PUBLIC SESSION

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9:30 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[9:30 a.m.]

CHAIR VERLON JOHNSON: All right. Good morning, everyone, and welcome to the April MACPAC public meeting. This is the last in the analytics cycle. We hope to end this cycle the same way we started it, with the commitment to objective, nonpartisan, and evidence-based analysis for the sole purpose of finding ways to strengthen the Medicaid program, we in this room and all of you on the phone are very much, very much passionate about. And that's Medicaid and CHIP.

Now, that approach remains especially important as Medicaid continues to be at the center of national policy discussions, and we know that while perspectives may differ, what remains clear is the program's foundational role in providing coverage and services to tens of millions of people across the country.

Our first two topics on the agenda today gives us the opportunity to really step back and review the core elements of the Medicaid program, who it serves, how it's financed, and the trends that will help shape its future.

And so with that, I'll hand it over to Janice,

Asher, and Chris to kick us off with a data-driven look at the people and the trends that define the Medicaid program today.

MEDICAID IN CONTEXT: PAYMENT AND FINANCING

* JANICE LLANOS-VELAZQUEZ: Thanks, Verlon, and good morning, Commissioners.

Today Asher and I will be presenting some key statistics and trends in Medicaid. First, we'll highlight who Medicaid covers and some of their characteristics. Next, Asher will review data related to Medicaid enrollment and spending, first providing the general landscape of the program and then putting it in context with other payers. Lastly, we'll wrap up by discussing selected services covered by Medicaid and its role within the larger health care landscape.

Before we begin, we would like to set the stage regarding the data used for this presentation. Our general rule was to use the most recent, complete year of publicly available data for the statistics of interest.

Most of the data in this presentation are sourced from MACStats, which is a publication updated annually that compiles a broad range of Medicaid and CHIP statistics from

multiple data sources, including census, enrollment, survey, and national- and state-level administrative data.

We also included data from other sources, such as data from Centers for Medicare and Medicaid Services, or CMS, and the Centers for Disease Control and Prevention, or CDC.

Throughout the presentation, you will notice the use of different years of data based on what was publicly available. We will note the year of data as we present for clarity. Please refer to each figure's data notes for more information regarding the data source and other relevant information.

All right. So, first, we'll discuss who Medicaid covers and their characteristics.

Federal statute and regulations mandate that states cover certain low-income populations in their Medicaid program, and they define the optional populations that states may choose to cover. These groups are known as mandatory and optional eligibility groups.

Among the mandatory eligibility groups, states are required to cover low-income related children and pregnant women, low-income families, foster care youth,

individuals who are either elderly or disabled, and certain low-income Medicare enrollees.

States may choose to offer coverage to optional eligibility groups, which include low-income children, pregnant women, and parents with incomes above the federal minimum standards, elderly and disabled individuals, also with incomes above federal minimum standards, and low-income adults without dependent children.

In fiscal year 2024, about 88.1 million individuals were enrolled in Medicaid. About 25 percent of those enrollees were in the new adult group, which covers individuals up to 138 percent of the federal poverty level.

Based on historical data, over half of Medicaid enrollees were in the individuals over 65, disability-related, or child-related eligibility groups.

Here, we have the demographic characteristics of Medicaid and CHIP enrollees in calendar year 2023. For these figures, we relied on survey data, which combined Medicaid and CHIP into a single category.

Over half of enrollees were female, or 56.2 percent. Most Medicaid and CHIP enrollees were under 65 years old with 44 percent ages zero to 18 years old and

47.6 percent between 19 and 64 years old.

The three largest racial and ethnic groups among enrollees were white non-Hispanic, with 40 percent of enrollees; Hispanic, with 31.5 percent; and Black non-Hispanic, with 18.4 percent.

And about one-third of enrollees reported income below 100 percent of the federal poverty level.

I will now pass it to Asher to discuss Medicaid enrollment and spending.

* ASHER WANG: Thank you, Janice.

For the next section, we'll look at Medicaid program enrollment and spending.

This graph shows the trends in Medicaid enrollment and spending from fiscal year 2013 to 2023. The top line shows full-year equivalent enrollment, also known as average monthly enrollment, and the bottom line shows total Medicaid spending. As you can see, spending and enrollment tend to rise and fall in tandem.

The trends reflect policy changes to Medicaid coverage, such as the continuous coverage requirement during the public health emergency, which was a driver in the growth in enrollment from 2020 to 2023.

Looking further into growth trends, this graph shows the annual growth rates in Medicaid enrollment and spending. From fiscal year 2013 to 2023, annual growth in Medicaid enrollment and spending averaged 5 and 6 percent respectively. These increases were concentrated in 2013 to 2015, when states began to expand Medicaid under the Patient Protection and Affordable Care Act, and in 2020 through 2023, due to the continuous coverage requirement under the Families First Coronavirus Response Act.

Excluding these years with sharp growth in enrollment and spending, the annual growth in enrollment averaged 2 percent, and the growth in spending averaged 4 percent.

Underneath these national trends, there's considerable state variation. As the map above shows, states vary greatly in their population's share of Medicaid enrollment, ranging from 16 percent to 48 percent of the population on Medicaid in 2023.

These enrollment rates reflect a variety of factors, such as state economic conditions and eligibility decisions, including whether to expand Medicaid under the new adult group.

In this map, states that did not expand Medicaid are indicated with hatched lines. Note that North Carolina has since expanded Medicaid in December 2023.

Medicaid has different eligibility groups that are typically defined by the populations they cover and the financial criteria that apply. Some benefits may be unique to certain eligibility categories. For example, children under 21 can receive the Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT benefit, which requires states to provide comprehensive and preventive health services for that population.

