BALLWEG: Yeah, and we'll also talk about that a little bit later. You're really excited, right, for our findings?

COMMISSIONER MICHAEL NARDONE: And I guess one of the other conclusions I made from this, and if it's the next session, it's not like one predominant model really kind of comes out, right. The theme that comes out is just basically the variation between kind of the various roles that people play in the system, and there just seems to be a lot of overlap there, that you kind of point out. But I guess there isn't like one predominant model that comes through to you, like most states use FMS, and the FMS does X, Y, Z. And most have support brokers, or don't have support brokers. I'm trying to get like my understanding around what is the predominant model.

GABBY BALLWEG: Yeah, I think we can speak to a little bit of that. So the FMS example, most states use a vendor FMS rather than doing that in-state. That's not the case for every state, and there are different reasons for that. And I think we tried to tease out a little, most states use the Fiscal/Employer Agent model or the Agency

with Choice model when they're looking at the type of FMS. But there are other options out there, and we see different states using different models for different reasons. It really is state by state, similar to the broader Medicaid program, as well.

COMMISSIONER MICHAEL NARDONE: Okay. And I guess would also like to understand better what the co-employer role is versus the employer role. I'm not sure I understand the distinctions there. The co-employer potentially could get to some of the points that Heidi is getting at, around health care. I want to make sure I understand that better.

GABBY BALLWEG: Yeah, and I will also direct you to the memo. We talk a little more extensively about that, just because there is a lot to unpack in the different models of FMS, and that wasn't fully our focus in these interviews, laying the groundwork.

But yeah, and like the Agency with Choice model, generally there can be some benefits that are provided to the worker in that model. We would have to explore a little further on that model specifically to understand what is being offered, and again, that could vary by state,

and even by program within a state, as you pointed out.

BRIAN O'GARA: And I'll just add -- sorry for adding at this late hour -- but the main difference is that with the Fiscal -- and we heard this from states, not to get into our later findings -- it comes down to what level of responsibility the beneficiary may want to have in exercising those employer duties. So Fiscal/Employer Agent model, they can oversee the worker, they can evaluate the worker, they can train the worker, but they may not be responsible for filing taxes and processing the payment. No sorry, that's the Agency with Choice model.

GABBY BALLWEG: There are so many models. So they generally do file taxes, process payments in both models, but the Fiscal/Employer Agent model, like Brian had alluded to, the responsibility on your worker and supervising workers is really focused on the beneficiary. In the Agency with Choice model, the agency might take a little bit of a bigger role. They might support the beneficiary a little more in some of their employer responsibilities. So maybe they're having trouble managing one of their workers. In that Agency with Choice model, they can go to the agency, and they can kind of help work

with them through that.

But we can definitely expand more on that piece, if that would be helpful.

CHAIR VERLON JOHNSON: All right. Thank you. We are a little bit over time, so what we'll do is we'll pause on the additional comments until afterwards, because we will be coming back. So we appreciate your enthusiasm around this topic, for sure, but we will have more time to talk about it.

We do need to go to public comment, though, right now, so I want to thank you both, and we will see you after lunch, for sure.

CHAIR VERLON JOHNSON: We do need to go to public comment. Now that we're open for public comment we do invite people in the audience to raise your hand if you would like to offer comments. Please make sure to introduce yourself and organization you represent, and we are asking you to keep your comments to three minutes or less if you can. We appreciate.

With that -- okay. First up, is it Christopher Beebe? You have the floor.

PUBLIC COMMENT

* [Pause.]

CHAIR VERLON JOHNSON: Okay. So Christopher, any comments?

[No response.]

CHAIR VERLON JOHNSON: All right. We will see if there are others.

[Pause.]

CHAIR VERLON JOHNSON: Okay. It doesn't look like it. Oh, we saw the hand up again? Okay. He took it down. Okay. This is real-time information here for you all.

All right. So it sounds like we don't have additional comments but we'll have another opportunity, of course, later on this afternoon. But I do want to remind you, as well, that you can also submit your comments through the MACPAC website.

So with that we are going to go to lunch, and we will return back at 1 p.m. See you soon. Thank you.

* [Whereupon, at 12:14 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:03 p.m.]

CHAIR VERLON JOHNSON: All right. Welcome back everyone, and I hope you all had a great lunch.

Right now, Gabby and Brian are rejoining us to discuss their interview findings on self-direction program design and administration. This should really help us with our next steps in this project as well.

So, Gabby and Brian, I'll turn it back over to you all.

INTERVIEW FINDINGS ON SELF-DIRECTION PROGRAM DESIGN AND ADMINISTRATION

* BRIAN O'GARA: Thank you. Good afternoon, Commissioners.

So Gabby and I are back, and this session, we're going to be discussing our interview findings from interviews with key stakeholders around state design and program administration of self-directed HCBS programs.

We'll begin with a brief background of this work. Gabby and I will discuss the interview findings split into two chunks. Those would be state design considerations and considerations for state administration, and we'll end with

next steps.

So earlier today and in December, we provided the Commission with an overview of key requirements and key actors in Medicaid self-direction programs, and to supplement that knowledge, we also conducted stakeholder interviews to gain further insights into how states design and administer these programs.

Specifically, we were looking for insights around three research questions, those being the statutory and regulatory framework that guides self-direction, how states design and administer these programs, and potential challenges to effective program administration for self-direction.

So we contracted with Mathematica. We interviewed some federal officials and other national self-direction experts and researchers, and from that initial round of interviews, we identified six case study states. And within those six case study states, we interviewed state Medicaid officials, state officials from other state agencies involved in self-direction, financial management services or FMS agencies, support brokers, MCOs, beneficiary advocates, and area agencies on aging.

And so between September 2024 and January 2025, we conducted 33 interviews between these state- and national-level stakeholders.

And so I'll be discussing our first bucket of findings, and those are around the state design considerations for these programs.

And so we'll begin by discussing HCBS authorities states use. So, by and large, we heard that most states use Section 1915(c) waiver authorities to offer self-direction, and that it is the most commonly used in the country, with 46 states currently offering a program through 1915(c) waiver authority.

And the states that we spoke with shared that 1915(c) waiver authority provides the most flexibility when designing these programs. Specifically, 1915(c) authority allows states to select specific populations, set enrollment limits, target specific areas of the state or waiving statewideness, and choosing which services can be self-directed.

States we spoke with also used additional state plan option authorities for a variety of flexibilities associated with those.

So, for example, 1915(i) state plan option authority does not require beneficiaries to meet a nursing facility level of care criteria, and 1915(k) state option authority, of course, comes with an enhanced FMAP. And so those were some of the reasons we heard for considerations around other authorities, but again, those are not as widely used as 1915(c) waiver authority. And many states also operate self-direction programs across multiple authorities.

Interviewees raised several considerations regarding deciding which populations to allow to self-direct their services. Interviewees agreed that many different populations are able to succeed in self-directing their HCBS with the appropriate level of supports and guidance. Interviewees we spoke with cited individuals with dementia, low technological literacy, or those experiencing homelessness as populations that may need additional supports to effectively self-direct.

And the example we heard from one state was that for individuals with dementia, they may still be able to self-direct their HCBS but also may need a contingency plan that identifies when they can no longer self-direct their

services. And so that's one of the considerations we heard.

We also heard that beneficiaries with strong natural supports, such as adult children who live close by or a robust social network, may need fewer additional supports to effectively self-direct their HCBS. And one researcher noted that advocacy may have contributed to younger people with disabilities being among the first populations to self-direct.

We also heard that states generally take one of two approaches when deciding what services to offer through self-direction, and either they choose from the services available under the state's existing authorities through a traditional service delivery model or they develop a new suite of self-directed services, oftentimes in response to advocacy efforts.

Researchers and state officials all agreed that states are more likely to allow personal care services to be self-directed, such as bathing and dressing, due to the intimate nature of these services.

And officials at two state Medicaid agencies shared that they also consider the level of training or licensing required to provide specific services when

defining which services can be self-directed. So, for example, we heard from one state that may select self-directed services based on qualifications that they make a provider meet.

Now we'll be discussing budget and employer authorities. So states have significant flexibility, and they can choose to allow budget authority, employer authority, or both authorities by service within a self-direction program.

And what we heard was that interviewees broadly categorized budget authority as the more comprehensive and administratively complex authority, while employer authority may be more straightforward for beneficiaries.

States are required to establish a process for determining a beneficiary's budget under the budget authority, and we heard from several states that this can be a complex process. One state Medicaid official noted that paying different rates for the same service can be difficult because their administrative systems normally associate a specific service with a single rate, which is not usually the variation permitted by self-direction. So this was a state that was allowing beneficiaries to set a

rate for a service within a range specified.

And for employer authority, states emphasized the importance of ensuring that beneficiaries understand the responsibilities and the risks as employers when they have employer authority, and this kind of ties back to what we discussed earlier around some of those specific employer duties that are part of the employer authority, such as overseeing the HCBS worker but also handling taxes and payroll duties.

All case-study states that we spoke to allow family caregivers to be paid employees for self-direction in at least one of their self-direction programs. Stakeholders agreed that allowing family caregivers can help address the national HCBS workforce shortage and provide culturally competent care for beneficiaries. Some researchers and state officials did raise concerns about the role of family caregivers, specifically concerns about beneficiaries' reluctance to report critical incidents involving family caregivers, and some concerns that decision-making and self-direction may include family members, including a family caregiver, and that can potentially undermine the autonomy or independence of the

beneficiary in that decision-making process.

And now I'll hand it over to Gabby.

* GABBY BALLWEG: Thanks, Brian.

So moving forward with our interview findings and looking at the considerations for state administration.

So, although some states choose to administer self-direction just through the state Medicaid agency, states can also consider administering the program across multiple agencies within the state. When a state operates across agencies, there's often variation in program administration. So, for example, an operating agency and a Medicaid agency may contract with different FMS agencies or use different FMS models. This approach requires extensive cross-agency collaboration, especially when trying to implement broad policy and operational changes in the program.

Moving into findings around the entities providing information and assistance supports for beneficiaries, states can vary in how they define and structure the roles of information and assistance entities, such as those that are providing case management and support brokerage services or Area Agencies on Aging, or

AAAs, and Aging and Disability Resource Centers, or ADRCs, who provide supports.

The roles of different information and assistance entities can often overlap and may be a little bit difficult to clearly distinguish both within and across states. Sometimes this overlap is intentional, like when a state combines the role of a support broker and a case manager. Other times, it can be unintentional. In the subsequent slides, we will explore these findings further with a focus on case management, support broker services, and supports from AAAs and ADRCs.

So through interviews with state officials, we found that states generally designate case management for self-direction across three different models. In the first model, a state can designate state-employed case managers, which we call in-house case management.

In the next model, the state could establish a partnership with an external organization to provide case management, such as contracting with a case management entity, which we would call "vendor case management."

In the final model, a state could establish a hybrid of both of these approaches. For example,

interviewees in one state shared that they provide in-house case management for all of their beneficiaries in self-direction, except for those served under their older adults waiver, who receive case management through a contracted entity.

Regardless of the model a state selects to provide case management, subject-matter experts and state officials emphasized that states must have case managers who are well-trained in the state-specific self-direction programs. They shared that case managers with insufficient training can significantly impact uptake rates in self-direction, and in addition to training needs, case managers may be limited in the amount of support they can provide if they have a really large caseload.

According to interviewees, these challenges could result in some unintentional overlap when a different information and assistance entity takes on some of the case management functions instead.

Through our interviews, we also identified three models that states can use to structure the support broker role. In the first model, which establishes an independent support broker, interviewees shared that these individuals

typically spend a lot of time with the beneficiaries but that having another entity involved is less streamlined and could potentially diffuse responsibility across the information and assistance support system.

In the next model, which nests the support broker role within the FMS agency, interviewees suggested that this approach may be more streamlined than the first model.

Additionally, FMS agencies shared that this approach may avoid some unintentional duplication of efforts between the FMS agency and the support broker.

However, a subject-matter expert also noted that an FMS agency's support broker services generally are provided virtually or through phone conversations, which could reduce access for some beneficiaries who don't have access to those electronic devices or internet.

In the final model, it integrates the case manager and support broker roles. Similar to the second model, this could streamline the state's approach to information and assistance. However, some interviewees shared that large caseloads could impact the quality of both case management and support broker services when the roles are combined and require other information and

assistance entities to supplement, which could cause some unintentional overlap in the roles.

AAAs and ADRCs provide resources and education to beneficiaries in self-direction. One subject-matter expert noted that states may designate these entities to perform information assistance support because they're already well-established within communities.

As a reminder, AAAs are funded outside of Title XIX, but as we mentioned earlier today, they could be funded by Medicaid in support of self-direction through a contractual agreement with the state or a third-party entity like an MCO.

Interviewers identified two approaches to AAAs and ADRCs supporting self-direction. They could either provide support before enrollment in a self-direction program, which could include things like options counseling or sharing resources with potential beneficiaries, or they could also support information and assistance for beneficiaries after they've been enrolled in self-direction. For example, one state required MCOs to contract with AAAs in order to provide case management supports.

Moving on to findings around FMS agencies. As a reminder, FMS agencies can fulfill a broad range of responsibilities in self-direction, like processing provider taxes or collecting and reporting data to states and relevant information and assistance entities like MCOs.

Interviewees shared that the state should set clear expectations when contracting with the FMS agency. For example, the state can specify benchmarks around customer service, like target response times to beneficiaries' requests.

States may also choose to contract with multiple FMS agencies, a single FMS agency, or provide the FMS in-house. There can also be variation in one state and variation by self-direction program in that state.

With regards to quality reporting, monitoring, and oversight, we found that states leveraged their information and assistance entities, including MCOs and FMS agencies, to support this process. For example, support brokers may file reports to the state, and one state shared that they received weekly utilization reports from these support brokers, which are monitored by the support broker and regional officials.

While self-direction is operated in a managed care model, the MCO monitors electronic visit verification, or EVV data, to ensure service delivery and identify potential instances of fraud, waste, and abuse.

FMS agencies also monitor service use and payments and ensure they remain within established thresholds. They can address instances of over- and under-utilization of a beneficiary's services or individualized budget, which may indicate a beneficiary needs more support in self-directing or flag a potential program integrity issue for further investigation. The FMS agencies notify the state when potential issues need to be escalated.

In the course of investigating quality reporting, monitoring, and oversight capabilities, we found that state and federal officials, as well as researchers, can be limited in their data analysis and reporting capacities for self-direction, as many of these systems are not designed to stratify self-directed HCBS beneficiary data from the overall HCBS population.

State officials shared that they need a robust data system to accurately validate hours for reimbursement, and FMS agencies generally have a robust data system.

However, some state officials shared that they may struggle to stratify self-directing beneficiaries in data analyses and reporting.

At the national level, researchers shared with us that they can't always compare costs and outcomes between self-directed and agency-directed HCBS.

Moving on to our next steps. We would appreciate Commissioner feedback on the findings that should be emphasized in a descriptive chapter for June and how these findings should inform MACPAC's future work in this area. Specifically, are Commissioners interested in learning more about the roles and responsibilities of information assistance entities, including FMS agencies and MCOs? Are there additional data and information that Medicaid should collect to learn more about program administration and quality of care?

We will return in April to present the draft chapter to the Commission, and with that, I will turn it back over to the Commissioners for discussion. Thank you.

CHAIR VERLON JOHNSON: Thank you, Gabby, again. Thank you, Brian, as well.

All right. So you can see where we want to go

with the questions that we have up here. I'm going to actually start with those who we did not get to the last time, and so that's going to be Doug, Dennis, and Jami. Then others, please feel free to raise your hand.

So, with that, Doug?

COMMISSIONER DOUG BROWN: Thank you again, both, for the work that you've done here.

Part of my question has now been addressed here, but I'm going to ask it anyway. In your work up, did you research any of the types of fraud, waste, and abuse that were identified by states in the program or the folks that did that work? And I guess the question is, are there areas within fraud, waste, and abuse that a policy change could help to alleviate or mitigate fraud, waste, and abuse in the system?

GABBY BALLWEG: That's a really great question. We definitely heard that it can occur. In general, subject-matter experts shared that it wasn't at, like, high levels of fraud, waste, and abuse. We would have to do a little more research to, I think, fully answer that question.

COMMISSIONER DOUG BROWN: Thank you.

CHAIR VERLON JOHNSON: Dennis?

[Pause.]

CHAIR VERLON JOHNSON: Okay. You're still muted, Dennis.

Yeah, we can hear you. Thank you, Dennis.

COMMISSIONER DENNIS HEAPHY: Give me one second.

[Pause.]

COMMISSIONER DENNIS HEAPHY: Gabby and Brian, thanks for the presentation. It was really very helpful.

I have a few things to highlight, and then I can send other things to you offline.

I think, first, for me, it would have been helpful to contextualize the models of care within two frameworks. One would be more of a medical model, and the other would be more of an independent living model.

I say this because we look at the nursing home bias that's also, in some ways, a bias toward agencies and states, and so it would be helpful to understand what the barriers are that states may put in place that prevent folks from moving from an agency model to a more consumer-directed model, the consumer-employer model.

But, also, it's also helpful to know that you

spoke with AAAs and ADRCs, but both of those agencies are really more geared towards aging populations, and so their mission is more towards helping folks remain safe in their homes, which is very different from independent living centers, which are more geared towards younger folks and desires to actually go out and get jobs, education, a lot of other -- as I say, the older folks wanted this as well, which was a model, which is a very different understanding of what their roles are. And there actually are independent living centers that do provide the same services as AAAs and ADRCs.

And then I think most important within that context is that ILC is really focused on consumer choice, control, and dignity of risk, and that goes to the idea that family members may not report a critical incident. And in the case of folks who get assistance from a family member or someone else, that they're -- I know a woman who in order to actually get from one place to another, she'll use walls. She'll go between two walls and use them: they bounce off them to get from here to there. But that's usually the way for her entire life. But if she's going to fall, she'll slide down the wall and then get herself back

up, but in a medical realm, that would be seen as a critical incident. You know, she fell down, but that's just part of her -- the way she's lived from childhood.

And so I think that's important, like really contextualize the two models and to know that Massachusetts -- actually, the Consumer Directive Model was established here in the -- I think it was late '70s by Charlie Carr and other disability advocates in the state. But I think it'd be helpful to give that background.

Some other -- a few other things that -- it would be helpful to look at research that was done by, I think, the Community Living Policy Center on consumer-directed care versus agency-directed care during COVID and how they -- and which one was it, which model of folks were able to get more care.

I think I'll send you all my other comments.

I'll say that, like, I actually had both models of care. When I was in an agency, because I'm a high-level quadriplegic, it can be very hard for them to find people to help me out, and so agencies don't guarantee that the person they're sending will actually be able to provide the services the person needs. They will guarantee that

they'll provide a person. And so I was often having to find people, family members or other folks to come in, because the person they would send actually did not have the skills I needed.

It's also important to note that depending on the state, depending on the rules, oftentimes HCBS workers who work for agencies are not able to provide a lot of nursing home -- not nursing home -- nursing-level services that can be provided under the consumer-directed model; for instance, maybe bowel and bladder care. And those things can be provided by someone, a consumer employer. The PCA, the HCBS workers can provide those services, but in the agency, they can't provide those services, and so a nurse needs to be brought into the equation. And that can cost. That can lead to much higher costs.

And so I'll just leave it there, and I'll send you on other questions about the demographics of folks who use agency versus a consumer-employer model and a few other things, but I think that's it for now.

Thanks.

CHAIR VERLON JOHNSON: Thank you, Dennis. Very helpful.

Jami?

COMMISSIONER JAMI SNYDER: Yeah. And just tagging on to what Dennis was just talking about, I'm certainly interested in learning more about when a consumer-directed model is preferable versus an agency-with-choice model from kind of the consumer perspective, and so I think that information that you offered, Dennis, would be really helpful to our discussion.

The other item I just wanted to touch on, I think on one of the slides you listed out six different types of information and assistance entities, and to your earlier point, Gabby, it seems like with all of those entities in the mix, there is a potential concern around duplication of effort.

When you talked with folks, did you hear at all from states around what they're doing to minimize duplication of effort among the I&A entities?

GABBY BALLWEG: We didn't hear a lot about efforts to minimize duplication. It seems like sometimes the duplication, I think we said, was on occasions intentional, like states wanted to combine the support broker and case manager role. So that's one area of

duplication.

But then sometimes I think that unintentional duplication maybe comes around. I think the example I had given was if a case manager/support broker maybe has a really large caseload, right, they maybe aren't able to sufficiently serve all of the beneficiaries with all of their needs. And maybe a beneficiary will go seek information elsewhere. Maybe that could be from the FMS agency. So we would definitely have to do a little more work there to kind of figure out ways that states are looking to minimize that if it's happening in the state.

COMMISSIONER JAMI SNYDER: I think any additional information we can gather around two -- some of the embedded models that you talked about, where the two I&A entities are paired together and how that might work to alleviate duplication, I think would be helpful.

CHAIR VERLON JOHNSON: Thank you, Jami.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: I just want to reiterate, Gabby and Brian, my gratitude for your work on this topic.

Sort of starting from the perspective of the

people who might choose to participate in self-direction, I do think that one of the things that we found really helpful was to standardize the education materials and even establish clear requirements around that education process to make sure that people fully understood the opportunity to participate in consumer direction or self-direction, the supports that would be available to them should they choose to do that, and to make sure that that was communicated to them in a clear way and documented, so we actually required a signature from the person saying whether they did or did not want to participate in an annual review so that it wasn't sort of a one-and-done. If someone said no now, maybe they might choose to do that later if they were experiencing any sorts of access issues.

I do think another thing that we did that was particularly helpful was to incentivize health plans to increase enrollment in consumer direction, and we did that using MFP funds.

Kind of turning to our work as a Commission, because we are an access and payment commission, I really feel like in order to make good policy recommendations, we need to be able to have a better understanding about how

cost and quality and program integrity and utilization, sort of all those key things are really impacted or different in self-direction programs versus agency-delivered services.

And I say that fully acknowledging, as you brought up, that it's really difficult to identify who is participating, let alone the services that they're getting. So maybe our recommendation should start with just some data recommendations to be able to really understand program participation and service utilization better so that we can make meaningful comparisons.