Eligibility pathways for individuals over 65 or have a disability generally have more complex eligibility criteria. Additionally, many of the enrollees in these two groups qualify for Medicaid coverage of long-term services and supports, or LTSS, once they demonstrate the need for assistance based on state thresholds for clinical and functional impairment.

As this figure shows, Medicaid spending is largely driven by enrollees in the disabled and aged eligibility groups. In fiscal year 2022, individuals eligible on the basis of disability and individuals aged 65

and older accounted for about 20 percent of Medicaid enrollees but about 51 percent of program spending. Children accounted for about 36 percent of enrollees and 15 percent of spending, and the adult groups accounted for about 44 percent of enrollees and 33 percent of spending.

Additionally, states vary in the services they cover as Medicaid services can be mandatory or optional. As mentioned in the previous slide, states must cover mandatory services such as EPSDT services for children under 21, but they could also choose to provide optional benefits like home- and community-based services, or HCBS.

The breadth of coverage, including the amount, duration, and scope of services also varies by state. This variation in state eligibility policies and benefit packages is reflected in part by the graph above.

This graph shows the state distribution of spending per full-year-equivalent enrollee by eligibility group for fiscal year 2022. Each bar represents the range of spending per enrollee across all states. Longer bars represent greater variation in spending across states.

As you can see, the disabled and aged eligibility groups have the greatest spending per enrollee. They also

have the greatest variation in spending across states compared to the other categories. Besides variation in the underlying health status of enrollees, this variation can also reflect state flexibilities in defining eligibility pathways for these populations and the breadth of services covered, particularly for LTSS.

We can see that the average spending per full-year-equivalent enrollee also varies across states, ranging from about $5,200 per enrollee to about $13,000 per enrollee in fiscal year 2022.

As shown in the previous slide, much of the spending is in the aged and disabled eligibility groups. So much of the variation in overall spending per enrollee across states also likely reflects the large variation in spending per enrollee that we see in these groups.

Other factors contributing to variation in spending per enrollee may include variation in provider payment levels and local health care markets.

We also broke down Medicaid spending and enrollment by delivery system. This graph shows that comprehensive managed care has grown over time and is now the predominant delivery system.

In fiscal year 2022, nearly three-quarters of enrollees were enrolled in comprehensive managed care, which is a roughly 50 percent increase from fiscal year 2010. The growth in managed care was concentrated in individuals over 65 and those eligible on the basis of disability.

We also see that managed care spending accounted for over 50 percent of Medicaid benefit spending in fiscal year 2022. For reference, total benefit spending amounted to approximately $773 billion in fiscal year 2022. Once again, this share is a marked increase from fiscal year 2010, particularly for individuals with disabilities and individuals over 65.

Our next key statistics will focus on Medicaid enrollment and spending compared to other payers. This graph shows Medicaid enrollment as a share of the total population as the dotted line and spending as a share of national health expenditures compared to private insurance and Medicare over time, the solid lines.

Around 30 percent of the U.S. population was enrolled in Medicaid at some point during fiscal year 2023. Despite the increase in the Medicaid enrollment as a

percentage of the U.S. population since 2020, the increase in Medicaid spending as a percent of total national health expenditures was more moderate.

Medicaid continues to account for a smaller share of national health care spending compared to Medicare and private insurance. In calendar year 2023, Medicaid accounted for about 18 percent of national health expenditures, less than Medicare at 21 percent and private insurance at 30 percent of national health expenditures.

In this graph, spending for health programs are compared with spending for other components of the federal budget for fiscal years 1965 through 2023. In general, the share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965, and Medicaid spending continues to account for a smaller share of the federal budget than Medicare.

In fiscal year 2023, the share of federal spending on Medicaid increased from the prior fiscal year. This recent growth reflects an increase in federal Medicaid spending from greater enrollment and the provisions of the Families First Coronavirus Response Act as well as a decrease in other federal spending related to the pandemic

relief.

Now I will turn it over to Janice to talk about Medicaid coverage of services.

JANICE LLANOS-VELAZQUEZ: Thanks, Asher.

In this section, we'll focus on key services covered by Medicaid and CHIP.

Medicaid and CHIP coverage has been associated with lower uninsurance rates and increased access to care and use of medical services.

In calendar year 2023, states that expanded Medicaid had an uninsurance rate of 6.5 percent, which was lower than the uninsurance rate among states that did not expand Medicaid, which was 9.9 percent. Based on data from the National Health Interview Survey, which combined Medicaid and CHIP into a single category, the data show that access to care and use of preventive care among non-institutionalized Medicaid and CHIP enrollees was comparable to privately insured individuals.

In calendar year 2023, 94 percent of non-institutionalized children and 78 percent of non-institutionalized adults that were covered by Medicaid or CHIP received a wellness visit in the past year. This was

comparable to the 95 percent of privately insured children and 78 percent of privately insured adults.

Within the health care landscape, Medicaid is the largest single payer of maternity care services and LTSS, and it plays a key role in its coverage of behavioral health services.

Medicaid covers maternity care services such as prenatal care, delivery, and postpartum care, and most of these services are considered mandatory Medicaid benefits.

Federal statute requires states to cover maternity care services through 60 days postpartum. However, states have the option to extend postpartum coverage to 12 months, and the vast majority of states have adopted and implemented this extension.

Medicaid is the largest single payer of births in the United States, financing 41.2 percent of all births in calendar year 2023. In rural areas, Medicaid paid for a larger share of births, financing 46.9 percent of births.

Data show that in calendar year 2023, women whose birth was financed by Medicaid accessed timely and consistent prenatal care. Almost two-thirds of women started prenatal care in their first trimester, and about

70 percent received at least nine prenatal care visits throughout their pregnancy.

On this map, we show the share of births covered by Medicaid by state in calendar year 2023, which ranges from 18 percent to 63.5 percent. Medicaid financed between 30 and 49 percent of births in 42 states, or those in the light blue and dark blue shading, and in four states, Medicaid financed over half of their births.

In addition to maternity care, Medicaid also plays a key role in the coverage of LTSS. Medicaid is the primary payer of LTSS, covering 47.5 percent of health expenditures related to these services.

The only two mandatory LTSS benefits in Medicaid are nursing facility stays and home health services. All other LTSS benefits are considered optional, including HCBS, such as personal care services, supported employment, non-medical transportation, and home-delivered meals, and some institutional LTSS are also considered optional benefits, such as intermediate care facilities for individuals with intellectual disabilities.

Based on MACPAC's analysis of LTSS utilization data, in calendar year 2021, over 3 million Medicaid

enrollees used HCBS and about 1.5 million used institutional LTSS.

As mentioned previously, Medicaid paid for 47.5 percent of expenditures related to LTSS in calendar year 2022, making up a larger share than Medicare, which paid for a little over 10 percent, and private insurance, which financed less than 8 percent of LTSS expenditures.

On this slide, we are highlighting the age and eligibility group distribution among Medicaid and CHIP enrollees who used HCBS and/or used institutional LTSS in calendar year 2021. Most HCBS users were adults, with 45 percent between ages 19 and 64, and a little over 30 percent were over 65 years old. However, almost a quarter of HCBS users were children between zero and 18 years old.

Taking a look at the distribution of eligibility groups among HCBS users, over 70 percent were in the aged, blind or disabled eligibility groups.

Among institutional LTSS users, over 60 percent were 65 years or older with a greater share aged 85 years or older compared to HCBS users.

And similar to HCBS users, the largest share of institutional LTSS users were in the aged, blind or

disabled eligibility groups, with the largest share among the aged group with 63.7 percent.

Lastly, we'll discuss Medicaid's role in covering behavioral health services, which encompass mental health and substance use disorder treatment.

Behavioral health services are not a specifically defined benefit category in Medicaid. Some of the services are covered under mandatory benefits, such as psychiatric inpatient services and SUD treatment, and other services could be covered under optional benefits, such as community-based services to support persons with disabilities.

However, behavioral health services are considered a mandatory benefit for children enrolled in Medicaid or Medicaid expansion CHIP through the EPSDT benefit, if those services are considered medically necessary.

Based on calendar year 2022 data, about 20 percent of Medicaid and CHIP enrollees received a behavioral health service.

The utilization data for this figure are sourced from CMS and include CHIP enrollees in the analytic

population. Looking at the behavioral health utilization data in calendar year 2022 by different demographic characteristics, we see that enrollees between 40 and 64 years old were more likely to receive a behavioral health service with almost a quarter receiving a mental health or SUD service, and that 16.5 percent of children between 12 and 18 years old receive the mental health or SUD service.

Among the different eligibility groups, enrollees in the blind or disabled group were most likely to receive a behavioral health service, with 40.9 percent of enrollees in that group receiving a behavioral health service.

And looking at utilization based on enrollee's geographic location, the data show that about a quarter of enrollees in rural areas received a behavioral health service compared to less than 20 percent of enrollees in urban areas.

And with that, we'll pass it back to the Chairperson.

CHAIR VERLON JOHNSON: All right. Well, thank you all so much for that.

Before I do turn over to the Commissioners, I do want to commend the three of you for really bringing

MACStats to life. It's obviously a booklet that we really look forward to, as well as the public, and so it was really helpful to give us that picture. I mean, when you looked at the data, I think we can all say that it really does show that Medicaid serves a very large population but also a very diverse one if we really look at the numbers. And so it's a reminder that the program supports people across a wide range of communities, geographic areas, and, of course, by stages, and for -- if you translate that, for the general person, that means that that's their neighbor, that's their family member and their friends, right? And so it's really important that we really focus on this program in a meaningful way.

So with that, I'll turn it over and open it for the Commissioners for their reflections or thoughts or other things that stood out for them.

So first up, Heidi.

COMMISSIONER HEIDI ALLEN: Hi. Thank you so much for this.

Wondering if you could go back to slide -- I think it was 6 or 8, but it was the one on the income distribution of Medicaid.

No, not that one. Nope. It was the one about FPL, that had FPL in it, like what the FPL was of people on Medicaid. Oh, maybe that was it. I'd say yes.

Could you say a little about the 200 to 399 percent FPL? I think some people would be surprised to see that population and wonder who they are.

CHRIS PARK: Sure. There are some places where states can cover, like, pregnant women who are higher income, and so that's the groups that are included there. Also, some people may qualify for long-term services and supports, and those are also individuals who may be in that 200 to 400 percent group.

But, generally speaking, a lot of it is the optional groups that states have chosen to cover.

COMMISSIONER HEIDI ALLEN: And would that also include some children with special health care needs that require a lot of care?

CHRIS PARK: Yes, that can. Yeah.

COMMISSIONER HEIDI ALLEN: The second question is on Slide 8 that showed Medicaid enrollment and spending over time. I think that one thing that is interesting to note is that we see an increase, and maybe this is not even

the right -- Slide 8, yeah. We see the increase related to the initial ACA Medicaid expansion, and then you still see this increase over time. And I just want to point out that that reflects the staggered adoption of Medicaid expansion over time, many of those that were initiated by citizen ballot initiatives, where communities mobilized to get Medicaid expanded. And so it's not a creep of other types of initiatives, but it reflects other states choosing to adopt Medicaid expansion.