And then the other thing I would just say -- and I say this as a lifelong family caregiver -- underscoring the critical importance of family caregivers and also the availability of self-direction, I do really want us to dig into, because I've heard this from states. Any concerns regarding potential conflict of interest, when the person or persons that are being paid to deliver care are family members or friends, that could be negatively impacted by changes in service utilization when those are appropriate based on the needs and preferences of the individual. And truly, those are conflicts that sort of also exist in the

agency-directed world, but they're different, right, when that person is a family member or friend of the individual and just create some unique dynamics that I think we need to better understand and to understand if there are ways that states have been effectively able to address that particular concern.

CHAIR VERLON JOHNSON: Thank you, Patti.

Carolyn and then Mike.

COMMISSIONER CAROLYN INGRAM: Thank you.

Just a few questions, and maybe it's more something that we need to dig into, but bouncing off of Doug's conversation or questions, did we look at the difference between what staff the state has to oversee these types of programs versus managed care entities, that when the programs are in fee-for-service versus in managed care?

GABBY BALLWEG: We didn't. We did hear that, you know, managed care organizations play a big role in that oversight when, you know, it is operated in managed care. So there definitely are differences, but we didn't look into the specific staff and like the fee-for-service versus managed care model.

COMMISSIONER CAROLYN INGRAM: I think that's something we might want to do because my gut says probably the state staff don't -- you know, are overseeing some of these programs with very few staff in the managed care companies because they're required by contract to look for fraud and abuse, and these programs have a much more robust oversight and quality program, and so it would be interesting, I think, to see that comparison.

And then to Doug's question, just generally, what's done to oversee these programs to prevent some fraud and abuse, I think they do serve a really great function. In fact, when I was Medicaid director, we created and applied for these waivers and got them for our state, you know, really early on, I think, when a lot of states weren't doing this. So I know they serve a really important function, but I'm concerned, again, that there's some people who don't have the best intentions and sometimes take advantage of fragile populations inappropriately. And it's not even the family or the person that's receiving the services. It's outside entities.

The other question I had about was the EVV

systems. Did you all get a chance to look at just the cost of those EVV systems and how well they actually operate in producing reports? Because it seems like the reporting we're asking for here and some of the transparency should be coming out of those EVV systems.

GABBY BALLWEG: Yeah. So EVV kind of came up tangentially. It wasn't the focus of this work. So we didn't explore that specifically.

I will say that some states are still in the process of their EVV implementation, or it's really new, so states aren't always using the EVV data for self-direction quite yet. So that might take a little bit more time to dig in there.

COMMISSIONER CAROLYN INGRAM: Yeah. In my experience -- and again, this is just on the ground in a few states, but that they cost a lot of money, and they're not great at providing those reports and the data that's needed. They're not very adaptable, I guess I'll say. They're not fast to accommodate or flexible. So it would be interesting to see if there's some recommendations around improving that or if that would be a system that could be used to get some of this information out.

Thank you. I think that's it for right now. Thank you.

CHAIR VERLON JOHNSON: Thanks, Carolyn.

Michael?

COMMISSIONER MICHAEL NARDONE: So I think Carolyn and Jami actually have mentioned a couple of things I was interested in.

I was also interested in the potential of EVV. We talk a lot about fraud and abuse. The EVV systems, one of the reasons why they were put in place is because of concerns around appropriate authorization of services and people showing up to provide those services. And I know that EVV isn't specific to self-direction, but you would hope that given that investment, that that might have some dividends down the line in terms of some of the discussions we're having around fraud and abuse.

Also, just to maybe build off of what Jami was talking about, the one thing that comes home to me, based on the analysis and the great work you guys have done in this area, is there does seem to be an awful lot of overlap in the information and assistance roles. And I'm wondering, did that come up as a concern that people raised

when you were talking to state people or maybe when you were talking to consumers or other stakeholders in terms of the need for better, for less overlap, and more consistency of definitions, or did the folks think that in their state, it was pretty clear, even though there was overlap in those functions?

GABBY BALLWEG: Yeah. So that's a really great question. I think there were differing opinions on that. The area where we heard more concerns were from some beneficiary advocacy organizations. They felt that sometimes the beneficiary didn't have all of the information and assistance that they might need in some cases, and so I think that's where the concern was raised more often.

At the state level, I think states were maybe a little less concerned about potential overlap, and again, sometimes they structure their program with overlap being intentional. So I think there's definitely different opinions around that, and we could potentially explore that further as well, so really great point.

COMMISSIONER MICHAEL NARDONE: I mean, I think one of the questions I continually have with this model is

ensuring that the caregivers have the support that they need to provide the services, and that might be training and education, like Patti's talking about. It might be real-time assistance of a case manager, making sure that the programs are structured so that the caregivers have the supports they need and also maybe have some respite from provision of services. So I think that's one of the directions and one of the things I would really like to learn a little bit more about, too, as you go forward with this work.

CHAIR VERLON JOHNSON: Thank you, Mike.

Let's go to Angelo and then back to Dennis.

COMMISSIONER ANGELO GIARDINO: I just want to reiterate some of the positive things that my fellow Commissioners have said, and I'm having a day of gratitude. So I'm delighted that you're looking at this.

You know, I'm glad we're on a march towards improving this type of program, and I understand that "self-direction" is kind of a policy word, and it means a lot to policy people. But when I zoom out, this is really an element of Medicaid that I'm particularly proud of because it allows our friends, our neighbors, our family

members to make decisions about their life and how they receive the care that they need, and our society is committed to those persons, and Medicaid provides a vehicle for that.

Now, I think it's great that we're going to make it better, and all these elements are important, but in Atul Gawande's book, "Being Mortal," he talks about the basic human dignity of being able to make decisions about your life. And to me, that's what you're talking about.

So I'm just thrilled that we're looking at this, and this is one of the reasons why I'm really proud of Medicaid, because we do -- it would be a lot easier just to stick all these people in institutions and just run the institutions quite effectively, and, you know, it would be probably cheaper. But that's not a good thing, and I think our society is committed to these people because they're our friends, our neighbors, and our family members. And I think that's a really noble purpose, and I'm really proud of Medicaid for doing that.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Angelo.

Let's go to Dennis.

COMMISSIONER DENNIS HEAPHY: Give me one second.

CHAIR VERLON JOHNSON: Okay.

[Pause.]

COMMISSIONER DENNIS HEAPHY: It was funny you mentioned Atul Gawande because he and I have worked together on stuff, and something we've discussed is a person can't have control without choice. And so even if I'm talking about consumer control versus agency control, sometimes they both have strengths and weaknesses and have benefits to both, but it should really be the consumer, the beneficiary, and their family members who decide and make that decision versus specific to the populations.

But I just wanted to raise a couple of things, clarifications, that not all employers have budget control, and so I don't have control over the budget. And the hours that I get are determined by a time-per-task tool and not a care plan necessarily. How you raise the idea of someone paying insurance for their HCBS worker, that if they only have a certain amount of hours and they need all those hours, then they don't have the flexibility to actually skim off some of those hours and use them to provide insurance to someone. So it's one of those situations

where there's just no give. I know that's true in the number of hours I have.

Then with MCOs, there could also be a conflict of interest in having MCOs determine the number of PCA hours, because they're using just a Time-on-Task tool and not actually looking at what a person's overall goals and whatever their situation in life may be, that they actually might reduce the number of hours that a person gets in order to reduce their own costs.

That's it. Thanks.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Let's go to John and then Jami.

COMMISSIONER JOHN McCARTHY: I think Jami hit on this, and I know you guys did a little bit of this already, but it sounds like there's a lot of things we're still learning in this area, and it is complex. But do we have any time or budget left to do some more interviews of individuals, not advocacy groups but individuals under the two different models?

GABBY BALLWEG: Yeah. So we're thinking about this project as more of multi-cycle work. So this is kind of like our first brush, right? And then we're going to

kind of take another bite at it in the next cycle, so definitely something we could look for pursuing in the next cycle as well. So that's helpful.

CHAIR VERLON JOHNSON: All right. Thanks, John.

And Jami.

COMMISSIONER JAMI SNYDER: Yeah. I just actually had a clarifying question. I know when EVV initially rolled out, there was some debate among states around whether to use EVV in the self-directed care space, and I was just curious to know whether you have any information on, I guess, the percentage of states that, in fact, are applying or using EVV around self-directed care.

GABBY BALLWEG: We don't have that information. We could look into it a little more and get back to you.

Again, it's still kind of early days in that space. So the availability of information might not be as available yet.

BRIAN O'GARA: I would say that debate still lives on, though. We heard a mix of opinions on EVV from various stakeholders, specifically balancing accountability with privacy concerns.

COMMISSIONER JAMI SNYDER: Yeah, exactly. And I

know a couple of Commissioners mentioned EVV is a real tool to prevent fraud, waste, and abuse, but I think that's just something we need to take into consideration, that there are certainly states that decided not to implement it in the SDS space because of those reasons.

CHAIR VERLON JOHNSON: All right. And then Dennis?

COMMISSIONER DENNIS HEAPHY: Just a clarification. EVV is actually federally mandated. All states have to implement it, and so some states are still rolling it out. And so we don't know where things are right now, but it is federally mandated.

And so I think what would be helpful is to consider doing an entire chapter on EVV and the costs and benefits of that.

COMMISSIONER JAMI SNYDER: I was just going to ask the question. Dennis, do you have a sense of the states that are actually using EVV in their self-directed care programs?

COMMISSIONER DENNIS HEAPHY: Yes. It's required.

COMMISSIONER JAMI SNYDER: Okay.

COMMISSIONER DENNIS HEAPHY: Yeah.

COMMISSIONER JAMI SNYDER: Thank you.

COMMISSIONER DENNIS HEAPHY: I'm using EVV now.

GABBY BALLWEG: Yeah. So I think to Dennis's point, it is required. All states aren't doing that yet, but yeah.

COMMISSIONER JAMI SNYDER: Got it. Thank you.

CHAIR VERLON JOHNSON: Okay. Any other Commissioners with questions?

[No response.]

CHAIR VERLON JOHNSON: I think you all have a lot of information that we have. I just want to add a couple of things, if I can.

I heard a lot about program integrity, and just as we're thinking about that, I want to make sure minimizing administrative burden on beneficiaries when we're thinking about that angle, for sure.

Also, when we're thinking about our future work, I'm really thinking about how we can expand access for underserved populations, and so really understanding how states are actually supporting non-English speakers, people with cognitive disabilities are facing administrative burdens. How are we going to do that in the future?

And then, lastly, my wish list is -- this is what happens when you're the Chair. You can actually add other stuff. Workforce and Medicaid data integration, it would be really cool if we could really figure out how can we use the data that we have to track all of this and really be able to ensure better provider availability around self-direction as well.

Well, again, thank you all so much for your work on this. Again, we are very excited about this and very passionate. So that is why we keep going over in time, and that's okay. Thank you so much. And we look forward to you all coming back in April.

All right. So Melinda is going to join us, and we're going to a session focused on access to MOUD and Medicaid. She's going to actually walk us through some findings from stakeholder interviews, and we're looking forward to learning what she learned.

Melinda, to you.

IMPROVING ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER (MOUD): THEMES FROM STAKEHOLDER INTERVIEWS

* MELINDA BECKER ROACH: Thank you, and good

afternoon, Commissioners.

Today I'll be discussing findings from stakeholder interviews designed to further the Commission's understanding of factors that affect access to medications for opioid use disorder. I'll start by providing background information and then discuss key takeaways related to federal policies and funding, stigma and misinformation, provider availability, and utilization management before concluding with next steps.

MACPAC has been examining access to MOUD and Medicaid, which covers nearly 40 percent of people in the United States with an opioid use disorder and plays an important role in facilitating access to treatment. MOUD are effective, evidence-based treatments for opioid use disorder, which can reduce illicit opioid use, lower the risk of overdose death, and help individuals maintain recovery.

In recent public meetings, the Commission has reviewed federal policies affecting access to MOUD, as well as utilization data from our analysis of Medicaid claims.

Federal lawmakers have pursued a variety of Medicaid and non-Medicaid policies to improve access to

MOUD, including requiring state Medicaid programs to cover all forms of MOUD, namely methadone, buprenorphine, and extended-release injectable naltrexone.

This session rounds out the Commission's analytic work by providing stakeholder insights into the effects of the MOUD benefit mandate, other policies and factors affecting access to MOUD, and Medicaid levers that could address barriers to MOUD.

MACPAC contracted with Acumen to conduct interviews between July and September of last year. We interviewed a variety of stakeholders, including federal officials at CMS and SAMHSA, beneficiary advocates, and other national experts, including providers and researchers.

We also conducted interviews with Medicaid and behavioral health officials and managed care organizations, as relevant, in six states: Connecticut, Georgia, Idaho, Louisiana, South Dakota, and Tennessee.

We identified common themes from the interviews, some of which are specific to Medicaid and many others that affect access to MOUD more broadly. The first set of findings pertained to federal policies and funding.

Stakeholders generally had positive views of the requirement that state Medicaid programs cover all forms of FDA-approved MOUD. They noted that coverage is an essential component of access, and therefore, the benefit mandate was an important step toward improved access for beneficiaries.

While many stakeholders cited the addition of methadone coverage as a major effect of the mandate, some of the states we interviewed said they were already on the path toward covering methadone when the SUPPORT Act was passed.

Stakeholders also highlighted the importance of regulatory changes that were put into place at the start of the COVID-19 public health emergency and later extended. Several noted that the ability to initiate patients on buprenorphine via telehealth has been an important avenue for increasing access to MOUD. The use of audio-only visits has been particularly helpful in rural and frontier states, where patients may live far from their providers and have limited access to broadband.

Stakeholders were also encouraged by regulatory changes that have made it easier to access methadone and

noted the need for state action to implement those policies.

In a final rule published last year, SAMHSA permanently extended flexibilities for methadone take-home dosing which were put into place during the PHE and made a number of other changes to remove barriers to methadone.

States may need to revise their OTP rules and payment methodologies to take advantage of these regulatory changes. Several interviewees described cross-agency efforts at the state level to align state regulations with the updated federal rules.

Finally, states noted that non-Medicaid grant funding, such as the state opioid response grants and funding provided through the American Rescue Plan Act, has been critical to their efforts to expand and sustain access to MOUD for Medicaid beneficiaries and others with opioid use disorder. States described using these funds to build infrastructure and to pay for services such as peer supports that may not be covered by their state's Medicaid program.

Stigma and misinformation were commonly discussed as major barriers to MOUD. Methadone and buprenorphine are

often stigmatized as, quote/unquote, replacement drugs because they're opioids, whereas naltrexone is not. Because of these biases, some treatment programs won't accept individuals who are taking MOUD.

One health plan described instances in which beneficiaries had to taper off methadone or buprenorphine before entering abstinence-only treatment programs, which are commonly a step down from residential treatment. These programs can disrupt MOUD treatment for individuals who need or have been court-ordered to stay in those settings as they transition back into the community. Stigma can also reinforce structural barriers to MOUD, particularly for methadone.

For example, in some states and localities, there may be restrictive zoning laws or certificate of need requirements that make it difficult to open new OTPs.

Federal rules can also contribute to stigma and provider hesitance to prescribe MOUD. Stakeholders discussed how fear of running afoul of DEA rules can prevent some pharmacies from dispensing buprenorphine or increasing their supply of the drug, which creates challenges for patient access.

Federal rules don't limit the quantity of buprenorphine that pharmacies can order. However, pharmacy orders of opioid products are monitored, and suppliers have a legal obligation to notify the DEA of orders that are atypically large or otherwise suspicious.

Stakeholders also noted that federal regulations regarding privacy of substance use disorder treatment records under 42 CFR Part 2 can cause fear and confusion and can make some providers hesitant to prescribe MOUD. In its prior work, the Commission has recognized and made recommendations to address these and other concerns about Part 2 regulations.

State Medicaid programs and MCOs have conducted outreach to educate their providers and community leaders on the benefits of MOUD and address concerns. For example, one state Medicaid program described working with their behavioral health agency to release informational bulletins and meet with providers to address concerns about pharmacies stocking and dispensing buprenorphine.

Provider availability was another common theme across our interviews. Stakeholders cited many challenges to expanding the number of MOUD providers, such as general

behavioral health workforce shortages, a lack of training and support needed to recruit primary care and other non-addiction specialists, low Medicaid reimbursement rates in some instances, and federal regulations that limit the availability of methadone providers by restricting dispensing to highly regulated OTPs, as well as state and local zoning restrictions and certificate of requirements that were previously mentioned.

Stakeholders described a number of efforts to address these challenges, including the use of non-Medicaid funds to recruit and provide ongoing support to buprenorphine prescribers who might not otherwise feel they have the training and resources needed to manage complex patients with opioid use disorder. These funds have been used to provide additional staff for case management and to support provider participation in teleconsultation models, such as Project ECHO.

Stakeholders also described the establishment of mobile OTPs, which can bring methadone dispensing to areas that lack a traditional fixed OTP, as well as efforts to have providers in emergency departments prescribe MOUD and make warm handoffs to other providers who can offer ongoing

treatment.

Finally, stakeholders highlighted Section 1115 demonstration opportunities through which states are improving the availability of MOUD. Most states are now operating Section 1115 demonstrations that have allowed them to expand coverage for beneficiaries receiving substance use disorder treatment in institutions for mental diseases.

Participating states must assess the availability of MOUD providers and require IMDs to provide MOUD directly or to facilitate access off-site.

States are also increasingly pursuing re-entry demonstrations that allow them to provide pre-release Medicaid services, including MOUD, to Medicaid-eligible individuals who are nearing release from incarceration.

Utilization management is the last major theme that arose in our interviews. States and MCOs establish utilization management policies, such as prior authorization, to ensure the delivery of appropriate care and to reduce the potential for fraud, waste, and abuse. However, many stakeholders we interviewed took issue with the use of prior authorization for MOUD, saying that it

delays care, creates administrative hurdles for providers, and contributes to stigma.

These interviewees emphasized the need to capitalize on every opportunity to engage individuals with opioid use disorder in treatment, given the potential that patients waiting for medications will overdose or not re-engage once their treatment is authorized.

Moreover, some expressed the view that concerns about medication diversion are overblown, given that diverted MOUD is most often used by other individuals with opioid use disorder, hoping to avoid the painful symptoms of opioid withdrawal.

Daily dosage caps are another utilization management strategy used by states and MCOs. Several states took issue with the use of daily dosage caps for buprenorphine, which they described as problematic for patients who have used fentanyl or have a long history of opioid use and need higher doses of buprenorphine to stabilize.

Some states have increased the daily dosage cap, and the FDA recently began encouraging labeling changes to clarify that higher doses of buprenorphine may be

appropriate for some patients.

As far as next steps, we'll be incorporating findings from the stakeholder interviews into a chapter for the commission's June report to Congress. A draft of the chapter will be presented at the April meeting.

We're also getting ready to launch a new phase of work that will more closely examine the use of prior authorization for MOUD.

For your discussion today, the slide includes two questions. First, it would be helpful to know if you'd like us to emphasize or elaborate on any of the issues raised by stakeholders when we're putting together the chapter for June. Second, we'd appreciate your input on what questions you'd like to see addressed through the Commission's future work on prior authorization for MOUD.

Thank you very much.

CHAIR VERLON JOHNSON: Thank you so much, Melinda. We appreciate that. Great work.

And so, with that, let me open it up to the Commissioners for questions.

All right. Doug.

COMMISSIONER DOUG BROWN: Thanks, Melinda. Good

presentation, as always.

A couple of foundational questions here and some comments. From the prior authorization standpoint, I'd like you to investigate or see if there is a difference between prior authorizations operationalized by MCOs versus fee-for-service programs and see if they are, in fact, different and what that might look like.

Also, draw a distinction between the prior authorization for the drug and the quantity limits or maximum dosages for those drugs. So when the interviewees kind of talk about the barriers to that, are they talking about not being able to get the drug, or the drugs available but not at the dosage that they want? I know you mentioned the idea of some states have a limit of 24 milligrams and the FDA looking at bumping that dose up to 32 milligrams, but I think in that particular case, the FDA label for that drug maxes out at 24 milligrams.

And so while the FDA label is such, the state has to be in compliance with that label. Obviously, everyone is looking at it for higher doses now with fentanyl and higher potency drugs that are on the market. Absolutely appropriate for those, but the state is putting controls

around those to be aligned with what the current label is for particular products.

So I think those are the couple of things that are top of mind for me as we look at this, but I'll reserve that other comment, and I'll come back into the mix if I have another question. Thank you.

CHAIR VERLON JOHNSON: We wouldn't expect anything else, Doug. I appreciate that.

All right. Jenny and -- oh, your hand is back up again. That was quick.

Jenny.

COMMISSIONER JENNIFER GERSTORFF: All right. This is great, Melinda. I felt like the themes really highlighted a lot of what we've previously discussed and kind of reinforced that, and they all feel very important to really display in the chapter.

There were a couple of small things within the themes that I felt like could be reinforced, maybe come out a little bit more. One is in the patient outreach of meeting people where they are, and it fell under your provider availability here. But I've heard from people on the ground, that's really important, especially for people

addicted to fentanyl.

And along similar lines, I think we kind of talked about how the opioid crisis has changed a lot over time, and there's a lot more use of fentanyl, and treatment needs have changed significantly. And the FDA hasn't necessarily caught up there, and there are a lot of ways people are trying to deal with that. But I think highlighting more of those struggles would be helpful.

MELINDA BECKER ROACH: Yeah. I think we can absolutely address those things, and as you were talking, I realized I don't think we, you know, and the meeting materials to date have provided much context on sort of how the crisis has evolved over time, which is important to understand as you're thinking about dosage caps and how that affects patients. So thank you.

CHAIR VERLON JOHNSON: Thank you, Jenny.

Dennis?

COMMISSIONER DENNIS HEAPHY: Thank you. And once I finish, could you put me on mute?

So thanks a lot for the report, and I think -- I mean, what stands out is we're seeing, probably for a moment, an overall need to reduce barriers to MOUD. And

that was the theme I saw throughout the entire report is we need to do that.