And then I just always think, on Slide 10, like, noting the two things, which is that so much of Medicaid spending, like. half of Medicaid spending is for people who are elderly or disabled, and much of that is related to long-term care services and supports. And I think that the general population is not always aware that Medicare, you know, America's health insurance for elderly people and people with disabilities, doesn't actually pay for nursing home care as part of their benefit package, and that many people are required to burn through their assets, receiving the care that they need until they are so poor that they qualify for Medicaid. And if that were to go away, that would be devastating. It's not sure where -- I'm not sure

where people would go.

And then I also think it's worth noting how -- what a good value children are on the Medicaid program that we serve, that it makes up 35 percent of Medicaid's enrollment but 15 percent of its spending. So I think that that just shows really good value.

Thank you for this. That's the last of my comments.

CHAIR VERLON JOHNSON: Thank you, Heidi.

Angelo.

COMMISSIONER ANGELO GIARDINO: I just wanted to thank Commissioner Allen for reminding us what a great value children are, and Medicaid really is a safety net for so many children. I think your slides really show that.

One thing that I was really impressed with is that you really highlighted just how much the safety net extends to the rural population. So could you remind us again that percentage of folks on Medicaid that are from rural areas? And I'm wondering if you know anything about those folks. Are they primarily elderly? Are they children? And whenever I think of rural communities, I think of industries like farming. So I'm just wondering if

you could just remind us of the implications of Medicaid being so important to the rural part of our country.

ASHER WANG: Yeah. Medicaid is one of the main funders of safety-net hospitals. So this includes like critical access hospitals, which are hospitals that are sometimes a sole provider in their community. They're often rural, and Medicaid is often the main payer for them. So they are crucial in often like preventing hospital closures, especially in rural areas. So that's one of the key ways that Medicaid is really important for rural states as well.

CHRIS PARK: And because Medicaid eligibility is tied to income, areas with lower average income would generally have a higher percentage of people in their state with Medicaid coverage.

COMMISSIONER ANGELO GIARDINO: Thank you. I think that's a really important point for us to keep reiterating. Thank you.

CHAIR VERLON JOHNSON: Thank you, Angelo.

Doug.

COMMISSIONER DOUG BROWN: Hi. Thank you for the data here. It's really always great to see this and kind

of put the Medicaid program in context with the spending and where the money is allocated to.

A couple of just quick questions here is -- I know we've talked about it in previous meetings, directed and supplemental payments. Are those included here as part of the total spend and total program spend that we're seeing in the numbers here?

CHRIS PARK: Yes, those would be included.

COMMISSIONER CAROLYN INGRAM: Okay. And then the new adult population, am I thinking about that correctly? Is that the expansion population generally?

CHRIS PARK: Yes, that's the expansion population. It would include certain enrollees who were previously eligible in certain states under, like, waiver options who would now be considered part of that new adult group but were not newly eligible under the ACA.

COMMISSIONER DOUG BROWN: Okay. Thank you.

CHAIR VERLON JOHNSON: Thank you, Doug.

John.

COMMISSIONER JOHN McCARTHY: Yeah. I have two questions.

Number one is, if you go to Slide 11, that is a

very large difference in the disabled and aged communities in spending per enrollee. I mean, you're looking at over 50,000 dollars to below 15,000 for the disabled and 40- to 10,000 for the aged. Is there anything you can tell us about that? What is the main driver of those differences?

ASHER WANG: Yeah, so states have a lot of variation in the optional eligibility groups and optional services that they can provide. So for example for the people who are disabled or over 65, states can include these optional pathways that allows them to cover this population beyond federal minimum income standards.

There's also optional services that states can provide. So, for example, institutional LTSS services, some of them are also an optional benefit that states choose.

So because of these different state policy flexibilities, you're able to see a lot of variation in these categories.

COMMISSIONER JOHN McCARTHY: And, Asher, I agree with you on the second part. The first part not so much, because if you're just adding people, it's just being divided by more people, your total costs.

But the second part is the services, right? It's what level of services. What about payment rates? Did you see anything? Have you looked at payment rates in that analysis?

CHRIS PARK: We haven't looked specifically at, like, how much of the, you know, variation may be driven by certain factors such, like, local market conditions in terms of the payment rates or state decisions on that front.

Some of it may be tied to, as Doug mentioned, like, some of the supplemental payments, and certain states have historically paid more under, like, the disproportionate share hospital program, and so some of that might be captured in the variation. And because the disabled and aged groups have more hospitalizations, states with, you know, larger supplemental payments to hospitals, you would probably see them paying higher on those populations than other states.

And so long story short is, you know, there's so many factors we haven't taken, done any analysis to try to tease that apart.

COMMISSIONER JOHN McCARTHY: And then the second

question is the next slide, Slide 12. You know, it looks at the big differences in what states are spending on Medicaid services for enrollees, and I have asked for this one before. You know, just looking at this chart, you can make a bunch of assumptions but may not be true. But have we looked at this chart yet in relationship to, you know, for no better measures right now, HEDIS measures to see how does spending in the program tie to quality?

CHRIS PARK: We have not tried to, like, compare, like, HEDIS outcomes to spending. You know, I think one challenge we will always kind of have is the underlying population characteristics. You know, like, even if we try to look at children versus children, like, what is the distribution of, you know, like, children with special health care needs within, like, state A versus state B, and that might be, you know, part of the driver of the outcomes that we're seeing where a lot of the outcomes data are, you know, maybe not as specific, you know, to know -- to isolate like subpopulations within various groups.

COMMISSIONER JOHN McCARTHY: It --

CHAIR VERLON JOHNSON: All right. So it looks like we have lost our Zoom connection. So are we still on

live on Zoom? Okay. Okay. So it's just -- okay. So, hopefully, you all are still listening for sure. Thank you.

[Pause.]

CHAIR VERLON JOHNSON: Can we go ahead and have the Commissioners go the old fashioned way and raise your hands? That would be great.