I live in an area where there's a lot of opioid misuse, abuse, and folks often use together in small groups. And it doesn't matter whose intervention it is in the group. If someone's got it, they should be able to use it on their friend. It should not be who it's just prescribed to. That's my feeling.

But, at the same time, I also think to Doug's point is, what are the possible risks of reducing the barriers? So it's like making sure that they were doing due diligence and saying, what are the potential abuses for, like, really emphasizing on, like, reducing the barriers? I just see people overdosing all the time, and so it's just a tragedy.

So that's my input. Thanks. This is really important.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Heidi and then John.

COMMISSIONER HEIDI ALLEN: Thank you so much for this work. It's really important, as everyone has said.

I was really excited about the Project ECHO. I

can see where people in certain contexts would feel unprepared to prescribe MOUD, that it would feel like out of their wheelhouse, that they would really not be sure what doses, how long. That seems to me not just about stigma but also kind of about people's scope of practice. But we know that the way that people use care when they're in addiction is you kind of have to help them when they come in, no matter who you are.

And so I really love the idea of a model where providers could reach out through telehealth to an expert and say, "I have this patient in front of me, and I really don't know how I would offer them MOUD." And so thinking through those kind of really creative ways of helping people expand their capacity in the settings where people are using care seems really beneficial.

And then I also am very interested in the prior auth because, like the interviewee, it seems like such a tragic thing that when you have a person who's like, "I want to do this. I'm ready to do this," that you would delay that care, potentially costing that person either their recovery or their life. And I'm wondering if we have any data on time between being prescription and when the

prescription is filled. Obviously, that's not a perfect measure, but it seems to me like it could be interesting, especially in places that do have prior auth, maybe compared to places that don't.

You're looking at your --

MELINDA BECKER ROACH: So it's just in the last couple of days, I was reading about how in one state they use that data from their claims to make the case to remove prior authorization. So it was something -- started thinking about. We haven't seen that kind of data in the literature. There is a good amount of research on prior auth and MOUD and some evaluations in states that have removed it. So we'll take a closer look at that and think more about your specific question about sort of the time between prescription and fills -- or diagnosis and fills, rather.

COMMISSIONER HEIDI ALLEN: Yeah. And then I think that I would be really interested in a panel of -- you know, like the Project ECHO, but different places that are trying to think about how to address the issues of stigma and capacity in a meaningful way, because I think that those could be really scalable and worth considering

what CMS's role could be in encouraging us. So thank you so much.

CHAIR VERLON JOHNSON: Thank you, Heidi.

John?

COMMISSIONER JOHN McCARTHY: For the future work, one of the things I definitely think we need to keep focused on is -- and you touched on here a little bit -- is reimbursement methodologies for this service. How this service is paid for is one of those that is one of the more non-straightforward ways of payment. So I think that's one of the things that if we could see some examples from different states and looking at that.

And what I mean by that is, really, there's a couple of components, right? There's the physician component, and it's not something special. It's just an office visit, usually, that gets paid for, and sometimes those rates are really not at a rate that's sustainable for somebody that's seeing mostly all Medicaid.

And then the next piece you have is labs, and so your lab gets a payment. Sometimes that's where states have those rates, maybe covering the cost that should be on the physician side.

And then, lastly -- and you hit on this in there, which is the dispensing of some of the drugs, and you actually pointed to an example of where the incentive doesn't work to have somebody get a week's worth of drugs versus daily. So if we could really touch on that, because I think that hits that provider side of the issue also. Thanks.

CHAIR VERLON JOHNSON: Thank you, John.

Doug?

COMMISSIONER DOUG BROWN: One quick follow-up question. The SUPPORT Act requires states to cover these products, make them available, and I know that prior authorization is allowed. My assumption has been that the prior authorization is allowed when you have two drugs that have the same chemical ingredient. You prefer one. You non-prefer the other. The PA is there. But there's one component of each of these products that's available without prior authorization.

And I guess, as you're doing your search, if you can look at that and confirm that assumption, that would be good to have for us to react to.

And the other thing about preferred drug lists,

kind of looking at this from nationwide or doing a survey of the landscape is not all -- these drugs don't always show up on a preferred drug list in a state, and in those cases, one might make the assumption that they're not covered because they're not on the list. And that's -- you have to kind of go one more step beyond that to find out what the coverage is, and they may be off the preferred drug list because they're all preferred or all available.

But, again, I think the other question I have is my assumption is that you don't need a prior authorization to get to all of -- to get to the drugs in the class. It's to get past the preferred to a non-preferred drug in the class, but the primary active ingredient is available in one form, available without prior authorization. But I'd love you to double-check that for us.

MELINDA BECKER ROACH: Yeah. We can absolutely do that. We're sort of digging into that data on state and MCO policies now.

Some of the information we have is a little bit outdated, but appreciate you raising those questions.

CHAIR VERLON JOHNSON: Thank you, Doug.

Jenny?

COMMISSIONER JENNIFER GERSTORFF: I have a couple of things for the future work that I just wanted to bring up. One is looking into what types of cost offsets we might see when we lift prior authorization. So for increasing spending, increasing access, like, where other areas that we're expecting to see savings, and where have those been demonstrated maybe?

And then social benefits of successful programs, so things like reduced justice involvement, increased employment, that sort of thing.

CHAIR VERLON JOHNSON: Thank you, Jenny.

And just kind of pulling a little bit more on what you just said as well. So -- and then, Doug, you're also educating me a lot as well. When we talk about prior authorization, I mean, again, it could be a barrier it sounds like, but it sounds like we're going to do a little bit more research around that.

Have any states -- if it's more towards fraud prevention and that kind of thing, have they ever done post-payment audits as opposed to -- have you seen that at all?

MELINDA BECKER ROACH: Yes. And I think -- I'm

recalling one of the states that we interviewed talking about how they had removed prior authorization, but they had other -- I'm not recalling the exact terms, but they had other mechanisms that they used to ensure that the prescriptions were appropriate, like at the point of sale at the pharmacy and different pharmacy edits, if I recall.

CHAIR VERLON JOHNSON: Okay. I think for future work; I'd love to see a little bit more around that as well --

MELINDA BECKER ROACH: Yeah.

CHAIR VERLON JOHNSON: -- to help us think through that.

MELINDA BECKER ROACH: Yeah. That's a great point. Thank you.

CHAIR VERLON JOHNSON: Thank you.

Any other comments from Commissioners?

[No response.]

CHAIR VERLON JOHNSON: Okay. Well, again, thank you so much, Melinda. I know we'll see you back in a couple of seconds for sure.

But we're going to go ahead and go to public comment right now. Okay. So we are open for public

comment. We do invite you to raise your hand if you'd like to make a comment. Please make sure you're introducing yourself and the organization you represent, and as always, we do ask that you keep your comments to three minutes or less.

Arvind, you're up.

PUBLIC COMMENT

* DR. ARVIND GOYAL: Unmute. Can you hear me?

CHAIR VERLON JOHNSON: We can hear you, yes.

DR. ARVIND GOYAL: Thank you very kindly. My name is Arvind Goyal. I'm the Medical Director for Illinois Medicaid Program, Department of Healthcare and Family Services, my 13th year in the business.

I am very pleased with this discussion that you just held because it is, you know, just like the vaccines prevent vaccine-preventable illnesses, this MOUD initiative can prevent opioid overdoses and deaths. I think that message needs to be honed in, distributed, disseminated widely, because remember about 20, 25 years ago, physicians got in trouble for prescribing opioids and anything like what we have today, methadone, buprenorphine, et cetera. And it has taken several acts of Congress and some

accommodations by HHS, DEA, et cetera, to get to where we are today, recognizing the value of MOUD plus counseling when available.

I want to talk about a few things. Our state has had no PA for any MOUD, either for opioids or for alcohol or for tobacco use, for the last, over 10 years. And I think we've been blessed with that, that prior authorization for these essential drugs is probably hurting patient care. It is also driving patients to overdoses with opioids specifically and also opioid-related deaths.

Somebody talked about the cost. The cost of these medications is peanuts compared to the cost of lives that we would lose to the use of drugs, to the cost -- the money that we will spend for first responders, for emergency rooms, for hospitalizations, and for destroyed workplaces and family lives. I think it is extremely important. I don't mean to be passionate about it.

But now combine that with the delay in starting a patient on MOUD when they deserve to be started. Let us say the patient is in the emergency room. There is an issue with methadone prescribing, which is limited to three days by regulation at this time, and buprenorphine, we have

not been able to get a very clear direction. The DEA rule says seven days of dispensing very clearly. Now, does that mean you can only prescribe it for seven days, or does it mean you can dispense it for seven days, but you can prescribe it for longer?

Then there is the issue of continuity of care once the patient leaves the emergency room setting, and if there is no guarantee that somebody would follow them -- and it can be very hard for Medicaid patients to access specialty care like addiction medicine care. After they leave the ED, if they need dose adjustment, if they need a bump up or bump down, if they have any side effects, complications, I think that needs to be clarified, and I hope that will be one of your recommendations as to what happens.

Then talk about the pharmacy deserts in rural areas and even in inner city areas. We see it in Chicago. There are zip codes where we do not have a single pharmacy. We have managed care rules. You have to be so many miles or so many minutes away from the patient's residence. And we have significant number of our people, about 17 percent who are homeless. You can deliver medications, but there

is a problem.

CHAIR VERLON JOHNSON: Thank you so much, Arvind. We really appreciate your comments, and if you have additional thoughts, please feel free to send them to us directly.

DR. ARVIND GOYAL: Thank you.

CHAIR VERLON JOHNSON: Thank you so much.

DR. ARVIND GOYAL: Yes.

CHAIR VERLON JOHNSON: Any other comments at all?

[No response.]

CHAIR VERLON JOHNSON: Okay. Looks like none. Again, if you do have comments later, feel free to submit them through our MACPAC website.

And for right now, we'll be taking a break until 2:45 p.m. So we'll see you back then. Thank you.

* [Recess.]

CHAIR VERLON JOHNSON: All right. Welcome back. I'm excited to see Melinda back up there. And we are very excited about the next session. This is our expert panel on SUD 1115 demonstrations. And I am going to turn it over to Patrick and Melinda to facilitate the panel. Thank you.

PANEL: SUBSTANCE USE DISORDER (SUD) SECTION 1115

DEMONSTRATIONS

* PATRICK JONES: Thank you. Good afternoon, Commissioners, and thank you to our esteemed panelists for joining this discussion on substance use disorder Section 1115 demonstration projects.

The substance use disorder, or SUD, demonstration opportunity allows states to cover residential SUD treatment delivered to Medicaid beneficiaries in institutions for mental disease, or IMDs, which is otherwise generally prohibited under federal law.

CMS introduced this demonstration opportunity in 2015, in response to the opioid crisis and the increasing need for residential and inpatient SUD treatment, and issued revised guidance to states in 2017. Nearly two-thirds of states are operating these demonstrations.

In addition to receiving federal financial participation for services delivered to Medicaid beneficiaries in IMDs, states participating in the demonstration are expected to make progress towards specific milestones designed to improve access to the full continuum of SUD care.

The SUD demonstrations have been cited as an

important strategy for states to improve access to medications for opioid use disorder. As part of the Commission's ongoing focus on access to medications for opioid use disorder, we want to create space for the Commission to more closely examine the demonstrations and the extent to which they are achieving their stated goals.

To discuss the demonstrations we have convened three experts that bring perspective from both the state and national level. We are joined by Cindy Beane, Commissioner of the West Virginia Bureau for Medical Services; Henry Lipman, Director of the New Hampshire Division of Medicaid Services; and John O'Brien, a National Advisor at Manatt Health, who previously worked on SUD policy at CMS. You can find their full bios in your meeting materials.

So, John, can you start us off with an overview of the SUD Section 1115 demonstration opportunity and the challenges it is intended to address.

* JOHN O'BRIEN: Sure. Good afternoon, everyone, and thank you for inviting me to this conversation. It is good to see some familiar faces that I haven't seen for quite some time.

There are two points in time that I think we need to consider in answering that question. The first was the 2015 State Health Official letter, Patrick, that you referenced, followed by the 2017 SHO, as well.

In 2015, the overarching goal of that SHO was to ensure that there was a continuum of care that was available to individuals with substance abuse disorders. That was paired with the Innovation Accelerator Program for substance use disorders, that was intended to really assist states in providing some smart thinking as it relates to their implementation, not only by 1115 waivers, because there are only a handful of states that had 1115 waivers at the time, or thinking about 1115 waivers, but also those states that were just trying to do better in the space of substance use disorder.

As you mentioned, the 2015 and subsequently the 2017 guidance really did, in fact, open the door around an old-standing policy, a 50-year-old policy around the exclusion of payment for services to individuals that were in these types of facilities, with the exception of some inpatient services.

The intended goals of the 1115 in 2015 weren't

terribly different than what we saw in 2017. Let me just highlight a couple of those. First of all, it was to promote strategies to identify individuals with substance use disorder and then to engage those individuals in treatment.

Second was really around building the full continuum, including, in 2015, we really wanted to have states think about aftercare, aftercare in terms of residential, aftercare in terms of some of the intensive services like recovery support services, including recovery coaching.

And then similar to what we saw in the 2017 guidance, the 2015 guidance also focused on trying to make sure that there was good integrated care between physical health and substance use disorder treatment for those individuals with a substance use disorder.

As I indicated before, the 2017 guidance was different than the 2015 guidance. I think the goals were kind of, sort of the same. Again, some of what we saw was that the initiative, in 2017, focused on opioid use disorders, probably more strategically and more focused than the 2015 guidance, and some of that was directly

related to increasing, I think, attention paid to the overdoses, especially around opioid use disorder.

There were some key differences between the two State Health Official letters, and I think towards the CMS approach to these. One was that we were pretty laser-like in the 2015 approach that states pretty much had to dot their I's and cross their T's before they got an approval for an 1115 waiver. So states, for the most part, led by California and others, really wanted to kind of move into this space quickly, but again, I think we were cautious because this was a new policy endeavor. We really wanted them to be as clear as they could be and as diligent as they could be about having the policies in place.

The 2017 SHO actually opened the door a little bit more and said to the states, we're going to say that you've got to have some milestones, or you're going to have to address some milestones that are necessarily in order for you to implement the 1115. It was the beginning of the CMS's efforts to really think about milestones, that's kind of continued through today. And I believe states had about two years to be able to implement the milestones, could get FFP for some of the work that was being done to implement

those milestones and some of the services that were covered under the milestones.

The 2017 SHO, not surprisingly, also focused more on really creating the residential continuum. It wasn't agnostic about some of the other community-based service, but really focusing on the residential level of care, and in particular, those residential levels of care ability to either offer medication for opioid use disorders or be able to facilitate it in a meaningful way to those individuals with MOUD, or with an OUD.

And last but not least, and I'm sure the states will talk about this, was the reporting requirements. In the 2015 SHO, we whittled it down to about three measures that we thought were important to be able to have states report on. In the 2017 SHO, there were about two dozen measures that were required, and then another 10 or 12 that were voluntary to be reported. But again, it was really more to be able to make sure that states were reporting data to be able to meet their milestones.

So those were really what I see as kind of both the impetus and the differences between the '15 and '17 guidance.

PATRICK JONES: Thank you, John. Turning to the states now to get some background from them. Cindy and Henry, could you tell us what you are hoping to achieve through your states' SUD demonstrations, and what some of the most significant changes you put into place under the waiver were?

Cindy, perhaps you'd like to start.

* CYNTHIA BEANE: Sure. We started as soon as the opportunity came up because West Virginia was kind of a state that was really hit hard with the opioid epidemic, and we would say us and the Appalachian region was really the epicenter of the epidemic. So as soon as the opportunity came out, we started working on it.

West Virginia had never done an 1115 before, so it was all kind of new to us. The whole budget neutrality, the report, all of that was new. And so one of the key factors of our demonstration, we started in 2015, we got our approval in 2017, kind of right under the time before that new 2017 letter that John was speaking about came out.

One of the things that we really wanted to build out was a continuum of care, and we had lots of discussions with CMS because in West Virginia, even though we were the

epicenter of the epidemic, we were not covering all forms of MAT in the Medicaid program at that time. So one of the things that we had in our waiver that's probably a little bit unique is we put our methadone treatment in our waiver in order to politically get it covered in West Virginia.

Also, we had zero beds in residential care. We went from zero beds in residential care to today we have 1,799 beds for SUD treatment.

We also focused on peer recovery support. We had had that piloted through grants, through our Bureau of Behavioral Health. We saw that they were working, but it wasn't a statewide coverage. It was kind of grant funded, and different pockets of the state would have that peer recovery support, but it wasn't statewide. So we put that in our waiver, as well.

West Virginia was really hit with a lot of OD deaths, so another factor in our waver was Naloxone distribution and covering of Naloxone and really working with our EMT professionals to open up separate codes for that.

So we really went from the Medicaid program being a peripheral player in the SUD treatment with regards to

prior to the waiver we offered Suboxone, we offered counseling, to really becoming an integral part with offering all the ASAM levels of care, withdrawal management, and intensive SUD residential services, as well as outpatient services.

The goal was for us to create a continuum, and it was very successful in the fact that we were able to also partner, at the time, with our other state agencies. So at the same time we got the waiver approved, we also got state funding called our Ryan Brown funds, that helped put the seed in the infrastructure to build out some of the residential capacity.

So with regard to the milestones and the reporting, we immediately, West Virginia Medicaid, I always say we're small but mighty on the state side, but we also have to rely on the nurse. So we immediately engaged our WV health systems to help us with all the evaluation pieces of it, and we engaged a vendor to help us with the budget neutrality piece, which was really something new to us and a little bit of a challenge for a state who had never done it before, to kind of get through the whole application process, and how that would work, and all the reporting.

But I would like to say, it has put a strong infrastructure in West Virginia for treatment for individuals who are seeking treatment.

PATRICK JONES: Thank you, Cindy. And Henry, can you tell us a little about New Hampshire's goals and their approach.

* HENRY LIPMAN: 2018 is when New Hampshire secured its IMD waiver, and from a synergistic and catalystic standpoint, I would like to kind of highlight what it meant here in New Hampshire.

We began an SUD benefit of a real nature in 2014, for our expansion population and for our regular Medicaid population in 2016, so building up a continuum with the benefit was really important.

When I used the term catalystic, I'm looking at how the effort of putting together 1115 waiver in addition to how it could be synergistic not only to the benefits that were put in place. Similar to West Virginia, we were among the highest states. I think we're in the top five in terms of overdose deaths when we started Naloxone and medication for addiction through SOR funding was leveraged, recovery support worker and recovery programs were put in

place. We also became part of the MOM, Maternal Opioid Misuse demonstration project.

We started peer support and peer recovery, and again, sort of in a synergistic way, in 2023, we have an adult dental program, because one of the ways that we would see a lack of access to dental care as being a source of substance use disorder and ER visits. In our managed care program we added APMs and also contract metrics, which again helped to get people into treatment and take advantage of building out a continuum of higher level ASAM criteria services. We sought a 1915 supportive housing waiver. We've taken advantage of the local crisis stabilization components that have come after.

I think New Hampshire has liberalized the types of providers that can provide treatment, in terms of physician assistants being able to practice independently, the use of telemedicine, and more recently starting certified community behavioral health centers, part of the CCBHC demonstration.

So I guess, all in all, I think building out that continuum and synergistically putting pieces in place as we could, as you get the benefit of the funding that comes

from the waiver, is kind of what I think I'm demonstrating here, that New Hampshire was able to achieve, and was our goal in going after this waiver to begin with.

I'll stop there.

PATRICK JONES: Thanks, Henry. So continuing our look at state approaches, what challenges did you encounter when implementing your state's SUD demonstrations? Henry, I'll toss this one to you first.

HENRY LIPMAN: So in terms of the challenges, I think in terms of operating the waiver, getting everybody up to speed on budget neutrality and how the waivers affected, for example, in New Hampshire we're a managed care state, the issue of what goes against budget neutrality if, for example, someone covered by managed care, it's the capitation rate for the month. If you don't get individuals enrolled and eligible under managed care they come in in fee-for-service, and the hit, financially, that hits your waiver is much greater. So there's sort of like, what I'll call sort of the business aspect of running the waiver.

I think in terms of awareness and how the community comes together, from a systems standpoint, that

took some time to work with stakeholders that were in this space.

One of the important things that left out earlier was New Hampshire, through its SOR funding, established accessed points for the state to initiate access to treatment, called Doorways, and helping, if you will, a lot of the substance use disorder community in New Hampshire were like subsistence farmers. They were not sophisticated Medicaid billers and providers. And sort of engaging support to them to help them master being enrolled and billing in Medicaid was an early factor.

It also showed up in peer support, that the conventional ways of billing, we're still working on that. In fact, we're working today on, we have a community re-entry waiver, part of our 1115 waiver, another thing I left out earlier, that in terms of engaging peer support post-release for inmates in New Hampshire that are eligible for the community re-entry waiver, making sure that there's a model there that supports ongoing connection so that they can maintain themselves.

And then I think in terms of the opioid providers, in terms of taking feedback from them on how

rules needed to evolve. Based on SAMHSA criteria, nationally New Hampshire, it was stricter than some states and trying to get more current on some of those practices.

Withdrawal management I guess would be my last point is that scenario that we would like to build out better and probably the one part of the New Hampshire system that still needs further development.

PATRICK JONES: Thank you, Henry. And Cindy, what challenges did West Virginia encounter?

CYNTHIA BEANE: Some of our challenges are very similar to New Hampshire. Like I said, we had pockets of different service delivery happening our state that were mainly grant funded. So to switch a small grant-funded provider into the Medicaid space, that level of sophistication of claiming and doing your business, that was a learning curve for some of the providers.

One of the lessons learned that I would say West Virginia had experienced, we were so excited to get our waiver finally approved, our MCOs weren't ready yet with regards to their systems and getting everything ready. So we put our services in fee-for-service for the first six months, our residential services, and then the transition

to the MCO. So we had two kind of transitions with them. So lessons learned. I wouldn't have done that, looking back on it, because it kind of caused a lot of provider abrasion and those kinds of things.