Tricia.

COMMISSIONER TRICIA BROOKS: I just want to thank you guys. This was really -- we've done so many basic 101 presentations, but this went deeper. It's a little more comprehensive. I think it's really excellent, and I actually learned something.

I did not realize that nearly a quarter of people receiving LTSS are children, and I know we've been doing more work on children with special health care needs. But it's just really important as we reflect on changes in this country that we consider the breadth and depth of the Medicaid population and the fact that there -- you know, that it is an efficient program and it does add value.

So thank you so much for the work.

CHAIR VERLON JOHNSON: Thank you, Tricia.

Jami?

COMMISSIONER JAMI SNYDER: Thanks so much for this. I really appreciated the slides that were dedicated to the coverage offered to beneficiaries that are able to obtain LTSS and BH services and just the critical role that Medicaid plays in offering those types of services.

When it comes to LTSS, as we know, in order to qualify for LTSS services, individuals generally must be at immediate risk of institutionalization, but states have worked really hard in recent years to rebalance and to offer services in individuals' homes or in the community at a significant savings to the state.

I'm just curious to know. Can you talk a little bit more about the types of HCBS services and BH services and SUD services, for that matter, that individuals can take advantage of through the Medicaid program?

JANICE LLANOS-VELAZQUEZ: Sure. So for HCBS, I think one of the most common ones we think of is, like, personal care services, but there's also supported employment or non-medical transportation which -- as well as case management which, in our analysis of HCBS utilization and spending, we found that round-the-clock

services was the biggest driver of spending in HCBS, but services like case management and supported employment were on the lower end of spending.

And for behavioral health and SUD services, we don't have the data right now, but some of the, like, SUD treatment that comes to mind is, like, medication-assisted treatment. And for behavioral health services, so there's psychiatric care, there -- which that one was considered mandatory, but there are also benefits such as outpatient services, outpatient therapy, which can be in the optional bucket. But we know that some states have selected to offer that. I don't know if there's anything --

CHRIS PARK: Behavioral health isn't just like a narrow, like, well-defined category. So there are a lot of services that -- and we are trying to do some work to kind of identify people who have behavioral health conditions and what services they are using that we're starting on right now. So, hopefully, we'll be able to expand on kind of the breadth of the services they are receiving in the fall.

CHAIR VERLON JOHNSON: Thank you.

Mike.

COMMISSIONER MICHAEL NARDONE: Hi. Thank you for this great information.

It always -- the popular perception I think is that Medicare is the funder of long-term services and supports, and actually, I think what this presentation really kind of hones in on a little bit is how important Medicaid is to the LTSS provision of services related to long-term services and support. So I thank you for this. It's always great to have that reminder.

I was wondering, in this work, do you have updated statistics on dual eligibles? Because people who are both Medicaid and Medicare eligible -- because my recollection is that -- or my understanding is that that also represents a significant portion of this funding for Medicaid and LTSS, along the magnitude of 35 percent, even though it's a relatively small population. I wonder if that still holds.

JANICE LLANOS-VELAZQUEZ: Yeah. For this presentation, we don't have it right in front of us, but that is something that we can look into. And we have it. We just don't have it with us.

COMMISSIONER MICHAEL NARDONE: Okay. Thank you.

Sorry, sorry.

But I think it is a group where I think we need -- I mean, this Commission has done such great work on advancing kind of a focus on that population, and so I think it's important for us to keep our eyes on that, particularly as there may be some changes with respect to how the program is administered at the federal level to make sure that we are continuing to focus on this population as well as how they receive the services that they need.

CHAIR VERLON JOHNSON: Heidi.

COMMISSIONER HEIDI ALLEN: Can I go?

CHAIR VERLON JOHNSON: Oh, did you have --

COMMISSIONER DENNIS HEAPHY: I just wanted to follow up a little bit on what Mike was saying, that -- well, two things. One is, in Massachusetts, I'm a person with a disability who benefits from actually the ability to buy into Medicaid in the state, and so my income is high in the poverty level. And because Massachusetts has a buy-in option, I'm able to work and also maintain my Medicaid, and this is critically important for folks whose commercial insurance does not cover LTSS or inadequately covers LTSS,

that the state can actually provide a wraparound for that person to maintain their employment. So it's really a cost savings and a means of supporting people to be employed. So, again, it's a cost savings.

And then with LTSS, access to LTSS can actually drive down Medicaid costs, even though it increases Medicaid costs. Medicaid is absorbing the cost of reducing spending on hospitalizations and Medicaid costs, and so I think that's the thing also we really need to focus on is, like, what is the value of investment in LTSS and reducing costs in other areas?

And the final thing I was actually thinking is, how do we show the value of investment in community-based LTSS versus institutional? So I would love to see a map that actually can show the differences in the expenditures per state and where the savings are through expenditures in community-based LTSS versus institutional care. And some of those things are intangible, like the ability of folks to engage in the community and things like that, but it would be helpful just to see what the numbers are. I don't think people really -- people seem to understand, oh, the person, of course, that costs more because they need to be

in an institution. So we need to invest in that, but they seem to lose sight of the fact that people who live in the community also need those services and that investment in order to be in the community. And so it's, I think -- so now we have to address that sort of -- yeah, that mindset that loses sight of the need for those services matters whether someone's in the community or if they're in an institution and that the savings are on the community side.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Heidi.

COMMISSIONER HEIDI ALLEN: Kind of along with the last two comments, I've just been reflecting on the way that the delivery system works with Medicaid and particularly for long-term services and supports.