But with regard to other challenges that we've had is our peer support, we really went from like zero to 100 miles an hour really fast in that peer support arena. We didn't have enough safeguards in the training around that peer support in order to make sure that it was doing what it was intended to do. We have since put some different certifications in for peer supports, and we're expanding who all can do peer supports.

We have recently received a renewal because the feedback and the qualitative analysis of the waiver is that the peer recovery coaches and the peer supports is really an integral piece of that person staying in recovery. So we see the value in it. We have expanded to where all those individuals can be employed.

But we have put some more certification around it in order just to make sure that those peers that are working with the individuals are trained in what they're doing, and that they've had a period of recovery themselves

to where they're not going to kind of fall back into addiction themselves. And we were finding where we did not have enough safeguards around that, predominantly the individual that was receiving the peer supports, but the peers themselves. So I feel like that's been an improvement, and that was kind of a lesson learned, as well.

And the other lesson learned, I would say, is just the education of the community on how to access the services, where to go for the services, and having a more single point of entry. In the beginning we were kind of scattered, so through the years we've gotten that much better with call lines and places to refer, where you can figure out where the access is, even if it might not be specific in your hometown or county, we always have a bed open somewhere if a bed is what is needed.

And also the education of, it's not necessarily always a bed or a residential level of care that's needed. It is also the outpatient level of care, with perhaps wrapping a peer around that individual will be enough. And really tailoring it to the person's need. In the beginning, I think we were very prescriptive with regard to

how individuals were to go through those ASAM levels, and now I feel like we're getting more individualized treatment as the program has matured.

PATRICK JONES: Thank you, Cindy.

John, there's a lot of interest in understanding what progress has been made as a result of the SUD demonstrations. Can you orient us to the variety of monitoring and evaluation efforts underway at both the state and national level?

JOHN O'BRIEN: Sure. I think, as I said before, the 2017 guidance requires states to report on about two dozen measures, and those measures are then used to be able to talk about the health of the 1115 OUD waivers. CMS, through its contractors, has released several reports that are helpful to understand the impact that these waivers had, vis-à-vis these measures.

There are a couple of caveats that I want to make, when I talk about these outcomes or these measures. First of all, certainly nobody could have anticipated that there would be a pandemic, back in 2015 or 2017. So I think some of what we saw in some of what was released really was impacted by the pandemic.

I think the second caveat is that it takes a while to be able to change direction. You know, we have had a 50-year-old policy, or we had a 50-year-old policy, that prohibited IMDs, or spending for IMDs, and that just takes a while to be able to get those facilities and those services in place for those individuals, as both Henry and Cindy talked about.

And the third caveat that I would just make is that the data that's available, from CMS through Mathematica, is really good data. It differs, though, in terms of the type of beneficiary, and it differs, for instance, whether or not the person is under age 18, whether the person is over 65, whether the individual is pregnant, whether or not that person has some sort of criminal justice history.

So I caveat that just so you take that into account when I talk a little bit about some of what we have been seeing from those waivers.

The good news is that I know that Mathematica found that there was an increase in beneficiaries being able to access and use SUD and OUD services, and that's really important because, again, some of the benchmark

baseline showed that some states really needed that kind of push, or they really needed that ability to be able to access some of those services for those individuals.

In addition, not only just utilization but true engagement in these services was something that was seen by those reports that showed that individuals actually did stay in services. And in particular, the one thing that they highlighted, Mathematica highlighted, was the length of time that people would stay in treatment once they left an inpatient setting or an emergency department setting. That was a huge cliff for a lot of individuals, and the extent to which the 2017 guidance really shone light on we've got to get those systems in place to be able to have that cliff be reduced was really important.

We also saw decreases in terms of actual use of MOUD, prescription MOUD, and benzos. I would pronounce the longer name but I always botch it. Anyway, we saw a pretty significant decrease in the concurrent use of those two drugs. And then there was a decrease in higher dosages of MOUD for individuals that had OUD, that weren't diagnosed with cancer. So I think that's important.

What we didn't see progress on -- and again, some

of that has to do with the caveats that I talked about -- was overdose deaths. Although we've seen those taper off or decrease recently, during this period of time we didn't see a change. We actually saw an increase in overdose deaths.

Use of emergency department and inpatient, some of this, I think was truly related to the pandemic. People couldn't get access to community care, so where do they go? They went to emergency departments and they went to inpatient units in order to be able to get that care.

And then, not surprisingly, the converse of that is that we didn't see an increase, we actually saw decreases, in individuals seeking preventable care, meaning primary care and other kinds of care, again, things that I think were related to the pandemic, and it will be interesting to see what that looks like moving forward.

PATRICK JONES: Thank you, John. I just want to --

JOHN O'BRIEN: Well, just -- oh, okay. Sorry. Am I out of time?

PATRICK JONES: I do just want to get to the states again. I think we'll have a lot of time to discuss

that with the Commissioners.

JOHN O'BRIEN: Yeah. Right.

PATRICK JONES: So turning back to the states, I'd like to hear a bit about what's been achieved so far through your demonstrations, and where you're hoping to see progress. Cindy, I'll let you get started.

CYNTHIA BEANE: Well, I will say John is exactly right. We felt like our numbers were trending in a good way, and then the pandemic hit and our numbers exploded again. And I'm going to read this part. I hate to read during a presentation, but I'm afraid I'll get the numbers wrong if I don't. Our numbers are significantly better, and it really shows some good progress in West Virginia. Our current data shows that there was a 41.7 percent decrease in overdose deaths from January to August of 2024, compared to that same period in 2023. With that reduction expected to remain at 35 percent as sitting cases are resolved, year-over-year figures in the 12 months in August 2024 revealed a 32.79 percent decline in drug overdose deaths in West Virginia, surpassing the natural average of 23.7 percent.

So for us to be above the national average and a

decrease, when we were really the epicenter, is a huge accomplishment for us. So with this projection it basically translates that there's 386 more West Virginians alive right now, today, that are able to continue their journey towards recovery. So that's the real impact of these waivers. People are staying alive, bottom line.

PATRICK JONES: Thank you, Cindy. Henry, what has New Hampshire achieved so far, and where are you focused on making progress in the future?

HENRY LIPMAN: As I mentioned to start with, I think we've built an ecology around the waiver, where different pieces are acting synergistically to one another. So we're seeing increase in treatment. We're seeing particularly an increase in outpatient treatment in New Hampshire. Overdoses are way down. Where we were in the top five, I think we're probably somewhere near the middle of the nation at this point. We have seen reduced ED utilization. Our neonatal abstinence births in the state, under our managed care program, are down substantially.

And I know you're managing time so I'll stop there, but I think we also, in our managed care program, worked on the issue that John mentioned earlier about the

concurrent use with benzos, and we have made a lot of progress on that, as well.

PATRICK JONES: Thank you, Henry.

And John, for a last question, can you tell us what you're seeing as the biggest gaps in our understanding of the demonstrations? What are you hoping we'll learn as more research and evaluations become available?

JOHN O'BRIEN: Sure. I would say that we still need data collection. We may not need to collect all the information that we had in the 2017 guidance, but definitely continue to collect information. Because between what Cindy said and Henry said, we're actually seeing differences than what we saw in that 2022 report.

In addition to that, I think that you've got to deal with workforce, and I don't have a silver bullet or a magic wand for workforce. But it's one of those things that I know states are paying particular attention to, to figure out what are the right incentives to increase the workforce.

And then I would also suggest that the extent to which a number of these individuals were or had spent time in jails and prisons, that there be some connection, as

Henry said, between the 1115 OUD efforts and the states' reentry efforts, because they go hand in hand.

HENRY LIPMAN: The number one reason for recidivism in our state is individuals who have SUD or mental health issues, or both.

PATRICK JONES: Thank you. And thank you all for all the thought and detail you put into your answers today.

We will now turn the panel over to Verlon for Commissioner Q&A.

CHAIR VERLON JOHNSON: All right. Thank you so much. Great panel conversation so far, and I know it's going to get even better with the Commissioners. And so good to see all of you. And John, I learned what SUD was from you, so I appreciate you being on this panel today, for sure.

With that, let me see. We'll start with Heidi, and then go to John.

COMMISSIONER HEIDI ALLEN: Thank you for this really wonderful panel. It's so exciting to see what the states are doing and to hear about your success and your learnings. And I just want to say to Cindy, it's great to see a social worker in power. And I feel like I see a

social worker represented in what you're doing there, because if you were to ask me like what I think is one of the most important investments to make in this area I would've said peer support specialists. And it's wonderful to hear that your work with that has evolved, and now you have a certification program and some structure.

And I'm curious about a couple of things. One, are your peer support specialists able to get Medicaid? Or do they make too much money for Medicaid? Because I was just thinking about how Medicaid could continue to support their recovery, as well.

And then my other question to both states, and to John if you know anything nationally, is there any connection to child welfare and how to help support people maintaining their relationships with their kids, and hopefully for people who have lost custody of their kids to be able to be reunited.

CYNTHIA BEANE: With regard to the peer support question, it just depends on the individual. If they're not working a whole lot, not making a whole lot of money, then yes, of course they could still qualify for the benefit. A lot of our peer support work full-time, and

depending on the rate of pay that they are getting, most of them work for a behavioral health agency, that would just depend.

With regard to the supports from mothers and families, we also have a drug-free mom and babies program that we operate that has been very successful. Like Henry mentioned, we have seen our neonatal abstinence births really go down from that.

At the same time, we saw the SUD epidemic exploding in West Virginia, we also had an explosion in our child welfare with regard to increased foster care, increased children being taken from the home, because of the SUD epidemic. So we also launched what we called a CSED waiver. It's a waiver for children with severe mental health needs or trauma and those kinds of things that happens in these types of homes on occasion.

And so that provides a wraparound, so we have been able to -- we opened that up so it's any child who qualifies in West Virginia. So we've had, as of today -- I just pulled this over. I had a budget hearing this morning so it's fresh in my mind -- we have 500 kids that have successfully had treatment in that program, who have stayed

with their families without hitting the child welfare system. In addition, we have thousands of kids who also have hit the system, that we can provide that wraparound support in the family. So that's how we're kind of doing that.

And then we have some specialized SUD providers that actually the mom and the baby and the family unit can all be there together, as well.

COMMISSIONER HEIDI ALLEN: Can I ask a follow-up question to that, really quickly? Is that okay?

CHAIR VERLON JOHNSON: Sure.

COMMISSIONER HEIDI ALLEN: Are you able to coordinate with the child welfare agency at all? It sounds like you have now a lot of capacity in your residential treatment and your beds. But I know it's sometimes difficult when people are given a deadline for reunification and for completing substance use treatment in order to be able to keep their children, and that sometimes without the coordination with the Medicaid agency there's not a priority system to make sure that people can get in. Have you had any trouble with that, or do you just have good enough access at this point that if you're ready for

that treatment, it's available?

CYNTHIA BEANE: I won't say it's perfect. There are always challenges when the two systems are working. But we have a structure of leadership here in West Virginia where I meet with my counterpart in the child welfare system weekly, to kind of go over. Because when we have this CSED program and the SUD waiver program, they also have programs for kids that they call it like Safe at Home and 4E programs. So what we do is we coordinate so those are not overlapping, and if a child can qualify for our programs, we make sure we're using that program in order to keep that family unit together.

I will say that we meet weekly, and we have changed that program. That particular waiver is a 1915(c) waiver. We have changed it multiple times through the course of that waiver in order to accommodate the changing needs of the community and the foster care families that receive that, as well. Because a lot of times the kid does into foster care but reunification is the ultimate goal, and to make sure that the SUD program is working over here while the CSED program is working over here, and they can work with that family in order for that reunification to

happen.

CHAIR VERLON JOHNSON: Thank you. John, and then Dennis.

COMMISSIONER JOHN MCCARTHY: Hey, Henry and Cindy, this is a question for you guys, and as a former Medicaid director we have always got to ask this question, which is, the IMD exclusion was put in place a long time ago, mostly focused on inpatient hospitals for mental health. It probably wasn't really thought about SUD treatment back in 1965 residential at this level. So right now you have to do an 1115 waiver to do this program.

If you guys had your magic wand and you could wave it and change the law, would this be one of those areas where we wouldn't need an 1115 waiver to do this, or would you say, no, we need 1115 waivers to do this?

CYNTHIA BEANE: I am waving the wand.

COMMISSIONER JOHN MCCARTHY: I am asking because as MACPAC we often make recommendations to Congress about things like this, and this could be one of them, like should we ask for an exception around this.

CYNTHIA BEANE: I am waving the wand. I would love not to have to go through -- I mean, like I said, we

have to pay a vendor, because we don't have the capacity of the budget predictions and the different things that you have to do for budget neutrality. And then the reporting. I still think we would still do reporting, but maybe not as robust. It's just a lot of administrative extra costs to do an 1115. If we could just offer the service, it would be a lot easier for a state to take off a lot of the administrative burden. So I would wave that wand.

HENRY LIPMAN: I would wave it, as well. I would like to point out something that kind of connects the two questions that have come out. When you talk about transitions, there is a lot of good work, for example, that is done in the correctional settings in New Hampshire in terms of getting people in treatment. The community re-entry waiver allows us to get things established before release, so there's a smooth transition there.

And the issue that I still see out there, which I would redirect some of the savings that Cindy was relating to in terms of administrative costs, and we're doing a little bit of this as a state, is when people, for example, went to the ACA market for exchange coverage, if you happen to have that available, that the cost-sharing that's

available there can be really problematic for people. And we do use some general fund dollars here in New Hampshire to help support individuals, to help effectuate the transition and continue treatment engagement.

But I think if there was a savings there, some of that could be put to good use in terms of helping people further their transition when they leave Medicaid, because all that good work that's happened in the prior two stages can go down the drain. So I think that's an important area to look at, particularly as potentially policy around ACA subsidies may change, as well.

COMMISSIONER JOHN MCCARTHY: And as a follow-up to that question, if you did get rid of the 1115, and Cindy you brought up you had zero beds and you went to 1,700 beds, are you concerned about an oversupply of beds, or at some point where the beds will be empty and then providers will be coming to you and asking you to increase the rates to keep empty beds? Or has that not even come into an issue at all? Henry, too, also the same question.

HENRY LIPMAN: I guess if I could, I think that responding to different market incentives is a continual evolution, and it's like let's not set it and forget it. I

think right now that wouldn't be an issue, but I think partly when you see the populace of a state, I think West Virginia, like New Hampshire, have a lot of rural characteristics, so it doesn't necessarily generate that kind of maybe excess demand that might be in more urban areas.

CYNTHIA BEANE: West Virginia, where we did explode so fast, there has been a concern at the state legislature about certain counties being overpopulated with beds. So we have state legislation that pretty much says how many beds can be in each county. So I think that, in and of itself, would be a safeguard for us. That's probably a unique thing to West Virginia, though.

And I do think that the free market would kind of take care of itself. Once you get saturation, you know, competition, and if providers can't make it, they can't make it, once you have enough providers out there.

CHAIR VERLON JOHNSON: Great. Thank you.

Dennis?

COMMISSIONER DENNIS HEAPHY: Thank you all. You don't know how wonderful it is for you to say that these folks are alive today. We so often are listening to

numbers and hearing numbers, that just to say they're alive today, and that's enough. And it's wonderful.

And my question I guess is, starting with John and then either of you folks, that is, what diversionary services, if you -- again, another magic wand -- what diversionary services would you like to see states providing that you think would have the most impact on people's lives?

JOHN O'BRIEN: That's a good question, and by diversionary, I'm assuming you're meaning diversionary --

COMMISSIONER DENNIS HEAPHY: Right.

JOHN O'BRIEN: -- from inpatient or residential or both?

COMMISSIONER DENNIS HEAPHY: Primarily inpatient, but yeah, residential.

JOHN O'BRIEN: Okay.

COMMISSIONER DENNIS HEAPHY: Whichever, yeah.

JOHN O'BRIEN: Well, certainly the ability to be able to access MOUD is incredibly important, and granted, somebody may need an inpatient visit or an inpatient admission for various reasons, for OUD or SUD, but to the extent that that's more available, I think that's going to

help.

The extent to which crisis teams can be really modified or to be able to address individuals with OUD and SUD -- mostly they've been focusing on mental health -- I think that could be helpful, too, to divert them from even emergency departments. So those are at least two efforts that I think could be helpful.

And maybe, you know, Cindy or Henry has other --

COMMISSIONER DENNIS HEAPHY: And just for you guys, do you think like crisis stabilization units or -- I don't want to put words in your mouth.

JOHN O'BRIEN: Yep, no, I mean, the range of crisis services, from mobile crisis services to, you know, anything that might even look like urgent care, which would be, you know, 23-hour beds or less to crisis stabilization units. I know that there's a state for probably two and a half decades have really used their crisis stabilization units to focus on diverting individuals that have both mental health and SUD issues and have been fairly successful at doing that.

COMMISSIONER DENNIS HEAPHY: Thank you.

And, Cindy, you're --

CYNTHIA BEANE: I will say in West Virginia; we do use crisis units.

Also, I think one of the new services that we are -- we just got a renewal that we are planning to implement in the next year with the justice-involved individuals. I think by getting in there, working with those individuals, what we see is a lot of times those individuals were released, not the best outcome. They're not connected to services. By having that connection and being in there 90 days before release, making sure that their MAT treatments are already set up, coming out, then hopefully, you know, one, you avoid the overdoses, which we were seeing with that population, but also, two, you can stay in outpatient treatment and not necessarily need that next level of care.

But I think the good thing about the waivers, it's given that there are levels of care. There's outpatient. There's -- we don't pay for recovery housing, but we partner with recovery housing with our Bureau for Behavioral Health. You have that whole continuum. So it really meets the person where they're at in their recovery.

COMMISSIONER DENNIS HEAPHY: Thank you.

HENRY LIPMAN: What we've observed in New

Hampshire is that residential has not grown, as you might otherwise expect it to be, or inpatient. Outpatient treatment seems to be the favored approach, and, you know, supplementing that with mobile crisis, with certified community behavioral health centers, with crisis stabilization centers, I think are all things that move us along that direction.

I think the area where the withdrawal management on a non-institutional basis, I guess, would be, you know, something I think that would be helpful, too.

I think a lot of people who are able to work prefer to be able to maintain a continuity in their life as opposed to sort of going away as they did in the old days.

COMMISSIONER DENNIS HEAPHY: That's really helpful. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you so much.

Jami and then Mike.

COMMISSIONER JAMI SNYDER: Thanks so much, John, Cindy, and Henry, for joining us today. It's great to have you with us.

I know you've talked a little bit about this

already, but we have been doing some research and analysis around access to MOUD treatment, and a couple of the barriers that we've talked a lot about are around workforce and reimbursement. And I'd just be curious to hear from you, Henry and Cindy, what you've done to kind of address those barriers, because I'm sure they're present in both of your states.

HENRY LIPMAN: Cindy, would you like to go first?

CYNTHIA BEANE: Sure.

Well, first, we've definitely -- and this is really pandemic related. We opened up telehealth completely. That has helped some. We also -- to the extent that we're allowed with the DEA, we allow extenders, physicians, assistants, nurse practitioners, as much as possible.

I do think that the other thing that we did, we've done a campaign to really encourage this, your family physician, and there are different laws in West Virginia about like when you're considered a MAT treatment center versus this, a doctor, and so that each doctor in West Virginia has so many patients they can see without kind of jumping through those extra hoops. And so that's helped us

some.

We have seen doctors that prescribe Suboxone and Vivitrol in a family practice setting increase during that campaign. But to say that we have full access, especially when it comes to methadone in West Virginia, is probably not a good statement. Methadone in West Virginia, when methadone clinics kind of first popped up, there were some -- and this was years ago, before the epidemic got really bad. There was a moratorium set in our West Virginia legislature. So we have nine methadone clinics around the state, and we have not been able to kind of bust that open.

Every year, we do some education and try, but with regard to that particular form of MAT, we are limited. And we continue to try to -- there's still a stigma around MAT in certain areas of the state with certain populations, and so that's something that we continue to try to work on.

HENRY LIPMAN: So earlier, I mentioned that we try to take a look at how New Hampshire standards compared to some of the latest research by SAMHSA and, for example, one, counseling in terms of the degree to which counseling has to occur upon each visit, depending on where someone's at. We've sort of relaxed that standard to be more like

the national standard. There is workforce shortage there.

In the prior last two legislative sessions, we had record increases in Medicaid funding. I still hear from the MOUD providers that there's more needed there. We're not in an environment where that's likely to happen in this particular session coming up, but I do think that there's a piece of that funding that still probably has to come into play to open it up further.

CHAIR VERLON JOHNSON: All right. Thank you so much.

Mike?

COMMISSIONER MICHAEL NARDONE: Hi, John, Cindy, and Henry. Great to see you.

Cindy, great. Sounds like you're having some really positive results, and as we talk about the value of Medicaid to provide services to vulnerable populations, it's so great to have that kind of validated in such a vivid way.

I assume that both of you -- I guess what I'm trying to maybe -- wanted to get a sense of is maybe what you see as the future directions that you want to go with your SUD waivers.

I think, Henry, you talked a little bit about the withdrawal, non-institutional withdrawal, and I assume that both of you had to recently re-up your 1115. So I'm trying to think of what -- going forward, what are the things that you want to prioritize, given some of the positive results you've seen to date?

HENRY LIPMAN: If I could go first on this one. So we did renew our waiver this past July, and we also, in 2022, sought an SMI waiver as well.

But I think the intersection of mental health and SUD that often -- and some of the most challenging cases that are out there, the connection between both a mental health issue and an SUD issue and the ability to have infrastructure to treat that, I think is kind of where the CCBHC initiative is going in terms of trying to build up some of that strength and capacity.

I know on a national level, in terms of that operating, that model is more expensive, but it's kind of like, where do you measure the savings? Do the savings happen in the Medicaid program or in the larger environment in your state? And that's, I guess, one of the things I think have to be proved out in terms of how we continue to

leverage what's happening in the SUD and SMI waivers there.

Hopefully, that's a little bit helpful perspective.