My grandma is 91, lives in Idaho. Her savings have kept her -- has kept her afloat all of these years, but she needs to go into memory care now because she can't remember to take her meds, and she needs help bathing and all of this other stuff. And she couldn't find a memory care that would take her, because she didn't have a full year's worth of money left to guarantee a full year. So she had to go to one that accepts Medicaid because, at some

point during the year, at the rates these memory cares charge, she's going to run out of money. And so she had to go to one that accepted Medicare and that would accept her transitioning to Medicare.

And I was just thinking about, if that hadn't been an option, how people who are lucky and blessed enough to have a long life like that can really become in dire straits in the last few months and years of their life when they don't have the resources. So it just -- you know, an interesting thing about the way that the delivery system is so dependent on Medicaid as well.

COMMISSIONER DENNIS HEAPHY: Not that your grandmother is relying on Medicare, she's relying on Medicaid.

CHAIR VERLON JOHNSON: All right. Thank you.

Carolyn.

COMMISSIONER CAROLYN INGRAM: Thank you. So one of the areas you talked about are programs that are allowed to be optional and mandatory under Medicaid, and I just wanted to get some clarification. Are states allowed to use FMAP to cover undocumented immigrants through Medicaid?

JANICE LLANOS-VELAZQUEZ: States aren't allowed

to enroll undocumented immigrants using federal dollars. However, there are some narrow circumstances such as emergency Medicaid services that they can use federal funds to pay for their care that hospitals are required to provide.

COMMISSIONER CAROLYN INGRAM: I think some of my colleagues also brought up the area of behavioral health and substance abuse. Can you just clarify again for me? Medicaid's allowed to cover behavioral health and substance abuse. Medicare doesn't cover much at all. So if we have folks who are in long-term care facilities with behavioral health issues or folks trying to live out in the community with mental health or substance abuse issues, it's really Medicaid that covers that, not Medicare?

JANICE LLANOS-VELAZQUEZ: That's right. And for example, for HCBS services, in the analysis that we did, looking at HCBS use and spending, that was one of the sub-populations, those with mental illness, SMI and SUD conditions. That isn't a population that they can cover for HCBS. So they would largely access those services through those waiver services.

COMMISSIONER CAROLYN INGRAM: Okay. And also, in

rural communities where there are a lot of especially Native Americans or Tribal communities, I know that they get services and money paid through the federal government to pay for contracted health, but those dollars run out after a -- very quickly. Do you know about how many Native Americans or just an estimate of those populations that are actually eligible for Medicaid and also being covered by Medicaid when those dollars run out by the federal government?

JANICE LLANOS-VELAZQUEZ: We don't have the information on the spending side of how much the dollars go into Medicaid, but for the Native American population, I mean, it's -- the demographics show it's about 1 percent. We don't have it broken out in rural areas, which I'm sure the distribution would change.

COMMISSIONER CAROLYN INGRAM: Thank you.

CHAIR VERLON JOHNSON: Jenny.

COMMISSIONER JENNIFER GERSTORFF: Can you guys go back to Slide 11? I just wanted to tie together a few things going back to John's comment and then several comments from the other Commissioners that wide variation for aged and disabled members. I think states that are

more likely to rely on home- and community-based services than nursing facilities and institutions are going to have a lower average cost per person as well, and so that is another factor that can contribute significantly to this gap.

CHAIR VERLON JOHNSON: All right. Thank you.

Any other comments?

Mike.

COMMISSIONER MICHAEL NARDONE: Thank you, Verlon.

I was interested in the chart that's on page 15 because I just want to make sure that I understand that.

So what we see is and what my experience has been is a lot of the increase in Medicaid costs from year to year are directly attributable to enrollment, and what we see in this slide, I think, is despite the fact that Medicaid enrollment has increased significantly, that its share of expenditures has remained relatively flat, which tells me that the average cost per person has -- when you compare it to the rest of the health ecosystem has been relatively constrained.

And when you also add the fact that what we're talking about in the discussion about long-term services

and supports, behavioral health, the program is serving some of the individuals in our country who have the most complex health care needs.

So I just kind of wanted to -- I mean, that's my interpretation of the data, and I guess I just want to have -- to focus on that because I think it's a really important point when thinking about Medicaid and as well as, you know, what we get for what we spend under the program.

CHAIR VERLON JOHNSON: Thank you, Mike.

Anyone else?

[No response.]

CHAIR VERLON JOHNSON: All right.

VICE CHAIR ROBERT DUNCAN: Sorry, Madam Chairwoman. I was trying to get back on here.

So, first of all, thank you for the great work. I am going to go off my notes versus computer, since I can't get it back up.

Slide 5 on the demographics, I thought were extremely interesting, particularly as we think about Medicaid and its original formation. So when I look at the sex, I'm not surprised women tend to make up a higher portion of that based on taking care of the pregnancies,

and you highlighted more than half the births. Also, the age, as we look at children, the 44 percent. And then the race and ethnicity, I thought was really interesting to see the breakout of that.

But when we get down to the income portion of that, you know, when we talk about 100 percent FPL, federal poverty level, and stuff are 200 percent, people can make up their own mind. And so I just wanted to kind of do a check. So as we think about that, the 100 percent poverty level, you're really talking about a family of four making income of less than $32,000, basically. And if we look at the next level, going to 200 percent, that's a family of four of about $68,000. And so when -- or excuse me -- $64,000.

So, in reality, about 70 percent of the population we're covering are those most vulnerable families under $64,000, if you think of family of four, and so I think that's interesting.

And then I'd like to go to Slide 15, because, again, there you look and see the portion of the number that are insured. But if you look at that very bottom line, that's the spending.

And I think if you go to Slide 16, it shows even better. So when we think about federal programs and the spend that the federal government is going and we think about the great Medicare program, at the end of the day, the Medicaid program is the smallest sliver of the federal outlay of cash, yet it's covering a large portion of our most vulnerable populations.