CYNTHIA BEANE: Yeah. So you're right, Michael. We just renewed. So we have some new services in our waiver that we will be rolling out. We have a supportive housing component to kind of get people, especially, you know, after going through the continued care of treatment. Stable housing is something that is very important in order for that person to stay in recovery.

We also have what we call "recovery-related support services," which is kind of like a supportive employment service, to help that individual to seek employment, maintain employment, and also the justice reentry services.

We are also going to update our current residential treatments to align with the new fourth edition of ASAM, and like I was saying before, we've expanded our peer support services as well -- those can be delivered -- and how those individuals get certified.

And then the last thing that we've added is something that has historically been grant-funded in West

Virginia. We call them our "quick response teams." These are teams that go out after somebody has had an interaction with either law enforcement or EMT around an overdose and naloxone has been utilized.

We go right back out, visit that person, try to get them at that point into treatment services, whether it be outpatient or inpatient, and we go with a team of individuals.

It's a community force team with a social worker, somebody from EMT services or somebody from law enforcement services, but they don't go out like in a police thing. They go out this kind of plainclothes as a team coming in to talk to that person right after that type of an incident to try to discuss treatment options and to get them into treatment.

So we're hoping those additions will just enhance the services we're currently providing and be able to strengthen that continuum of care.

COMMISSIONER MICHAEL NARDONE: Can I ask as a follow-up? One of the things that as I'm thinking about as you're talking about the interaction of these different waivers, the 1115s, you have the prison-involved

population, you have the SMI, you have the SUD. How do you protect against the possible silo-ization of those various waivers versus coordinating across the different systems to move forward on these? I mean, I would think that that would be a challenge.

CYNTHIA BEANE: We rely heavily on our managed care entities. All of our waivers, unless it's our IDD waiver, agent-disabled waiver, are in a fee-for-service environment. But the serious emotional disorder waiver, our 1115 SUD waiver, all of it and all these services and behavioral health -- we don't have carve-outs. The only carve-out we have in West Virginia for managed care, of course, is long-term care is still carved out and then pharmacy.

But pharmacy, there is a daily feed that our MCOs are privy to so they can look at any time in the system and see what pharmaceuticals that their clients are on. So we really rely heavily on them to kind of manage this.

And then, too, I think a new addition that Henry spoke so well about during this conversation that we just started -- so I'm hopeful, but I can't say for sure how it's going to work out -- is we just started CCBHCs as

well. We started in October. We have six CCBHCs up and running.

And one of the things we did to help provide our capacity -- because at the same time, we all know there's a workforce shortage to basically work on all these waivers. We said if you're going to be a CCBHC, you also have to provide the CSEP waiver services. So you have that children's services and the substance abuse part of CCBHC was already built in as well.

So that's kind of how we're -- can I say that it's a perfect system? No. But it is -- I do think by putting the onus on the managed care companies, having them report out how some of this stuff is working is helpful for the state.

HENRY LIPMAN: In New Hampshire, we have an advantage of being an umbrella health and human services organization, and the mental health and substance use director equivalent to me is 14 feet across the hall here from my chair. So in terms of coordination, that's really good.

But also, just another plug for social workers in our community reentry, our Commissioner of Corrections is a

social worker who also spent time in managed care, so in terms of understanding what we're trying to do and the cross-connections.

In addition, I think just -- I've been working on running what I call "Medicaid academies" here in New Hampshire within the division of -- not just within my division, but within the whole Department of Health and Human Services, trying to bring in child welfare, public health, mental health, and just making sure they're aware of what are the success factors in operating these waivers. As I try to communicate that, the success of a waiver often is not about what Medicaid does. We're sort of the referee and scorekeepers of the program and finances, but the people who actually play the game, if you will, of the operational successes -- our CEO of our state hospital is also under the same umbrella and just trying to make sure that people are aware of the factors that drive both operational, clinical, and financial success -- and training and retraining there, because states have turnover in their agencies. We're not forever people.

COMMISSIONER SONJA BJORK: Thank you.

CHAIR VERLON JOHNSON: Thank you. That was

great.

Doug?

COMMISSIONER DOUG BROWN: Thank you.

This question dovetails into Jami's question, and it's for Henry and Cindy.

Typically, the team here at MACPAC is working on prior authorization, and the question that I want to pose to both of you is what's your -- do you have PA or UM criteria around MOUD in your state? If you do, what does that look like?

CYNTHIA BEANE: I'm going to say we used to. When it first started, our thought was, well, if you're going to be in MOUD treatment and MAT treatment, you have to have counseling. We want to make sure you have that counseling component, and so we have pretty strict criteria about how many counseling sessions you had to have and all these kinds of things.

But as we have learned and as it has evolved, we do not require that any longer, and so there is no kind of utilization management other than that we do have -- and I probably can't quote them, but we do have some milligrams on the pharmacy side on, like, how high the milligrams can

get on Suboxone. I can't remember what they are off the top of my head.

And the reason we did that, when we first started the program, we were finding individuals going out of state into different kind of doctor shopping and getting really high doses, and so we did put -- our pharmacy team did do some safeguards around that piece.

HENRY LIPMAN: That's a really good question in terms of -- I think in terms of New Hampshire; the prior authorization criteria are not a barrier to getting into treatment.

I think we're very much promoting getting into treatment. I think in terms of, okay, now that you're in treatment, what are our expectations with respect to following the criteria and the quality of documentation? Those are things we're having our MCOs work extensively, and we've provided incentive programs for our MCOs to work with the MOUD providers in particular in terms of, you know, some of our -- or most of our network in New Hampshire here is national players, and so understanding how to practice in New Hampshire is, I think, one of the things that we continue to have to work on.

But I think our whole concept of the doorways is that it's really to facilitate getting the access. I think the access is important, and then following up with the criteria in terms of treatment is where we focus.

COMMISSIONER MICHAEL NARDONE: Thank you both.

CHAIR VERLON JOHNSON: Thank you.

Sonja?

COMMISSIONER SONJA BJORK: Thanks. What a great panel.

Cindy, you mentioned moving a little bit away from ASAM into more individually tailored-type plans. Isn't that part of prior authorization, or is it just called assessment for treatment, or how do those things work together? Or can people just right away say, "I know I need residential," and so it's a quick path right to residential? How do you work with the different types on the continuum of care?

CYNTHIA BEANE: Yeah. Well, we're still going to do ASAM. We're moving to this -- and John will probably can speak to this better, but there's an ASAM fourth edition that we're having to move to. And I don't -- I know probably enough about that to be dangerous.

But with regards to -- they can, but we do rely on our MCOs to really manage the level of care, and so like people can initially go straight into residential. But then what we want to see is that they're kind of going through those ASAM levels. We don't -- an individual technically could be in an IMD-type setting for 20, 30 days, but not necessarily at that highest level. And so what we want to see is that individual kind of, like, flows through that continuum of care from the highest ASAM level down to like the 3.1 level is what we're wanting to see.

And so one of the things that we're currently working on -- this is something that is very new. We haven't -- it's not set in stone, but we are working on basically purchasing a software system that all of our residentials would use in order to kind of, like, track the individuals and track some outcomes and making sure that they are at the right level of care at the right time. But that's something new, and that's something we haven't done yet, but that is something that's in the works.

HENRY LIPMAN: When I was talking earlier about doorways as our access point to having them distribute across state, they don't just work with Medicaid

individuals. They work with every type of individual in terms of whatever their coverage, Medicare, private insurance, or what have you. So I think in terms of what's intended at the access point is to be able to evaluate what level of treatment might be appropriate, and that there's an ability to access an access point 24/7 here in terms of we have overnight coverage and provided by our Dartmouth Medical Center, which is our academic medical center here.

So I think that's where I think if we have the beginning assessment evaluation correct --or hopefully, and then followed and supported by utilization management by our MCOs. I think that's where we're hoping to get people to the right care, right time, right place, and right level of care.

CHAIR VERLON JOHNSON: Thank you.

Heidi?

COMMISSIONER HEIDI ALLEN: Sorry.

We just had a -- our prior session was on MOUDs, and I remember that our work, I think, last month, we were looking at a table that showed kind of the distribution of what people were working with. And, Cindy, this came to mind when you were talking about the methadone and how

difficult that it's been to get methadone clinics.

Are you finding that people are able to access the long-acting injectable medications?

CYNTHIA BEANE: Yeah. We have those, and we've approved those. And we even approved Sublocade as well. So I don't feel like that's an access issue.

I think if you want methadone and you're not living in near one of these nine clinics, if that's the best form that works for you, that's probably more difficult in West Virginia.

But as far as Suboxone, Sublocade, Vivitrol, all the others, I feel like we can find a provider.

And I will say our MCO networks have been really helpful with us because we do have a list of all those providers, and if we do have somebody that kind of reaches their capacity, they're really good about finding that person, someone else that's able to give that medication.

HENRY LIPMAN: I've not seen that be a barrier in New Hampshire.

JOHN O'BRIEN: Heidi, this is John.

One of the things I would just suggest is that once you've seen one OTP, you've seen one OTP. And you've

got some OTPs that are really going gangbusters and trying to figure out how to get methadone in the hands of folks that really need it and want to use it, and then you have other OTPs that have some restrictive, if not somewhat archaic policies about how a person can access methadone in particular.

And so I know that SAMHSA is working on trying to figure out how to do better with OTPs, but that is definitely an area, both for this waiver and the reentry waiver, that is going to be critical to figure out.

CHAIR VERLON JOHNSON: Thank you so much.

Any other questions or comments from the Commissioners?

[No response.]

CHAIR VERLON JOHNSON: Okay. Well, I will say you all have given us a lot of rich information today. It's been a very good conversation, and I'm going to channel Melanie Bella because, you know, Cindy, you had that wand waving, and she always talked about that magic wand.

So what's like one maybe policy change at a federal level or something else that could really help this

population more so that you would love to see the federal government do in support of the states? And I'll leave that for all three of you to answer that question.

HENRY LIPMAN: Mine's a simple one. I think that the transitions are the most important thing. It's like those great investments made at different levels of the health care system to help people, and if you do a great job coming out of corrections, right, and then you end up on Medicaid and have a good experience there and then because of the cost sharing that exists in ACA coverage that you can't continue or it's a barrier to being successful, that's where I think integration of policy all the way up and down the coverage continuum to better manage transitions, because I think transitions are the points where there's the greatest chance of failure.

JOHN O'BRIEN: One of our goals for the 2015 guidance really was to figure out a way to be able to get better information, more data on whether or not these interventions worked; in particular, residential. And I do think that it would be helpful for, you know, some targeted focus, now that we've got the data, to say that these, you know, various modalities work or they could improve if you

did X.

And so kind of back to John's point, I do -- John McCarthy's point, I do think that there is some ability to loosen the restrictions around whether or not states need 1115s to get there, but it would be really helpful to be able to have this information to stop the noise about whether or not these interventions work or don't.

CYNTHIA BEANE: I would agree with everything everybody said. I agree with John about waving the magic wand around the IMD.

I do think as the epidemic kind of continues to evolve -- you know, we went from, you know, heroin to fentanyl. You know, who knows what's next? I mean, honestly. And so different forms of treatment are necessarily the best practice. So you have MAT as a best practice, but then contingency management, that's something we don't do here in West Virginia. That's something that, you know, I believe you need a waiver for.

But this -- the discussion on a national level, how treatment looks different for everybody and there's different forms of best practice of treatment, and it might not all be MAT. There might be contingency management.

And kind of normalizing that as a service and promoting what these services look like and the efficacy of these services, because I think they're -- again, in West Virginia, which is hit really hard, most people in West Virginia know somebody with the disease of addiction. There's still a moral failing. You're paying somebody not to do things, you know, those kinds of conversations. If at the federal level, they're really promoting addiction as a disease is helpful as well.

CHAIR VERLON JOHNSON: Thank you.

HENRY LIPMAN: Expansion funding. We're one of the 10 trigger states, I think, in terms of we see an expansion population, a higher use of these services, and I think it would be pretty devastating if how that's handled at a federal level is sudden or severe. That could be pretty destructive to, I think, the progress that we've made.

CHAIR VERLON JOHNSON: Well, thank you for all those remarks. Your insights are going to be really helpful as we continue to explore this path further. So, again, Cindy, thank you. Henry, thank you. And, John, thank you. We appreciate all of you.

HENRY LIPMAN: Thank you.

CYNTHIA BEANE: Thank you

CHAIR VERLON JOHNSON: And so now I'm going to turn it over to Melinda and back to Patrick to address some of the questions that were brought up.

PATRICK JONES: Sure. Yes, there was a question about other options besides Section 1115 waivers that are available to states, and we just want to address that the SUPPORT Act did introduce a state plan option to cover SUD treatment in IMD -- for beneficiaries residing in IMDs. That initially was time-limited. However, it was recently extended indefinitely. So that state plan option does exist.

CHAIR VERLON JOHNSON: All right. Thank you.

So any other follow-up questions or thoughts from the Commissioners based on what we heard from the panel?

Yes, Heidi.

COMMISSIONER HEIDI ALLEN: I'd still like to get a little bit more into -- I don't know if you remember the table I'm talking, I referenced, but the issue people were having in accessing the injectable long-acting MATs, because what I seem to remember is, like, it was a lot of

states that were in that.

And I remember not everybody was in the sample, and so it was a restricted sample. But I seem to remember that, like, that seemed to be an area that was really difficult. And when you hear that transitions seem to be really hard, then the benefits of giving people -- and also you hear about difficulty and all the rules and requirements of how you pick it up, and when you get it and things like that, that things that are long-acting would be very promising. But I know that they're still more expensive. So I'd like to know more about that.

CHAIR VERLON JOHNSON: And Mike?

COMMISSIONER MICHAEL NARDONE: Yeah. I just wanted to ask Patrick. The SUD state plan option, there hasn't been a lot of uptake around that. So it was like three states, maybe. I'm trying to remember from the memo. So is it about -- what are some of the reasons for that? Is it that it creates a new -- there can't be a cap on the number of people who receive services? Do you have any insights into that in terms of why more haven't taken it up? Because we just, you know, in response to John's question around, like, well, if you could wave a wand, this

is what you would want to do. But, in fact, that option is available, but states aren't taking it up.

MELINDA BECKER ROACH: I can jump in and say it's not something that we've had an opportunity to really examine.

You know, as Patrick mentioned, the SUPPORT Act state plan option was initially limited to three years. So that may have sort of had a bearing on state thinking with respect to that option versus pursuing an 1115.

I think there are some differences between the state plan option and the 1115 demonstration. Notably, there's a maintenance of effort on spending on substance use disorder treatment and outpatient and community settings in the state plan option that doesn't exist under the waiver.

And I will say, too, I think in preparing for this conversation and talking to Cindy and Henry, I think we also got the sense that many states are in the midst of operating these demonstration programs that have invested a lot into those demonstrations, and so it's maybe not a top priority to think about moving their programs to the state plan.

COMMISSIONER MICHAEL NARDONE: And as I recall, there was a lot of complexity around figuring out maintenance of effort rate, trying to remember that provision.

MELINDA BECKER ROACH: Yes.

COMMISSIONER MICHAEL NARDONE: Yeah.

I thought it was interesting. You know, one of the questions I was going to ask, and I decided not to ask it, was around John's comment around waving the magic wand. And we didn't ask John to comment on whether or not he would -- he thought it was a good way to go with the 1115s.

But one of the things I was struck by was the value that the 1115, I think, process has really kind of helped states focus on with this additional flexibility around IMD, what are some of the other things that they could put in place.

Now, we may have gotten to a different place, like John said, but I thought that that was -- and that's something -- there was a value to going down the -- it feels like there was a value going down the 1115 route here.

CHAIR VERLON JOHNSON: Any other -- oh, Tricia.

COMMISSIONER TRICIA BROOKS: Just to follow up on that, not so much for Melinda and Patrick. I mean, the 1115s are supposed to be demonstration projects. At which point have we demonstrated their efficacy and we choose to make them state plan options? And we just haven't seen much of that in the 1115 world, and we keep rotating and talk about administrative inefficiency.

CHAIR VERLON JOHNSON: Thank you, Tricia.

Anyone else?

[No response.]

CHAIR VERLON JOHNSON: All right. Well, before we go to public comment, I just want to just pause and see if there are any other comments or questions from the previous sessions. I know we've been on a tight time frame. So I'll turn it over to Commissioners for that.

Sonja?

COMMISSIONER SONJA BJORK: Thank you.

Just going back to the hospital payment topic, we got a little tight on time, and I wanted to mention that some of those mechanisms can be really complicated and burdensome to administer. So there are times when states or even MCOs do have an administrative fee in order to get

it done.

There can be a ton of data exchange and analytics that go into figuring out which codes or which types of providers are benefitting from them. I know the people who work on the project are well aware of that, but I just wanted to point that out so that no one thought that that was not a thing. So thanks.

CHAIR VERLON JOHNSON: Thank you.

Anyone else? Tricia.

COMMISSIONER TRICIA BROOKS: Just one more comment. I just want to lift up Henry's comment about expansion going away and the impact, or, I mean, trigger law. We won't get into the details there, but it would be devastating.

And picking up on some of the comments of Commissioners earlier, the impact of parents having access to care on child welfare just can never be understated. So these are really important points to drive home as federal policy is being upheaved.

CHAIR VERLON JOHNSON: Thank you, Tricia.

Anyone else?

[No response.]

CHAIR VERLON JOHNSON: All right. Well, Melinda and Patrick, thank you. And, Patrick, congratulations on your first time up.

PATRICK JONES: Thank you.

CHAIR VERLON JOHNSON: You did a great job. We appreciate you.

All right. We're going to go ahead and go to public comment now. Again, we invite you to raise your hand if you'd like to offer comments. We do require that you identify yourself, of course, and the organization you represent, and we do ask that you keep your comments to three minutes or less.

PUBLIC COMMENT

* [No response.]

CHAIR VERLON JOHNSON: All right. It looks like we don't have any comments currently, but that's okay. If you think of a comment later, we do ask that you go to the MACPAC website and submit that.

But before we do adjourn for today, I did want to thank everyone for coming out and listening to the conversation and providing comments, either currently or I'm sure the ones you'll submit later.

Tomorrow we're going to focus on automation and prior authorization process and health care access for children in foster care. We'll start at 9:30 a.m. Eastern time, and again, I want to thank you all for coming out today. Have a great night.

* [Whereupon, at 4:07 p.m., the meeting was recessed, to reconvene at 9:30 a.m., on Friday, February 28, 2025.]

PUBLIC SESSION

Association of American Medical Colleges
655 K Street NW, Suite 100
Washington, DC, 20001

Friday, February 28, 2025
9:30 a.m.

COMMISSIONERS PRESENT:

VERLON JOHNSON, MPA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
DOUG BROWN, RPH, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
MICHAEL NARDONE, MPA
JAMI SNYDER, MA

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:30 a.m.]

CHAIR VERLON JOHNSON: Good morning, and happy Friday, everyone. Welcome back to day two of our MACPAC February meeting.

We have three sessions for you today. I'm going to kick it off with our first session on automation and the prior authorization process, and then Bob, our Vice Chair, will lead us through a discussion on health care access for children in foster care, and then he will end our day with a session that continues our discussion on residential services for children and youth.

I have to say, I am really excited about this first session because it hits upon a topic that impacts everyone in Medicaid, and that's prior authorization. We did talk about it yesterday, of course, in our MOUD discussions. We talked about it during the SUD 1115 panel, and, of course, it will be found in HCBS, hospital and specialty care services, and beyond, of course.

We all know that it's a critical process, making sure services and medications are appropriate and necessary, but we also know it can be frustrating. There

are times when we see prior authorization particularly delay care, create administrative burden, and leave both providers and beneficiaries feeling stuck in a maze, not to be confused with Angelo's lasagna and spaghetti metaphor of yesterday. But that's where automation comes in.

And there's a lot of excitement, of course, about how technology can speed things up, right, reduce paperwork, and make decisions even more consistent. But, at the same time, we need to ask those questions. Does it actually improve access to care? Does it introduce new challenges we aren't thinking about, and how do we know it's being transparent and fair? And that's what we're going to explore today.

And I'm smiling because we are very lucky to have both Emma and Katherine lead us to this new body of work in today's discussion, so I will turn it over to both of you.

AUTOMATION IN THE PRIOR AUTHORIZATION (PA) PROCESS

* EMMA LIEBMAN: Thanks, Verlon, for that great introduction. It's great to be here today, and as Verlon just mentioned, today Katherine and I will be presenting on our early findings regarding the role of automation in the

Medicaid prior authorization process.

Our goal for the conversation today is to hear Commissioners' reactions to the background information that we provide, including topics that may warrant particular attention as we move forward with this work.

I will begin by providing an outline of the goals and approach for this project, and then I'll pass it over to Katherine, who will walk us through the background on prior authorization in the Medicaid program and an overview of automation as it relates to health care more broadly.

We'll then move to presenting the findings from our literature scan, including common uses of automation in prior authorization, potential benefits and challenges of automation in the prior authorization context, and federal and state oversight efforts.

We'll, of course, end by opening it up to hear the Commission's thoughts and reactions in terms of next steps.

Okay. Today little is known about how automation tools are being used to facilitate the myriad decision points included in the Medicaid prior authorization process. While automation generally has the potential to

reduce administrative burden and promote appropriate care, without clarity on how automation tools are being used or managed, stakeholders have expressed concerns about risks associated with automation in the health care space.

The purpose of this project, therefore, is to better understand the role that automation plays in Medicaid prior authorization and discern whether states and the federal government have the tools to support the potential benefits of automation while mitigating potential harms.

Before getting into the project approach, it's important to clarify what automation means in the context of this work. Automation can hold a variety of meanings, but for the purposes of this project, we've defined it as the uses of technological tools, such as algorithms and artificial intelligence, or AI, that supplement or replace human action or decision-making.

Note that this definition does not include information technology tools that automate or validate information transmission. We've excluded these tools as their use is more transparent, and they don't have the same potential to supplement or replace human action or

decision-making.

Later in the presentation, Katherine will provide definitions for other relevant automation-related terms.

Moving to our study components, in order to achieve a better understanding of the role of automation in prior authorization, we designed the following approach. First, to better understand how states and managed care organizations, or MCOs, use automation in prior authorization, we conducted a literature scan and will present the findings from this scan today.

In the coming months, we will also conduct a federal policy review of the authorities that govern and oversee automation in prior authorization, profiles of seven states with varying levels of engagement with automation, and a series of stakeholder interviews with the seven states selected for state profiles, as well as federal officials, MCOs, IT vendors, and consumer representatives.

We'll plan to present findings from each of these analyses during upcoming Commission meetings.

So, with that, I'll pass it over to Katherine to provide an overview of prior authorization in Medicaid.

* KATHERINE ROGERS: Thanks, Emma.

So, as Emma mentioned, I'll take us through an overview of the prior authorization process in Medicaid. This has been the focus of analytic work in the last cycle for the Commission, and I'd encourage our online audience to revisit, if you haven't recently, our issue brief covering this meaty topic, which is available on our website.

Prior authorization is a process, often with multiple steps and parties involved, by which a payer authorizes a provider in advance of the provision of a service, device, or medication. From a federal standpoint, state Medicaid programs have the authority to impose prior auth or PA processes as a utilization management control and may determine which services require prior authorization. Those states may not impose prior authorization requirements on screening services under the Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, benefit.

States, in their oversight of Medicaid managed care organizations, may also require certain services be covered by managed care organizations without requiring a

PA; for example, barring health plans from requiring a PA for MOUD, as we discussed yesterday, emergency services, or transportation to a hospital.

State-by-state requirements for PA understandably vary between fee-for-service and managed care programs and plans.

This slide depicts a fairly simplified representation of the overall prior authorization process. Generally speaking, the process originates with a provider's determination of the medical necessity of a certain treatment.

The provider is generally responsible for contacting the payer, either a fee-for-service or managed care program, to determine whether a prior authorization is required and what documentation may be required to obtain a prior authorization. This process may also allow the provider to determine other utilization management elements, such as quantity limits, diagnosis requirements, and more.

If a PA is needed, the provider must then submit this documentation. Often because a PA is needed because of a medical necessity standard, the provider is best

positioned to supply the clinical information that is required.

PA processes may be manual, documentation may be submitted by phone or fax; or electronic, such as PA submitted through an online portal.

The request is reviewed by the payer, and there are federal regulatory standards requiring payers to ensure the process is fair and robust; for example, consultation with clinicians, tools for ensuring evidence-based clinical standards are reliably used, and more.

There are also established timeframes for a payer's issuance of PA decisions, which vary based on the urgency of the treatment.

When a PA is denied, thus denying coverage of the treatment if authorization is required, it may be denied for administrative reasons or because the service is determined to be not medically necessary. Administrative reasons may include missing documentation, the treatment is not covered, or the request exceeds coverage limits.

By regulation, payers must have a process by which they notify providers and beneficiaries of the denial, and in statute and regulation, beneficiaries have a

right to appeal denials, and payers must have a process by which a denial can be appealed, which includes state fair hearings for both fee-for-service and managed care enrolled beneficiaries.

State oversight of Medicaid managed care organizations provides a number of standards by which prior auth processes are bound. For the establishment of internal utilization, management, and appeals processes and policies, states provide oversight through plan readiness activities, contractual requirements, and the external quality review process.

The Managed Care Program Annual Report, or MCPAR, reporting additionally includes denials and appeals information that must be collected by states for all managed care plans and reported to CMS.

A new rule finalized in 2024 also imposes additional requirements on fee-for-service that are new, as well as amending some managed care requirements related to prior authorization. That rule, the 2024 Interoperability and Prior Authorization final rule, was finalized last year, obviously, and it applies pretty broadly to a variety of entities, including Medicare Advantage organizations,

state Medicaid and CHIP fee-for-service programs, Medicaid managed care plans, CHIP managed care entities, qualified health plan issuers on the exchanges as well.

Collectively in the rule, these are referred to as "impacted payers," and impacted payers are required to implement and maintain certain interoperability frameworks and application programming interfaces, or APIs, to improve the electronic exchange of health care data and streamline prior authorization processes. The rule is designed to promote efficient data exchange, improve patient provider and payer access to interoperable data, and reduce the burden of prior authorization processes.

While the electronic exchange of information and interfaces are a big part of the rule, it also imposes stricter standards on PA processes, shortening the time frame for non-urgent requests, requiring documented reasons for denied prior authorization and imposing reporting requirements, and imposing these to all impacted payers as identified in the rule.

While these rules are designed to improve the automation of data flows, as it were, our focus, as Emma mentioned, on automated health care processes isn't really

targeted to information exchange but on automation of processes that replace human decision-making. This rule was generally silent on artificial intelligence or other forms of automation that we're talking about here.

Now we'll turn to some context for the work that we've undertaken here. First, we'd like to step back and define a couple of things. Again, tagging on to what Emma mentioned earlier, while we reiterate that while technology is used in limitless ways in health care, this project's focus is on those uses that replace or supplant human action or decision-making. And that's the focus of the definitions listed here.

So "algorithm" is a term often used in discussions of automation and artificial intelligence. When we use this term, we are talking about a set of programmed rules that achieve a certain function or purpose. In some cases, this may be a simple set of rules set up for data validation, for example, do not process a claim if it's missing beneficiary or provider information; or a decision tree that is followed by a human user, for example, utilization management approval flows.

In more advanced machine learning models,

algorithms may be more complex and refined using artificial intelligence or we'll continue to use the acronym AI. To draw an important distinction, not all algorithms are AI, but AI relies on algorithms to do its work, and put another way, an AI model can serve as essentially a trained version of an algorithm that can adapt to new situations and improve over time based on new data inputs.

So AI is defined in federal statute, which is the definition we've paraphrased here. This refers to machine-based systems that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments. The algorithm is akin to the process or a recipe or rules, and AI leverages that process but can also adaptively amend its algorithms and create new ones to make predictions based on machine learning or artificial learning; that is, learning not coded by a human being.

Within the AI space, we'd also like to draw your attention to the distinction between predictive and generative AI. Generative AI is just how it sounds. These are models that draw from large swaths of existing data to create complex original content, such as long-form text,

high-quality images, realistic videos or audio. Whereas predictive AI draws from targeted historical data to find patterns and forecast future outcomes about the most likely upcoming event, result, or a trend.

AI models are increasingly leaning on large language models, or LLMs, that use exceptionally large volumes of data, including free text, to model and understand natural language processing. While this may have an obvious connection for generative AI, those models are better at generating text if they understand text well. It can for predictive AI as well, because those models are better and faster at processing free text instead of just numerical or binary data.

Finally, AI models may offer benefit in digesting, using, and learning from unstructured data. By definition, unstructured data just means data without a set format or structure, but it may include large natural language data sources, books, websites, or clinical notes, for example, but also data that are simply structured differently or different kinds of data in the same source, so, for example, a clinical record that contains numeric data, photos, visit notes, and more.

AI is an emerging policy area and clearly evolving very quickly. Both congressional and executive actions have acknowledged the need for federal policy action and oversight of AI, particularly specific to health care. These include a bipartisan task force in the House that issued recommendations about standards and risk management and Executive Orders from both the previous and current administrations.

Given the emerging nature of this policy area, our literature review and upcoming analytic work are intended to provide the Commission with some grounding in this developing space and an application specific not just to health care but specifically prior authorization, which is the focus of this body of work.

So next, Emma will walk us through some more detailed information about those applications and what we know so far.

EMMA LIEBMAN: Thanks, Katherine.

Okay. So we'll now move on to the findings from our literature review, beginning with the identified uses of automation and prior authorization.

As you can see on this table, we divided the uses

for automation tools according to the stakeholder that's using those tools. On the payer side, Medicaid agencies and MCOs may use automation to identify the level of oversight needed to for incoming prior authorization requests and then to direct them accordingly. In some cases, this could mean providing a real-time prior authorization decision. Note, though, that our findings suggest that automation generally only uses -- is generally only used -- I'm sorry -- to generate prior authorization approvals.

Payers have indicated that automated denials are typically verified before a final determination is made. Payers may also use automation to identify opportunities to reduce prior authorization requirements. This could mean pre-approving services that are nearly always approved in tandem, such as post-operative care following a surgery, or it could mean exempting prior authorization for a specific service for providers who have an exemplary prior authorization approval record for that service. Then, finally, payers can use automation to identify incorrect or fraudulent prior authorization claims.

On the provider side, Medicaid providers can use

automation to streamline the prior authorization submission, appeals, and resolution processes. Providers can use tools to pre-fill prior authorization forms, check compliance with prior authorization policies, or predict likely prior authorization decisions at the point of care.

Providers can also use automation tools to identify and retrieve necessary documents for the appeal of prior authorization decisions, such as clinical notes or test results, and they can even use AI to generate appeals letters.

On the right end of the table, you'll see that we also included a column for the potential application of AI across each automation use, which generally fall into the predictive or generative AI categories, calling back to the definitions that Katherine just walked us through. As you can see, in some cases, automation efforts may also leverage both predictive and generative AI.

We included these potential AI applications as we'll continue to monitor the impact of AI in prior authorization, but please note that AI may or may not be used in each of these cases. For example, payers may use predictive AI tools to identify services that could carry

reduced prior authorization requirements. However, payers could alternatively use a non-AI algorithm to identify patterns in the data for the same purpose.

Moving to the next slide, given the array of use cases for automation, automation has the potential to support various stakeholders, including providers, payers, and even patients.

Our review of emerging trends in automation have revealed the following potential opportunities in the prior authorization space. First, automation may help reduce some of the costly and time-consuming administrative tasks associated with completing prior authorization, such as submitting and reviewing clinical information.

Along the same vein, automation tools may also be used to speed up the prior authorization process by supporting the submission and review of relevant documentation. This can in turn reduce some of the delays in access that are associated with prior authorization.

This may also support payers to achieve compliance with regulatory requirements, such as the recent prior authorization final rule that Katherine walked us through.

Automation may also be used to standardize the services subject to prior authorization, the criteria used to make prior authorization decisions across plans, and interpretations of clinical guidance. This increased standardization has the potential to reduce bias in the current system.

And then, finally, automation may be used to identify appropriate cost-effective services or settings for patients' specific needs. For example, automation and prior authorization could be used to identify cases where drugs are prescribed without meeting clinical guidelines and redirect treatment to more effective and less costly alternatives.

Automation may also pose some potential risks or challenges depending on how it's administered and monitored. For example, the flip side of the potential to improve cost-effective and appropriate care could be an overemphasis on reducing costs aided by automation.

For example, in one state, an algorithm designed to standardize care and manage costs significantly reduced care hours for Medicaid beneficiaries without any changes to their medical conditions. In some cases, automation has

also been associated with increased rates of prior authorization denials.

Lack of clinical oversight over automated decisions may also pose a risk. As I mentioned before, payers report that automation-generated denials are always validated by clinicians, but there's lack of clarity around the level of clinical review, with one lawsuit alleging clinical review periods of under two seconds per request. There's also limited transparency or evaluation of automation tools as data inputs and decision outputs are not always public. This may raise concerns about potential for bias.

Privacy and cybersecurity risks are also a concern with any tool that collects and shares health care data. While the Health Insurance Portability and Accountability Act, or HIPAA, establishes standards for protecting private health information, the extent to which HIPAA covers all aspects of automation in prior authorization, especially given ongoing developments in the field, is still relatively unknown.

Finally, there's significant variation in states' ability to procure and implement automation tools, with

some states lagging behind those with more advanced IT infrastructure.

Moving to the existing oversight levers, our early findings suggest that there's little existing federal guidance or requirements around automation in the Medicaid prior authorization process.

CMS has issued some guidance related to automation and Medicare Advantage. A CMS FAQ document that accompanied a recent MA final rule clarified the appropriate uses of AI in MA prior authorization as well as offered some restrictions on its use. For example, the guidance indicates that AI alone cannot be used to make prior authorization denials.

While no such requirements or guidance exists for the Medicaid program, a 2023 HHS report on lack of transparency around automation in Medicaid prior authorization brought some attention to this topic and inspired a bicameral congressional request for information about the role of automation in MCO denials. However, this request was not mandatory, and there remains no formal guidance from CMS or Congress on automation in Medicaid prior authorization.

On the state front, oversight is varied with some states, such as California, Tennessee, and Washington, engaging in regulation or monitoring efforts, while other states have had less momentum to date. We'll continue to monitor and learn about current and emerging trends in state and federal oversight as this project progresses.

So moving to the next slide, the next step in this project is to return during the April meeting to moderate a panel on automation in prior authorization. Our main discussion question for today refers back to the series of potential benefits and challenges associated with automation in prior authorization. We would appreciate your thoughts or considerations, anything that you'd like to see reflected in our ongoing research.

And I'll flip to the next slide, which reviews those potential opportunities and risks. And with that I will pass it back to the Chair. Thank you.

CHAIR VERLON JOHNSON: Thank you so much, Emma and Katherine, for that. I will open the floor up then for the Commissioners' questions and thoughts.

We will start with Patti, and then go to Angelo.

COMMISSIONER PATTI KILLINGSWORTH: I really

appreciate the opportunity to talk about this. I think we have taken on a pretty broad topic when we talk about sort of automation broadly in prior authorization processes, and a pretty broad definition of automation, which I don't disagree with, but I'm just trying to imagine a world where we had no tools to support effective human decision-making.

I think one of my concerns as we sort of dig into this work is that we do not throw the baby out because we think there could be risks in giving the baby a bath. And I think it would be easy to do that, because there is so much concern around this particular topic.

I'm grateful that you pointed out the many potential benefits to beneficiaries that can really improve access to services while reducing administrative costs. And we wouldn't want to see those benefits go away. We want to do things that will streamline PA approval processes and improve access to services while reducing costs whenever we possibly can.

So I would like to see sort of our overall approach be that we are really looking for opportunities that will help us to maximize the potential benefits of technology as it evolves while really minimizing potential

risks.

As you pointed out, there are many tools that are already in use today that comply with all existing laws and regulations. So as somebody who has actually overseen medical appeals at a Medicaid agency, I just wouldn't want to see PA process that are void of tools to aid human decision-making. By the same token, I think human decision-making is a really important component.

So as we kind of continue I would like to see us maybe draw a finer line between algorithms and other kinds of technology that helps to support and inform human decision-making and help us to be more consistent and objective and efficient versus sort of more complex machine-based AI systems that can replace human decision-making altogether, when it would adversely impact beneficiaries. So things that streamline access to services, those are good. Things that make it sort of impossible for somebody to get a service, that deny them an individualized medical necessity review by an appropriately qualified medical professional, I think those are the sort of points of concern.

In terms of sort of things that would be helpful

to me, maybe a better understanding of existing laws, regulations, and guidelines that already apply and provide protections today. And then that will help us, I think, if we need to make policy recommendations, make sure that we're sort of aligning with existing standards or expert-developed guidelines in this particular area, and then really taking a risk-based approach that will help us to drive efficient resource stabilization, improving access, but making sure that we're identifying and mitigating risks in order to make sure that innovation is really happening in a responsible way that benefits beneficiaries.

CHAIR VERLON JOHNSON: Thank you, Patti. Angelo, and then Heidi.

COMMISSIONER ANGELO GIARDINO: Yeah, I just wanted to thank you for your really balanced approach. I think there can be some real benefits to automation, and I, you know, obviously love the idea of auto-adjudicating the approvals, because if you meet all the criteria you should just get the approval a couple of seconds after you submit it. I think that's great.

I do want to understand more how we hard-wire that if there's going to be a denial that whatever

regulations insist on clinical interaction, because sometimes the algorithms just don't have the robust nature to deal with the clinical nuance. So I think when it's going to be a denial and there's a clinical reason, that the provider feels that the beneficiary deserves that care, I would want to ensure that there's an expedited process for human interaction. So I think whenever there's going to be a denial there needs to be some level of human review.

So thank you for being so balanced.

CHAIR VERLON JOHNSON: Thank you, Angelo. Heidi, and then Tim.

COMMISSIONER HEIDI ALLEN: Thank you. I've very excited about this body of work because I, like my fellow Commissioners, see the potential for the benefits and the challenges, as well. And I do think it's a goal for us, similar to Medicare, to have an understanding and recommendations and policy for our constituents.

Some things that kind of stood out to me is how do we ensure that Medicaid providers have the resources and the training to utilize these tools in attaining prior authorization so that technology isn't one-sided, meaning

it takes providers hours to document and insurers seconds to deny.

I think it's notable that three-quarters of prior authorization decisions were overturned when this was looked at. And yet we know that somewhere less than 5 percent of prior authorizations are appealed, which that's a real imbalance, and makes me wonder is it that they are unfair denials or is it the materials kind of suggest that it also could be that providers don't have the tools to put together a strong case, and that there's things like formatting.

Which brings me to my next point, which I think that we really need to go into the administrative burden literature, which has really, in the last few years, become robust, because these do reflect administrative burdens, both providers and for individuals. I am concerned that there is widening technology and information gap between patients and their insurers. I think it's compelling that in the materials you note that the sophistication of the algorithms can quickly outpace human understanding, even when there is transparency. That's pretty alarming.

And just little things that I think can't be

underestimated, such as using AI to identify best price sites of care may obscure real-world logistical issues, like transportation barriers, like taking into account a mountain that stands between one site of care and the other. Things that a human would know, a human who lives in that community would know, the patient would understand, but an AI would not. Those are the kinds of things that I think we should really be thinking about when we're trying to wrap our minds around this.

CHAIR VERLON JOHNSON: Thank you, Heidi. Tim, and then Tricia.

COMMISSIONER TIMOTHY HILL: Thanks for the presentation. This is terrific work, and I'm glad the Commission is kind of moving in this direction.

An observation, kind of as I struggle through thinking about it. Automation, to me, kind of understates what we're really talking about here. Automation has been part and parcel of big human processes forever, so I think if we are talking about something more sophisticated here than automation, simply automation in an IT system.

And I also think while we are talking specifically here about prior authorization, which I think

is an incredibly important thing for us to be talking about the implications, the implications here are must broader. So when we think about AI it's not just prior authorization. As Heidi has articulated, right, the most cost-effective side of care, clinical decision-making. AI is -- I don't need to tell anybody here -- is just going to have implications far beyond what we've already thought about.

In terms of what I think would be helpful for us to dig in on and understand better is the potential for bias. We've done some initial work sort of where I am in thinking about how AI works and how the models work and how it looks at the data, and it really can be influenced by a lot of different things, including the people who are building the models. So I think it would be a good role for MACPAC to play to think about, for our populations and kind of who we serve, how bias is going to affect, might affect, how decisions are made versus the commercial population versus the Medicare population. I think it's just really important.

But thanks for the work, and I'm excited to keep it going.

CHAIR VERLON JOHNSON: Thank you, Tim. Tricia, and then Sonja.

COMMISSIONER TRICIA BROOKS: First a question and then a comment. Emma, you indicated that, at least I think you did, that automated decisions are verified. Can you explain more about that?

EMMA LIEBMAN: Yes. Our view of literature suggests that automated approvals don't necessarily need to be verified, but in the case that a denial is generated by automation, that denial is, as far as we can tell, typically verified. All payers suggest that they are not ever in a scenario in which an automation tool spits out a denial and that denial is taken at face value. However, that is not necessarily a formal policy, in all cases. That's what we've learned, but we don't know the full sense.

COMMISSIONER TRICIA BROOKS: Thank you. And I think about ex parte renewals. Is that AI? It's automation, right. The system is programmed to examine certain sources of data, compare it to the eligibility criteria to make a determination, right. So I think it's hard to tease out where is the dividing line, and what we

mean. Are there judgments? To me it's AI goes over to the side of there's some kind of judgment going on. It's beyond just does this income equal, below this amount kind of thing. So trying to better understand that and articulate that would be helpful.

And I think the other thing is just moving upstream. Do we need prior authorization on everything that it's being required on, or is it simply a way to contain cost for managed care companies when they are requiring it? So a lot of things that we do in Medicaid, when we talk about kids' health, we talk about moving it upstream and outside of the Medicaid world. But I think this is another area we're moving upstream to examine are we really overusing prior authorization to suppress cost.

CHAIR VERLON JOHNSON: Thank you, Tricia. Dennis, and then Mike.

COMMISSIONER DENNIS HEAPHY: I thought Sonja was first. Give me one second.

COMMISSIONER SONJA BJORK: You go ahead, Dennis. I'll go after you.

COMMISSIONER DENNIS HEAPHY: Thank you. I really appreciate the conversation, and the layout of the work you

provided was phenomenal.

I think, as a person who has gotten denials, my life is directly impacted by these AI, and everyone here is -- what insurance you have, it's really important that we focus on protections. And I looked at the EU, and there are so many protections outlined in the European Union, protect people's data, protect against our data being used to predict some predictive outcomes that are based in bias, based on protected classes of people, ensure they're not used against a certain class of people.

And so for me, at the highest level is that when there is a denial generated using AI, that it should not just go back to any provider. It should go to a specialist or subspecialist that is required. And anyone that is reviewing it should be conflict free, because that conflict piece is really important. These folks have been engaged in building the outcomes that are going to be generated, and they should not bring any bias in how they made the materials.

And the next piece is that there is a situation where we know bias is related to discrimination against the African American community. We know that there's bias

during COVID, and I don't know whether it was AI-driven or not, that led to poor outcomes for African Americans, folks with disabilities, and other populations. So we need to protect those sorts of things from happening through AI.

There's also the use of interstate data, and this has pros and cons, where a large national health plan can use data from different states to decide what the determination of need is. And yet every state Medicaid policy is different. So how can one state determine what's ineligible in Arizona really apply in New York, or vice versa. So how do you make sure that that population are protected from that.

I've got some other ones I'll share with you later, but it's really important to make sure that algorithms are used to actually address inequities and reduce bias in how providers are actually making decisions and utilization management. Utilization management actually has existing biases against certain populations, and we can actually track that and address those. I think that would be really exciting to see. So thanks.

CHAIR VERLON JOHNSON: Thank you, Dennis. Sonja.