And so as I was reading through this, it really hammered back home of what we're intending to do and why we're intending to do that. As we think about increasing the workforce and improving the workforce in this country, this is a population that we've got to have prepared and being able to meet those needs.

So I think you guys did a great job of laying out who we're covering and the importance of that, so thank you.

CHAIR VERLON JOHNSON: Thank you, Bob.

Any other Commissioners?

Tricia, please.

COMMISSIONER TRICIA BROOKS: I'm going back to the slide showing the income again, building on Bob's point.

So those in the 200 to 399 would be largely children or working disabled who are in the Ticket to Work program, some maternity, because maternity is up to 213 percent median across the country. So I just want to emphasize that piece, because as Bob says, people look at they're making four times the poverty level and still getting Medicaid, and it really is those specific populations. If you're not disabled, you're not going to find an adult in that group other than pregnancy and disability, so thank you.

CHAIR VERLON JOHNSON: Thank you.

Other Commissioners? Oh, Heidi.

COMMISSIONER HEIDI ALLEN: So you had a slide, and I can't remember which one it was, but I think it had the breakup of long-term services and supports by age. And it showed people 80 or something like that, 75 and older or something. Yeah.

So one of the things I was curious about is that seems, like, you know, really difficult for states to manage when there's distributions of older people that vary state to state. And then I was just thinking about how do states manage that with, I think, all but one state having

a constitutional amendment to have a balanced budget every year, when you have demographic shifts like the boomers who will be moving into these categories where they're more likely to return.

I would just love it if this is work that MACPAC could think about of how states are able to manage their priorities as they have an aging population, and I know it's a work that we've done for a long time trying to think about how to address home- and community-based services as a way to prevent institutional care and keep people in their homes longer. But I think that one of the things that isn't always clear is that states don't have the option to go into deficit spending like the federal government does.

And so they are really resource constrained when these kind of predictable shifts like the boomers aging into long-term care happen. They would have to take that money from education and roads and all these other things that they care about. And so it just seems like a really important thing for us to keep our eye on.

CHAIR VERLON JOHNSON: Completely agree with that, Heidi.

Others?

[No response.]

CHAIR VERLON JOHNSON: All right. I'm just going to say, I mean, I know we touched on maternal health and some of the other Commissioners' comments, but I just want to put a pin in that as well.

I mean, again, I remember when I first came to Medicaid and saw the numbers around the births that were happening in Medicaid, it was a lot, right? It was pretty amazing. And so as we think about that -- and I know that states have the 12-month continuous care, which is great, but I just want to make sure that we as Commissioners, as we continue to look at the issue around maternal health, think about how are states using that model to improve access to care and reduce disparities in the outcomes when it comes to postpartum care, and then also just in terms of how else are they able to use that for other ways to kind of improve the care of the women that they're serving. So just want to make sure that we're thinking about that too as we continue to look and see how well this is actually happening across the country.

Any other thoughts, last thoughts? Okay. Oh,

there we go. Yes. Thank you.

COMMISSIONER ADRIENNE McFADDEN: Madam Chair, I want to thank you for bringing it back around to the maternal outcomes, because I didn't want to go off topic.

I am brought back to sort of my time in public health, and we always used to talk about not infant mortality, but infant thriving. And I think this just puts an emphasis on the importance of Medicaid and making sure that there is coverage for pregnant women so that we can have thriving mothers who then lead to thriving babies, which means that these babies are reaching their first birthday. And that's an important outcome that I think we all can sort of rally behind for what is the value of Medicaid.

The other thing I want to just also emphasize is once a rural health director, always a rural health director. I was a rural health director before. Angelo, I think you brought up rural health before. The importance of Medicaid is sort of emphasized here, even looking at the maternity care with the percentage of pregnancies that are paid for in rural communities.

Secondarily, I think, Asher, you brought up the

critical access hospitals. Those are not only important for health delivery in those communities, but they are the economic driver in those communities, and so if Medicaid is keeping those doors open, it's actually keeping opportunities open, not just for health care but for economic opportunities in those communities.

CHAIR VERLON JOHNSON: Thank you. Okay. All right. I think you've heard that we were very excited about this particular session. You all did such a great job bringing the data to life for us, for sure.

I think you have a number of different things we want to probably focus on in the future, and you did a great job answering the questions. So we want to thank you all for taking the time with us today to put Medicaid in context. So we appreciate it. Thank you.

So, Chris, I know you're staying there, okay, as we move into our second part of Medicaid in context, payment and finance.

And so this particular session is going to give us that high-level overview of how Medicaid is financed, including how states fund the non-federal share and use supplemental and directed payments that many have been

hearing a lot about as of late.

And Chris is being joined by Holly. And I believe, Holly, this is your first time? Well, welcome to the stage. We're very excited to hear from you.

So, with that, I'll turn it over to both you and Chris.

MEDICAID IN CONTEXT: PAYMENT AND FINANCING

* HOLLY SALTRELLI: Great. Thank you, Verlon, and good morning, Commissioners.

Chris and I will continue the presentation about Medicaid in Context, focusing on how the program is financed through federal, state, and local funds, and how the types and amount of payments made to providers can be related to the financing structure.

This presentation reviews our prior work on Medicaid financing and how states use different financing sources and payment structures to support the program and target specific policy goals like rural access.

I'm going to start with the federal-state partnership and reviewing the structure of federal financial participation. Next, we'll examine the non-federal financing structure and the different ways that

states finance the non-federal portion of Medicaid expenditures. Then I'll walk through the different provider payment mechanisms and ways Medicaid funds are distributed to providers. Finally, we'll discuss the need for data on the cost of providers' financing of the non-federal share and the importance of considering both gross and net payments when assessing payment policies and how they relate to goals of quality and access.