COMMISSIONER SONJA BJORK: Thank you. I wanted

to add to the clinical oversight piece under challenges. If you can look into how to ensure the availability of peer-to-peer or clinician-to-clinician opportunities so that there's a chance for humans to talk, in addition to all the protections we have been talking about. State fair hearings can take a long time. They're super important. They can take a long time. But sometimes clinician-to-clinician discussions can get things straightened out much more quickly.

CHAIR VERLON JOHNSON: Thank you, Sonja. Mike, and then John.

COMMISSIONER MICHAEL NARDONE: Thank you. Thanks for this great work. Clearly this is really a topic that's top of mind for a lot of folks right now, given all the interest that there is in the Congress, the White House. So I appreciate you also, given the complexities of this, trying to find the right balance here between the administrative benefits that these policies or this AI can provide but also kind of the potential challenges.

And given where we're at, I really would like to maybe explore a little bit more what some of the state approaches are around this. You mentioned California.

Obviously, they are trying to figure out what the balance is. And to the extent that there are other examples out that we can look to, I think that would be interesting to me.

I would also just kind of, in terms of the issue of potential for bias, I think that is something that I also am concerned about, in terms of the use of AI. And I would like to understand more how when a bias has been determined, how does then the system adapt to that to kind of try to compensate for that.

But I think the one area, in addition to that, that when I read some of the work that you all put together, was some of the issues around privacy of health care information and kind of how the current legal framework protects information, health information. It sounds like there's some uncertainty around how privacy laws interact with IT vendors. I think having some clarity around that and understand that I think would be really important. So as we look at potential challenges, I think that's one of the areas that I would really like to understand a little bit better, and understand what type of recommendations we might want to make in that area.

CHAIR VERLON JOHNSON: Thank you, Mike. John, and then Adrienne.

COMMISSIONER JOHN MCCARTHY: I'm going to flip to the other side on this one. I think this is super exciting. I think this is an area that there are going to possibly be huge improvements in health care going forward. People have definitely raised issues that I think are legitimate and we have to be aware of.

But also, I want to make sure that you guys are focusing on those things that can really move things forward. For instance, for providers, who are also using AI, now there are tools where when you're with your patient you're not just typing into your computer the whole time, with your back to your patient. You are literally just talking to them, AI captures it all, it makes the physician's note for them, doesn't do a copy-paste. It literally is taking what's going on there, it's putting that in a form, and then also it knows what is needed for prior authorization, and doing all that work for the providers. Now, it's not perfect yet, but again, it's coming. So there are positives on that side for providers in doing those things.

Same thing, we have worked with some companies who do AI around diagnosing cancers, being able to find cancers way before a human can find them. Again, not perfect. In our research on that, those are some of the things I would like you guys to also be looking for and pointing out.

I think, obviously, we focus on the negatives that happen. I used to say this all the time. Some people are talking now about insurance companies and denials, and Tricia and I have had this conversation. When I was a Medicaid director, if I got things right 99 percent of the time for people, eligibility determinations and things like that, I thought I was doing an amazing job as Medicaid director. But advocates, if I got 1 percent wrong or 1 person wrong, they would be on my case for that one person, because it's their job of focusing on that.

So I just want to make sure we are balanced on this one from the standpoint of looking at all those possibilities, as Patti started out with, not giving the baby a bath because you're afraid. I want to go back to that, because I think this is really important here. I'm nervous about focusing on all the negatives here when there

could possibly be a lot of positives. Thanks.

CHAIR VERLON JOHNSON: Thank you, John. I appreciate that. Adrienne.

COMMISSIONER ADRIENNE MCFADDEN: Yeah. So I, too, would like to just express my gratitude that we're taking up this topic. You all may know that I spent a few years of my career in an AI company, so I'm actually an optimist about AI. In this particular context, I appreciate the ground-setting of automation across the many different opportunities and tools. I do think it's important for us to parse out AI from the other pieces because the other pieces have probably existed for far longer and have been way more established. So I would really love to see us get away from grouping them all together.

I would like to also echo sort of the concerns around bias. I think that's always important for us to keep that in the forefront. But I, having my AI experience, know that all AI tools are not created equally, and so would really be interested in how we are talking about accuracy and sort of benchmarking of the credibility of the tools that are in use. And similarly, from a

transparency standpoint, understanding how we're communicating the use of AI when we're doing decisioning or augmenting decisioning with the PA processes.

CHAIR VERLON JOHNSON: Thank you. I appreciate that. Any other thoughts or questions from the Commissioners?

[No response.]

CHAIR VERLON JOHNSON: So you can see no one is interested in this body of work.

Honestly, there's a lot of promise here, and you heard the excitement from the Commissioners and definitely from me, for sure, as well. And I think that John and Adrienne did a really good job of articulating the benefits of this. But there are some real-world implications that I think we do want to make sure we're getting down on, and I think everyone pretty much articulated those items, as well.

So do you think you have what you need in terms of how we think we want to move forward on this, additional questions that we had?

EMMA LIEBMAN: This has been great. Thank you, all.

CHAIR VERLON JOHNSON: All right. Thank you so much for this and thank you for helping us kick off this meeting in a great way. Appreciate it.

All right. So with that I will turn it over to Vice Chair Duncan to go with the next two sessions. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman. That was an exciting session, and I think we've got another exciting session getting ready to start.

This is our first dive into health care access for children in foster care. This is a topic that has been raised among a couple of our Commissioners over the years, and I'm excited to put our toe in the water and see what we learn.

So we've got Allison and Joanne joining us, and I'll turn it over to you, ladies.

HEALTH CARE ACCESS FOR CHILDREN IN FOSTER CARE

* ALLISON M. REYNOLDS: Good morning, Commissioners. We're here to introduce a new body of work: health care access for children in foster care. MACPAC first examined the intersection of Medicaid and child welfare systems in our report to Congress in 2015.

This presentation will begin with an overview of children in foster care, their demographics and unique health care needs. We'll then review the federal statutory and regulatory framework for both the child welfare system as well as relevant federal Medicaid rules. Next, we will present a summary of the law and research on four select policy topics: coordination between Medicaid and child welfare agencies, information systems and data exchange, EPSDT, and the utilization of psychotropics by children in foster care. We will conclude with next steps and commissioner feedback and discussion.

Taking a look at the foster care population, the number of children entering foster care has continuously declined during the last five years. According to the most recent national data, more than 368,000 children were in foster care on September 30th, 2022. While the number of children removed from their homes has decreased, those placed in foster care are spending more time in out-of-home care.

In 2022, the average time children in foster care spent in out-of-home placement was twenty-two and a half months. Additionally, more than one-third of children in

foster care experience more than two placements.

Researchers agree that poverty, child maltreatment, and racial bias conflate in the child welfare system, resulting in higher rates of referrals to child welfare, rates of investigation, and risk of confirmed mistreatment for families of color. Children of color are also more likely than white children to be placed into foster care once a child protective services investigation concludes.

Taking a look at their unique needs, children in foster care have substantial health care needs, including chronic and acute physical, behavioral, oral, and developmental conditions. These health care conditions are complicated by abuse, neglect, trauma, placement disruptions, and difficulty sharing information across child-serving systems.

Children in foster care are more likely to be in poor physical health compared to children in the general population with higher incidences of chronic health conditions, developmental disabilities, and the resulting activity limitations.

Children who experience foster care are also at

an increased risk of long-term medical issues such as cancer, heart disease, stroke, and diabetes based on adverse childhood experiences studies known as ACEs studies.

Children designated medically complex are uniquely vulnerable, as they may enter foster care due to their families' inability to care for their health care conditions.

Children in foster care are also more likely to be diagnosed with behavioral health conditions compared to children in the general population. Research shows they're diagnosed at three to four times the rate of other children of similar socioeconomic status.

The diagnoses children in foster care receive are impacted by their age, their history with the child welfare system, the length of time they spend in care, and the stability of their foster care experience.

Finally, children in foster care are also at risk of dental health problems due to inconsistent oral health care.

Let's next take a look at the federal statutory and regulatory framework of the U.S. child welfare system

responsible for children in foster care.

The Administration for Children and Families, a sister agency to CMS within the U.S. Department of Health and Human Services, administers the nation's child welfare program in partnership with a single agency within each state.

Titles IV-B and IV-E of the Social Security Act provide federal funding to state child welfare agencies to operate programs through capped grants and matching federal financial participation. These programs include the prevention of child abuse and neglect, child protective services investigations, foster care placement, and permanency, including returning children to families as well as subsidized adoption.

State child welfare agencies are the legal custodians of children in foster care and responsible to ensure their health care needs are met. However, federal funding for state foster care programs, specifically maintenance payments paid to caregivers, does not include the cost of medical care and health insurance for children in out-of-home care.

Federal rules require state child welfare

agencies coordinate with Medicaid by submitting enrollment applications, sharing health information, and depending on the child's individual circumstances, giving consent for health care treatment.

Each state child welfare agency must develop and submit child and family services plans, known as CFSPs, to the Administration for Children and Families for review and approval to receive federal funding. The CFSP is a five-year strategic plan that sets forth the agency's vision and goals to be accomplished to strengthen the state's overall child welfare system and the specific operating requirements to achieve those goals.

State child welfare agencies must develop CFSPs in consultation with other federal or federally assisted programs operating in their state. Three of the 15 required CFSP elements are relevant to this study of children in foster care and their access to Medicaid benefits, coordination of services, health care oversight and coordination plans, and case plans and case reviews.

Two of the CFSP elements relevant to Medicaid -- coordination of services with other federal programs and health care oversight and coordination plans -- require

state child welfare agencies to detail system-level compliance. The case plan and case review elements require the agency to comply at an individual child level, maintaining data for each child, keeping that data current, and sharing that data as necessary and permitted.

State child welfare agencies are required to outline how services they offer will be integrated and coordinated with services offered by other federal programs that serve children and families; for example, social, health, education, and economic support services. This integration aims to achieve comprehensive support for children and families by avoiding duplication and maximizing resource efficiency within a state.

Each state's CFSP must also include a health care oversight and coordination plan developed by the state child welfare agency in collaboration with the state Medicaid agency and in consultation with pediatricians and health care and child welfare experts. The plan must detail how the child welfare agency is going to work with the Medicaid agency and others to develop appropriate screening schedules, provide continuity of care, share health information, and prevent inappropriate behavioral

health diagnoses that prevent children from being placed in the community.

Finally, CFSPs must also detail how the child welfare agency is going to maintain current and accurate individual child care plans and how they're going to share that information with each child's foster parent or placement while in care and provide those case plans to young adults as they age out of care.

Next, let's review key components of Medicaid federal authority designed to address the unique health care needs of children in foster care.

Like child welfare, Medicaid is also a jointly administered program between the federal government and a single state agency. Similar to the Children's Bureau within ACF, the Center for Medicare and Medicaid Services within CMS is responsible for policy development; implementation of Medicaid law, regulations, and policies; and oversight of state Medicaid agencies with funding provided through Title XIX of the Social Security Act.

State Medicaid agencies have considerable flexibility to design programs that meet the unique needs of their vulnerable populations, including children in

foster care through waiver authorities. However, unlike Title IV, which governs child welfare programs, Title XIX and Medicaid regulations do not require state Medicaid agencies to consult with state child welfare agencies when designing their Medicaid program.

In regards to eligibility, virtually all children in foster care are eligible for Medicaid through one or more pathways. These pathways include categorical eligibility for children for whom foster care maintenance payments are made as well as children receiving supplemental security income benefits. Other pathways include eligibility based on certain health conditions, child-only income when living away from family, and expanded family income limits.

The recently passed continuous 12-month eligibility law also supports continuity of care for children in foster care as they move in and out of the system, and federal legislation provides continued Medicaid eligibility for former foster care children up to age 26.

In addition to federally required health care benefits, state Medicaid agencies are increasingly offering specialized benefits and customized delivery systems to

meet the unique and complex needs of children in foster care. These efforts include states seeking permission from CMS to waive the statutory prohibition on mandatory enrollment of individuals in the child welfare system in managed care.

A recent study of 50 states and Washington, D.C., found that enrollment of children in foster care into managed care organizations had increased to 42 states and D.C. Also, the study revealed 14 states and D.C. procured specialized MCOs for children in foster care as well as subsidized adoption. The same study found that 75 percent of Medicaid programs, including fee-for-service and managed care delivery models, offered enhanced services for children in foster care. These enhanced services include case management, specialized screenings, psychotropic medication monitoring, and non-medical services and supports.

Our work focused on several key areas that can affect access to health care services that meet the unique and complex needs of children in foster care. These selected policy topics were first explored by MACPAC in our 2015 report. We explored coordination between state

Medicaid and child welfare agencies, which is complicated by distinct federal policy and financing frameworks.

We also examined federal requirements regarding information systems both agencies must maintain as well as the increasingly detailed requirements for interagency data exchange. We assessed the confluence of Medicaid EPSDT requirements with screening and case management mandates placed on state child welfare agencies, and lastly, we conducted a review of the current federal requirements related to psychotropic medication monitoring for children in foster care as well as a literature review of their utilization.

Federal Medicaid rules do not specify the purpose, type, and frequency of coordination required by state Medicaid programs with state child welfare agencies -- -coordination that researchers indicate is necessary to meet the complex needs of children in foster care. Instead, federal requirements for cross-agency coordination rest primarily in child welfare statute and rules.

Coordination between state Medicaid and child welfare agencies is also fragmented at the individual child level. While child welfare agencies have legal

responsibility for children in foster care and maintain records including children's health histories, Medicaid agencies and increasingly managed care organizations are the entities who actually provide health care coverage and access to providers.

State Medicaid and child welfare agencies each maintain disparate health care data collection and information systems and federal expectations around interagency data sharing are not codified in statute. Consequently, the challenges related to timely, accurate, and effective data sharing between agencies to ensure children in foster care receive coordinated health care services that MACPAC first identified in the 2015 report to Congress appear to remain.

One challenge is that key health histories about children in foster care exist in child welfare systems known as "CCWIS," while current medical information exists in Medicaid information systems, including claims, encounters, and prior authorizations.

Also, Medicaid rules allow but do not require data sharing with other agencies, and state Medicaid personnel interpret permissive rules differently.

Third, the increased use of MCOs to deliver Medicaid benefits to children in foster care requires data exchange across three IT systems: the child welfare agency, the Medicaid agency, and the MCO. In recognition of these challenges, ACF and CMS do provide states with technical assistance and sub-regulatory guidance including a data-sharing toolkit.

Children in foster care up to age 21 are entitled to EPSDT services. Having a history of abuse and neglect combined with the disruption of their relationship with their home community health care providers caused by their placement in foster care makes this population uniquely vulnerable to developmental delays and health care conditions that EPSDT services are designed to detect and treat.

Research including by the American Academy of Pediatrics indicates commonly used periodicity schedules and federally required minimum EPSDT benefits for all Medicaid enrolled children under 21 may be insufficient for children in foster care.

Like other children covered by EPSDT benefits enrolled in managed care, MCOs are not permitted to limit

EPSDT screenings under federal law but may use prior authorization to evaluate treatment services for medical necessity.

Federal rules do not define children with special health care needs, and states differ whether they include children in foster care in their definition. This designation triggers additional benefits, such as automatic case management and care coordination.

A review of federal policy and research literature indicates the concerns raised in MACPAC's 2015 report to Congress that children in foster care are at risk of inappropriate prescribing of psychotropic medications remain, despite increased federal oversight requirements on both Medicaid and child welfare agencies.

In addition to the safety concerns for all patients under the age of 18, specific concerns regarding children in foster care include they're more likely to be prescribed psychotropics than children not in foster care, they're more likely to be kept on psychotropics longer, and they are more often prescribed psychotropics in the absence of a behavioral health diagnosis.

Please note that a thorough analysis of the use

of psychotropic medication among children in foster care was beyond the scope of our current work. At this time, we are presenting this brief overview of the subject for your information and as an update to the Commission's 2015 work, and we welcome your feedback if this is a topic that you would like us to explore further.

At this time, we welcome Commissioner's feedback on the federal requirements for both Medicaid and child welfare programs as well as the selected policy topics presented. In April, we'll return to present findings from seven state profiles as well as more than 30 stakeholder interviews.

With that, we'll turn it over to the Chair for discussion.

VICE CHAIR ROBERT DUNCAN: Thank you, Allison and Joanne.

All right, Commissioners. Tricia?

COMMISSIONER TRICIA BROOKS: Thank you for this work. It's great, and it seems like we've talked about transitions a lot in this meeting, and I think there are transitions here as well to be thinking about and particularly former foster youth.

In the materials we received, one of the things that wasn't specified is that states are not yet fully required to provide coverage to former foster youth that were in Medicaid in a different state until 2030, because the Support Act phased in by age how states are to cover them, which makes it administratively difficult, confusing to everyone.

I'm not quite sure why Congress chose to do that, because there are so few kids involved in these movements in between states. But, to me, this is a policy area that is ripe for Commissioner recommendation to go ahead and just get that done and not wait for it to be phased in, which it won't finish until 2030.

The other point I wanted to make is that the impact of Medicaid on foster kids is broader than the coverage they receive. It's coverage for adoptive grandparents who have taken on the responsibility of their children. It's coverage for their caregivers, for their foster parents as well. And so I hope that we don't try to silo this so that we don't understand the broader impact of Medicaid and potential impacts that might not impact kids but would impact the broader community. I think it's

important to keep those in mind.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Tricia.

Angelo, then Sonja.

COMMISSIONER ANGELO GIARDINO: Thanks for taking this important work on.

A couple of things. The use of psychotropics with children in foster care has been a topic in the literature for at least a dozen years, and my recollection when I was a chief medical officer for an HMO in Texas was that when we looked at that, it was something like, on average, kids in foster care were on upwards of five psychotropics per kid. And in response to that, the state of Texas did something pretty novel. They created a whole managed care system. I think it was called "STAR Kids."

So I think there might be some demonstrations, and some of them might end up being really best practices that we could learn from because that system's been up and running for about 10 years.

I guess the only other thing I would just say is, as much as I would love to be a clumper and say that children with special health care needs have kind of a

uniform problem and you shouldn't spike out kids with cystic fibrosis from kids with sickle cell disease from kids in foster care, kids in foster care are an absolutely unique population. On a Venn diagram, there's a little overlap, but there's a lot not overlap because, essentially, their families fell apart. So they don't have a devoted and capable family advocating for them. They are a very unique population, and they need to be spiked out.

What I would ask you to do is if you could really help us in your work understand how can we pursue policy options that get those different agencies that you were talking about to work together because, obviously, at a very, very macro level, all those agencies work for the same government. But when you get down a couple levels, it's like different worlds.

These kids really need child welfare and health care to work together, and again, I'm hoping that some of those state demonstrations will provide that.

So thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo.

Sonja, then Patti.

COMMISSIONER SONJA BJORK: Can you remind me

which of the seven states you were going to do the profiles on, or do you not know yet?

ALLISON M. REYNOLDS: We've actually conducted the work with the seven states.

COMMISSIONER SONJA BJORK: Oh, okay.

ALLISON M. REYNOLDS: And I'm just deferring to the Chair to share that information.

So California, Connecticut, West Virginia, Kentucky -- sorry. I'm trying to think through. I apologize. I may have forgotten. Illinois. And I feel like I'm forgetting one, and I apologize for that.

COMMISSIONER SONJA BJORK: No, that's okay.

ALLISON M. REYNOLDS: And the reason that we picked the seven states was we wanted states fee-for-service. We wanted states that had managed care. We wanted states that had specialized managed care as well as the considerations of state size, et cetera.

New York was the other state. Sorry.

So we spoke to child welfare agency directors, as well as Medicaid directors, as well as behavioral health agencies and managed care, and then as well as beneficiary advocates on a national level.

COMMISSIONER SONJA BJORK: That sounds great.

I'm glad that you included California, because in this last several years, they've been experimenting with a few things through their CalAIM waiver, and one is that every managed care plan has to have a memorandum of understanding with the local child welfare department. And it lays out some agreements about how often you'll meet and what the topics are and when should each party get involved in different aspects.

Then they also required each managed care plan to appoint a foster care liaison within their company, and that is really helpful, because then child welfare workers and attorneys and anyone else working with the foster youth, they don't have to figure out who do I call for a complicated program. It's published who their contact is, and that person gets to be well known in those groups and is a real great resource for some really complicated issues.

We've already gotten to work together on some tough ones. For example, an 11-year-old that got dropped off in the ER, because he was having such a severe mental health crisis, the ER didn't know what to do with him.

Child welfare had to get involved. You know how hard it is to find residential or other therapeutic placements, and so there was now a structure for a team to get together and everybody contribute what they could to finding a good spot for that child. In the end, he got an apartment with his dad, separate from everybody else, because he was showing the propensity to harm other family members. And they had a lot of supportive services set up, and that was kind of a bridge for what's this family going to do going forward. And that wouldn't have happened if everybody wasn't working together.

So I think by looking at California's model, you might find some great best practices that we can all learn from. So thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Sonja.

Patti, then Dennis.

COMMISSIONER PATTI KILLINGSWORTH: I support all of the policy areas that are identified in terms of further analysis and discussion; in particular, the one around psychotropic medications.

I thought Sonja's story was interesting because it may have -- and I don't know the details of her story,

but it may have highlighted a situation where a child who would have otherwise ended up in foster care placement was allowed to remain with his family by virtue of providing appropriate support.

This may be a little bit of a rabbit trail, but I think it's an important rabbit trail when we think about kind of going upstream and trying to figure out, can Medicaid do a better job of improving access to services in ways that prevent kids from going into foster care in the first place? So could better coordination for a subset of kids, whose needs are really challenging and families are struggling to meet them -- if we were to improve access and coordination, could that keep these kids out of foster care? Maybe that's a piece of this work. Maybe it's a piece of a different body of work, but I don't want it to get lost if we can prevent by improving access.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

Dennis, then Heidi.

COMMISSIONER DENNIS HEAPHY: I'd like a little more information on bias and its impact on kids and their families, like how it's manifest and how you compare, how you can actually determine that bias has been part of the

process and determination whether kids should be taken out of their home or not. What are the signs that, yes, there's bias in this case?

I think there are two other things. One is, if there's a way to have -- require that any kid in foster care does have an MCO, that that may be the only continuity of care in this kid's life, that they've got the same MCO from the time they're one or two until their ten years old. That's those same people in that kid's life, and I think it would be really helpful to understand how that might benefit them.

And the third one is -- I just spaced out on the third one. I'll come back to you. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Heidi, then Jami.

COMMISSIONER HEIDI ALLEN: Thank you for this work. I think it's so important. I'm really excited that we're taking it on.

I think that it's important to -- and this has been mentioned by prior Commissioners, but to really, really look at these intersections with other systems. And I think that when you focus on kids in foster care and

specifically their needs, which could be the result of physical abuse or sexual abuse -- it could be behavioral health needs -- that presents one picture. But there's a lot of reasons that kids are in foster care that have to do with their parents' needs, and so it's just really important that we think of the family as a unit.

And it reminds me of the conversations we had yesterday around access to MOUD and the waivers for substance use treatment, that many kids go into foster care because their parents have addiction issues. Many kids go into foster care because their parents have untreated behavioral health issues. And just focusing on the kids and their needs is often too late, because at that point, it's already a problem. But really thinking of parents that are receiving SUD, parents who are receiving behavioral health services, that they might need extra support to prevent their kids going into foster care, which is something that Patti noted.

And thinking about what -- I think Sonja brought up a really great illustration of how you really need these systems to not be siloed in order to meet the needs of the kids, and they need to be nimble, and they need to have

data exchange and information so that they can prioritize certain parts of the system. In Sonja's example, that would be, like, housing, probably.

And then overall, just the role of income security for these families, many cases of neglect are related to insufficient resources for, like, adequate child care, insufficient resources for housing. And how do we bring in the housing systems? How do we bring in welfare to really help these families protect their kids?

So thank you for this work.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi.

Jami, then Michael.

COMMISSIONER JAMI SNYDER: Yeah, thank you for kicking off our work in this area. I think it's such an important topic, and I really want to echo the sentiments expressed by Angelo and Heidi in terms of looking at policy considerations where we're compelling state Medicaid agencies and child welfare agencies to really enhance their coordination and collaborative efforts.

I think the points that you made around data sharing and the lack of data sharing, in particular, with the health history data that's in CCWIS and then we have

the claims encounter and PA data in the Medicaid system, I think that's a particularly important topic for us to explore because we all know that data is really critical to ensuring proper care coordination. So it just would encourage us to dig deeper on that particular matter.

VICE CHAIR ROBERT DUNCAN: Thank you, Jami.

Michael, then Tricia.

COMMISSIONER MICHAEL NARDONE: Thank you.

A lot of great points by other Commissioners.

I just wanted to say that one of the areas I'm really interested in is kind of the three different approaches that it seems that states take with respect to children in foster care. One is this more specialized health plan like Texas STAR. Then there's the general managed care with foster children being in that system, and then you also mentioned, I think, fee-for-service with enhanced services.

And I think that to the extent that the interviews that you conducted can maybe kind of tease out some of the strengths of those various approaches as well as maybe some of the challenges, I think that would be something that I would be very interested in learning more

about.

ALLISON M. REYNOLDS: You'll be very happy with the April work.

VICE CHAIR ROBERT DUNCAN: Thank you, Michael.

Tricia, then Dennis.

COMMISSIONER TRICIA BROOKS: I think what I left unsaid about transitions, former foster youth in particular, certain transitions when they age out of foster care and EPSDT screenings and making sure they're in good shape to go forward, but we just have to remember that foster youth who age out never went back to their families. They don't have families to rely on. And this issue of making sure that they do have access to care, where they do have the symptoms of trauma that they experienced over their years, interferes with their ability to become productive, independent adults. And so it's really important. Even though it's a very small population comparatively, it's really important that we look at former foster youth as their own needs, separate from foster kids themselves. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Tricia.

Dennis?

COMMISSIONER DENNIS HEAPHY: I'd love to see a panel from some states, a couple of states, with really good best practices in developing care transitions, transition plans for folks that start at a very young age and carry through to adulthood. And so you're smiling.

And then the other is going back to bias, and that's bias against folks with disabilities, parents with disabilities, folks who are deaf, folks with physical disabilities, mental health diagnoses, because there is some literature out there that shows there is bias, and kids are taken away from their parents because they just don't understand how the family functions.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Joanne, Allison, I think you've heard large consent from the Commissioners that we're excited and interested in this work, and so I want to thank you for that.

I, too, am supportive of the policies that were mentioned.

I'd like to add on top of Angelo's comments about STAR Kids in Texas, I'm aware of the program Care4Kids in Wisconsin, and as we talk about the data sharing in

Wisconsin, it's a state where the child welfare is run at the county level. So it adds another nuance of both data sharing and partnership and collecting that information.

So I'd recommend -- I know you do not have time and don't recommend doing it before the April meeting, but as we think through a panel or think through the research, looking at the best practices both in STAR Kids as well as Care4Kids.

ALLISON M. REYNOLDS: Thank you so much.

VICE CHAIR ROBERT DUNCAN: No, thank you.

All right. We'll make the transition. Joanne, you get to stay. Lucky you. But this is a continuation of our conversation that we've started on appropriate access to residential services for child and youth with behavioral health needs, and the interview findings. And we've been excited to hear the results, so we look forward to the learnings. Thank you, Joanne.

APPROPRIATE ACCESS TO RESIDENTIAL SERVICES FOR CHILDREN AND YOUTH WITH BEHAVIORAL HEALTH NEEDS: INTERVIEW FINDINGS

* JOANNE JEE: Okay. As Bob said, we will be talking about the interview findings from the work on

appropriate access to residential services for children and youth in Medicaid with behavioral health needs. This is a continuation of work that Melissa brought to you over the last several months, but today you get me.

Just as a quick recap, in September, Melissa provided an overview of residential treatment for behavioral health services, including the types of facilities that provide this type of care for children in Medicaid. In October, she presented on access challenges based on reports that were publicly available coming from a small sample of states, as well as some reports that were produced by federal agencies such as DOJ.

And then last month, you all heard from a panel of experts who shared their insights on opportunities and challenges in ensuring appropriate access to behavioral health, or BH, services for Medicaid beneficiaries, in particular youth who need residential level of care.

Today we'll do just a very quick review of federal requirements, as they are pretty complicated, and I think it's fair to say a little bit confusing. We'll very quickly just go over the approach to the interviews, and then we'll go right into the key findings.

To review some of the key federal requirements related to residential treatment services for children, I want to just go over a couple of things. It's been a few months, as I noted, since you talked about these things, but I'm pretty sure that these are quite familiar to you.

First, under the Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, benefit, children under age 21 with Medicaid coverage are entitled to medically necessary Medicaid-coverable behavioral health services, even when those services are not covered in the state plan.

Secondly, the federal institution for mental disease, or IMD, exclusion does not allow for federal financial participation for services provided in institutions with more than 16 beds, if those institutions are primarily providing behavioral health services.

There are, however, a couple of exceptions. The first is referred to as the psych under 21 benefit. This benefit allows states to pay for services provided to beneficiaries under age 21 in psychiatric residential treatment facilities, also referred to as PRTF -- we'll talk a little bit more about those -- or also in

psychiatric units of general hospitals.

The second exception I'll note for you is under Section 1115 demonstration authority, which allows states to receive FFP, federal financial participation, for services provided to beneficiaries with severe mental illness and severe emotional disturbances during short-term stays in facilities that qualify as IMDs, or for services provided to children in the foster care system in qualified residential treatment programs, which are referred to as QRTPs, and we'll talk about those some more too.

When we are referring to residential treatment facilities, there really are a few, in particular, that we think about. To start with, the psychiatric residential treatment facilities, PRTFs. These are accredited, non-hospital facilities that provide the psych under 21 benefit that I just noted. Prior to admission, a child's health care team is required to certify that community resources do not meet his or her treatment needs and that treatment of the youth's condition requires an inpatient level of care. So this is referred to as a certification of need.

Youth must receive active treatment that is specified in an individualized plan of care, and the use of

seclusion and restraints in these facilities is limited and must be documented.

Qualified residential treatment programs provide trauma-informed, time-limited placement of settings for youth in the child welfare system who have behavioral health needs. They are the only congregate care setting that received Title IV-E foster care maintenance payments, and those payments can cover the cost of room and board but not for the cost of care. Medicaid covers the cost of care for those services if the QRTP is not an IMD. Or if it is an IMD, it has to meet the requirements of a PRTF to get the payment.

There are other residential treatment facilities that can include, for example, public or private congregate care settings, that do not meet the requirements of a PRTF or a QRTP. These settings can include, for example, therapeutic schools, wilderness programs or camps, or treatment academies.

While states can regulate publicly funded programs, some states do not license or regulate private or faith-based programs. When states do oversee these programs, it is a state's function to conduct that

oversight.

I want to note that there is no common or uniform federal definition of these programs. Some states do claim FFP for services that are provided in these facilities by allowing Medicaid providers to bill just for the clinical or therapeutic services.

As I mentioned, we did several interviews over the fall, with assistance from our contractor. There were 16 semi-structured interviews in five states. We interviewed state officials representing state Medicaid agencies, state behavioral health agencies, as well as child welfare agencies, and we were looking for states that had a range of experience and approaches with respect to residential care. We took into account state delivery systems, their use of demonstration authorities, and geography, among other factors.

I should also say -- this is important -- that we talked to federal officials, as well, and other national experts and beneficiary advocates, and they really brought some important points of view. So I didn't want to miss that.

Moving on to some of the interview findings,

interviews verified what we have learned and what Melissa had shared in previous meetings from the literature review, mainly that there is no one national data source for residential treatment facilities or for the characteristics of youth who use those services. We learned that this creates difficulties in understanding which beneficiaries are referred to, admitted to, denied admission to, and discharged from residential treatment facilities.

While some states do collect some data on the use of residential treatment, they vary in what is collected and the level of detail in which they collect the data. For example, one state collects data on youth receiving residential treatment services by county. Another state collects data on the number of youth in state custody who also receive residential treatment, and the number of youth receiving state residential care. However, those data are not disaggregated by demographic characteristic or even by Medicaid coverage status.

State officials told us that they do not always have the information needed to understand what type of facilities are available to serve their Medicaid beneficiary population or the treatment modalities offered

by facilities or their particular areas of expertise. You will recall that Melissa explained in prior meetings that some facilities may have an expertise in, say, eating disorders, but another facility may have expertise in some other kind of behavior.

States are reporting some information about PRTFs to CMS, and CMS does make that data publicly available. And those data are sort of tied to data that states report to CMS stemming from their annual survey efforts associated with those facilities. Actually, I take that back. I'm not sure if that's annual, so I don't want to be wrong on that. However, CMS is not able to verify, or does not verify, that information coming from states.

Interviewees noted that having guidance on improving data sharing between state agencies about facilities and youth using or in need of residential treatment services would be helpful to better understand their level of needs and improve their ability to help them with their access.

All right. Varied assessment and admission processes may lead to inappropriate use of residential care, and is a concern. In the case of PRTFs, federal

rules specify that a care team must certify a child's need and that the resources available in the community are insufficient for meeting those needs, that inpatient care is required to improve the child's condition, and that inpatient care is expected to achieve that improvement. The care team must include a physician with competency in diagnosing mental illness in youth.

Referrals to QRTPs require that a trained professional or licensed clinician who is not employed by the state or connected to a placement setting use an age-appropriate, evidence-based and validated assessment tool to determine the level of care need.

There are no analogous requirements for referrals to the other types of facilities that I mentioned.

One interviewee expressed concern that emergency departments, when they refer, may actually be over-referring children to residential treatment because they lack the psychiatric staff on hand to appropriately assess children's needs, and because they may not be fully aware of the home and community-based services that might be available in their communities.

And lastly, there are no federal requirements

that CMS or states audit the appropriateness of admissions or denials of admissions for residential treatment. State policies vary, and one state told us that they do not have policies forbidding or limiting denials of admissions, and noted that admissions may be denied even if a bed is available. Still another state told us that facilities must accept referred children and any denial of admission must be approved by the state. So you can see that there are some varying approaches.

Federal and state coverage and payment rules play a key role in access to appropriate residential treatment services. That's probably not a surprise. But Commissioners, you may recall that under federal rule, Medicaid cannot pay for room and board except for in PRTFs, but these costs can be covered in QRTPs for children in the child welfare system through Title IV-E funds. Non-PRTFs and non-QRTPs, though, would require some other source of funding to cover those costs.

States are exploring and using payment levers to address access to residential care. Specifically, one state told us that it increased payment to PRTFs and is making supplemental payments, as well.

When states are unable to find a residential placement for a child they are entering into single-case agreements. These agreements allow them to place children in facilities that are non-participating in their state, in their Medicaid program, or in out-of-state facilities. So to do this, states are paying a higher rate for these services in those facilities than they would for services provided in-state or in participating facilities.

In effect, some facilities then reserve beds for out-of-state Medicaid beneficiaries in order to achieve that higher payment rate.

And finally, factors that are broader than the Medicaid program affect access to appropriate residential care for those who need it. Again, not a surprise, but these are pretty important factors so we wanted to make sure that we noted them today. Workforce shortages persist and can limit a state's ability to operate facilities at their licensed bed capacity. One state indicated that it has many, many more licensed residential beds than it can staff. Another state official said that finding, training, and retaining staff to work with certain populations is especially difficult. These include, for

example, populations who have co-occurring conditions and staff to work overnight, awake staff who work overnight in these facilities, to ensure the safety of residents.

And lastly, we also heard that the lack of available services in the community increases the demand for residential care beds and increases the length of stay, and the effect of this is that it actually limits access to beds for new people who need to come in and need those services.

State officials told us that using coverage and payment levers to increase access to community-based services to reduce the use of residential care is something that they're very interested in pursuing and that they are working on. For example, some states are trying to provide respite care through the targeted case management benefit to avoid caregiver burnout, and hopefully to avoid a residential placement.

So moving on to next steps, Commissioners, your comments and feedback on the findings today would be helpful, as well as any issues that require clarification, or factors that you think the Commission might want to consider if you choose to pursue policy options. Also,

your conversation today will help inform future analytic work on this topic.

So with that I turn it back to you.

VICE CHAIR ROBERT DUNCAN: Thank you, Joanne. I also want to say thank you for stepping in to do this topic. As you highlighted, there was another staffer that had been doing a lot of the legwork, but you've done a fantastic job of disseminating the survey findings and results, and we appreciate that.

With that I open up questions to our Commissioners. Patti.

COMMISSIONER PATTI KILLINGSWORTH: Can you go back to Slide 10 for me, please, for just a second, because I want to talk about the intersection of home and community-based services and residential treatment.

I do agree that access to home and community-based services is critically important. I would caveat that, though, by saying not just home and community-based services but home and community-based services that either include or are coordinated with access to appropriate behavioral health supports. Just as it can be very difficult for a family of origin to provide appropriate

supports, it can be really difficult for home and community-based services providers to do the same without appropriate access to behavioral health treatment and support.

So I know this is specifically about residential treatment, but here's the problem, is that we really have to think about this as a coordinated system of care, and it's very hard to focus on building out one aspect of the system without thinking about the continuum as a whole. So if there are not appropriate supports sort of pre-crisis or in the midst of a crisis, it increases the likelihood of a child needing a more intensive level of service.

When we think about sort admission and discharge processes, when we admit a child to a residential facility we should really not even just from day one but before day one, thinking about the what happens after, because these are supposed to be time-limited placements, and there does need to be ideally a community provider already engaged with family members and others, who will support that child upon discharge, who can be actively involved on an appropriate level, even in the treatment process there, so that there's sort of continuity and planning for that child

when it's time to leave. And I think that's just missing.

I think so often, especially in these out-of-state placements, kids get, like, there's no engagement with the family or whoever is going to be supporting that child. There's no engagement with a community behavioral health provider who can assist post-discharge, and then too often either discharges are delayed or they just end up not working because they didn't have the right supports in place.

Somehow, we have to sort of place this important benefit, and all of the challenges that are associated, which I agree with, within the context of that system of really being able to provide a continuum of care that will prevent placement, when appropriate, but when it's necessary and appropriate, make sure that it's really planful and strategic in always getting that child back to a successful transition back to the right placement in their community, hopefully with their family.

JOANNE JEE: Thank you for that comment. I just want to emphasize that over the course of the interviews, Patti, the point that you were just making is one that was made by essentially all of the people that we interviewed,

the importance of the continuum. And I think in September, we presented the plan, that this is not just like one project and then we're done. We do actually intend to carry this work forward, to look at other continuum issues.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti, and thank you, Joanne. Heidi.

COMMISSIONER HEIDI ALLEN: Thank you for this work. Like Patti, obviously I agree that the continuum of care is important. But if I had to do, from my perspective, really narrow the lens, I would narrow the lens to the discharge transition. And my thinking behind that is that that also addresses the access on the other end issue. If we have people who no longer need to be in residential out and back in the community, that frees up the beds for people who need it.

And it, to me, reflects such an injustice to have children in an institutional setting when they no longer meet criteria for that setting. And what that means for their life, for their education, for their social life and social skill development, for their relationship with their community and their connection to their family, and their ability to have friends, like all of that, the implications

are so big and important that I think if we really, really focused on that issue, we might be able to have a really positive impact.

And I wonder about T-MSIS and our ability to use T-MSIS to try to identify length of stay, try to identify where facilities are, the kind of patterns of use and care. Because the other thing that has made this body of work kind of frustrating is just how little we know. And it's really hard to act on the complete lack of information.

So from my perspective, if we were to -- I know every time we have to make a decision, of like when we're going to do an analytic body of work where we, ourselves, are either contracting or doing the work, I know that's a big investment. But really trying to look at patterns of utilization, try to understand length of stay and how that relates to need, and where people are going seems like a worthy investment of our resources, from my perspective.

VICE CHAIR ROBERT DUNCAN: Thanks, Heidi. Dennis, did you have your hand? No, okay. Thank you. Any other Commissioners?

I, too, want to weigh in and say thank you for the results. As both Patti and Heidi said, I think this is

ripe for opportunity for policy improvements to create the continuum and the coordination between Medicaid and other services.

My concern is, as I look for a hospital operator standpoint, when I have a child in our hospital for six months because we cannot find placement, and that is the only safe place, we are providing safe care for that individual, but to me it's a waste of Medicaid dollars housing a child, how do you say it, institutionalizing a child that needs to be somewhere they can receive the appropriate therapies so they can be discharged back into their community and home.

So I do think, as you mentioned, Joanne, this is just one leg of many legs that we will be working on, on this. But I think it is an opportunity that will help decrease the frustration that patients and families see. I think you heard that in interviews with the states, that states see. And frankly, after our last session last month, I was frustrated just because of the disconnects and the opportunities for better improvement for our business, and more important, better outcomes for our beneficiaries.

And with that, Michael, I see that you have your

hand up.

COMMISSIONER MICHAEL NARDONE: Yeah, I'm sorry, Bob. I couldn't get my hand up fast enough. You know, this is great work, Joanne, and I appreciate you taking it on.

I still kind of go back to just like this feeling, like we should have better data on how many kids are in PRTFs, how many kids are in this other category that are receiving Medicaid services. I mean, it just feels to me like we should have that information and understand the landscape a little bit better.

I think that the one point that I think I heard from the panel that talked to us, that presented last time, was just this whole lack of intermediate type services, and also Patti was talking about HCBS services. Hopefully people can just be returned to their home with appropriate supports.

But I think also, as we go forward, kind of understanding the different ways that federal authorities can be used to support some of these strategies that maybe states are employing to provide those HCBS services.

I think one of the things we find, that we talked

about last time, was also the importance of housing in some of this, where children can't be replaced back directly in their home but maybe in a more transitional. But I think that kind of understanding maybe how states have successfully negotiated that would be of interest to me.

JOANNE JEE: Yeah, thanks. I definitely hear you on the data points, and we can take a look and see what might be out there. I do know that there are some limitations in what's available through T-MSIS, but maybe we can try and dig into that a little bit more.

VICE CHAIR ROBERT DUNCAN: Thank you, Michael. Dennis, now you have your hand up.

COMMISSIONER DENNIS HEAPHY: I just wanted to follow up on what Michael was saying about the demographics, if there's any way to get demographics, like race, gender identity, sexual orientation, disability status, that would be extremely helpful.

There's one other question. Do they keep track of how many of these kids just disappear from the rolls? So they're in foster care, they're sent out of state, and then they just never reappear in the system, until they end up in prison or something.

JOANNE JEE: I would need to go back and see what kind of data states are tracking once they send kids out of state and what they know about when they come back.

COMMISSIONER DENNIS HEAPHY: I think that would be very helpful.

JOANNE JEE: Okay.

COMMISSIONER DENNIS HEAPHY: Thanks.

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

[No response.]

VICE CHAIR ROBERT DUNCAN: If not, Joanne, again thank you for jumping in and leading us through this session. We look forward to the work that continues. And with that, Madam Chairwoman, I turn it back over to you for public comment.

CHAIR VERLON JOHNSON: Thank you. Great conversations today. Thank you, Bob, for facilitating the last two sessions. And I just want to add my further thanks to Joanne for stepping in. We really appreciate you so much.

CHAIR VERLON JOHNSON: All right. Now we're going to go ahead and go to public comments. As always,

when we open up for public comment, we ask you to raise your hand if you'd like to offer comments. Make sure you introduce yourself and the organization you represent, and also please keep your comments to three minutes or less.

And with that, let's see if we have any comments.

PUBLIC COMMENT

* [Pause.]

CHAIR VERLON JOHNSON: All right. It looks like we do not, but that is okay. If you have comments later, we want to remind you that you can also submit those comments through the MACPAC website.

With this, this concludes our public meeting. I want to thank all the Commissioners, the analysts, the staff, of course, and all the stakeholders for your participation today. A reminder that our next MACPAC meeting will be held on April 10th through 11th. Let me just make sure I did not get the dates wrong. Okay, April 10th through 11th. We are looking forward to hearing and seeing you there.

And I also want to thank you again for your participation the last two days. Commissioners, safe travels home, and everyone, have a great weekend. Thank

you so much.

* [Whereupon, at 11:20 a.m., the meeting was adjourned.]

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