Let's begin with some context about the federal-state partnership that forms the foundation of Medicaid.

Since the program's inception, Medicaid financing has been a shared responsibility of the federal government and the states. States receive federal matching funds towards allowable expenditures, and each state administers its own program within federal guidelines.

In calendar year 2023, Medicaid represented 17.9 percent of national health care spending, less than Medicare or commercial insurance.

Federal financial participation in Medicaid varies year to year but typically hovers around 65 percent. Most recently in fiscal year 2024, the federal share was 64.5 percent nationally, though this varies by state. This

figure also reflects one quarter of increased federal match following the public health emergency.

The federal share for most Medicaid services is determined by the Federal Medical Assistance Percentage, or FMAP, which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average and vice versa.

HHS calculates FMAPs one year in advance using a three-year average of the most recent per capita income data from the Department of Commerce. While this formula typically provides budget stability, it also limits how quickly the federal share can respond to economic changes.

FMAPs have a statutory minimum of 50 percent and maximum of 83 percent, with D.C. and the U.S. territories having FMAPs set directly in statute rather than calculated by formula.

There are many exceptions to the standard FMAPs, such as temporary enhanced matches for natural disasters, such as Hurricane Katrina, or temporarily increasing FMAPs to provide additional assistance to states during economic downturns. There is no preset limit on the federal financial participation for Medicaid for the 50 states.

The federal match for Medicaid administrative activities does not vary by state and is generally 50 percent, though certain administrative functions have a higher federal match. Higher match rates often apply to activities requiring medically trained personnel, information systems for eligibility and claims processing, fraud control, and administration of services with higher medical assistance rates. For example, the design and development of Medicaid management information systems receives a 90 percent federal match, whereas ongoing operations of these systems receive 75 percent match.

Because states can establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines, variation in Medicaid is the rule rather than the exception.

This state-level flexibility, combined with varying FMAP levels, creates significant differences in the federal share of total Medicaid spending across states.

As you can see on this map, there is substantial variation in how much the federal government contributes to each state's program.

States must undergo an estimation and federal review process to receive their matching funds for state Medicaid expenditures. To receive federal matching funds, states estimate their quarterly Medicaid expenditures beforehand and report these estimates to CMS. CMS provides federal matching funds based on states' estimates through a fiscal intermediary through the HHS Payment Management System, or PMS.

States use these federal matching funds to make Medicaid payments to providers. Subsequently, states report actual expenditures to CMS, which reviews and reconciles states' actual expenditures and federal funds to ensure the federal government matches only actual state expenditures.

Like other federal payment programs, Medicaid must measure and report improper payment rates under the Improper Payments Elimination and Recovery Act of 2012. Improper payments are not necessarily an indicator of fraud or abuse. They are often due to instances where information required for payment was missing or appropriate processes for enrolling providers were not followed.

Through the Payment Error Rate Measurement

program, or PERM, HHS annually reviews fee-for-service claims, managed care capitation payments, and eligibility determinations to estimate the rate and amount of improper payments in the Medicaid program.

HHS assesses 17 states per year on a three-year rotation. The review year 2024 national Medicaid rate is based on measurements from 2022 through '24.

Medicaid paid an estimated 94.9 percent of total outlays properly, amounting to almost $580 billion federal dollars. The national Medicaid estimated improper payments are approximately 5 percent or $31.1 billion.

Missing or insufficient documentation accounted for 74 percent of the improper payments, and an additional 5 percent were technically improper, meaning that they were paid to the correct beneficiary for the correct amount, but the payment process did not comply with applicable regulations and statutes.

In total, most improper payments, 79.1 percent of them, were due to missing or insufficient documentation and technical issues, not necessarily payments to ineligible providers or services for ineligible beneficiaries.

Next, we'll discuss how states finance their

portion, or the non-federal portion, of Medicaid spending.

The Medicaid statute allows states to use multiple sources to fund their share of expenditures, including state general revenues, local government contributions, and specialized sources, such as health care-related taxes. Contributions from local governments can also include providers operated by local governments, such as county hospitals and school districts.

Federal rules require that at least 40 percent must come from the state itself, while up to 60 percent may come from the local governments. The extent to which states rely on funding sources other than state general revenue varies considerably and may be influenced by how states have historically split financing with localities for functions such as education, social services, indigent care, and corrections.

Local government contributions often take two forms, intergovernmental transfers, or IGTs, where local entities transfer funds to the state Medicaid agency, or Certified Public Expenditures, CPEs, where local entities certify the total expenditure incurred for Medicaid services or administration.

The non-federal share contributed by providers is frequently used to finance additional payments to these specific providers. Health care-related taxes, often called provider taxes, fees, or assessments, are defined as taxes where at least 85 percent of the burden falls on health care providers or services.

States can impose provider taxes on 19 classes of providers or services, with nursing facilities, hospitals, and intermediate care facilities for individuals with intellectual disabilities being the most frequently taxed. These taxes must generally meet certain criteria. They must be broadly applied to all non-governmental providers within the taxing jurisdiction, and they must be applied uniformly across providers within a class.

States can apply for waivers of these requirements if the tax meets statistical tests ensuring redistributive effects without unduly burdening Medicaid providers.

In addition, providers cannot be held harmless through a direct or indirect guarantee that they will be repaid for all or a portion of the taxes that they pay. However, the indirect guarantee test does not apply if the

tax rate falls within a safe harbor established under regulation. The safe harbor is currently 6 percent of the provider's net patient revenue.

This slide illustrates a simplified example of how provider taxes work in practice. In this scenario, we have two hospitals with identical net patient revenue of $1,000 each but different Medicaid volumes. Hospital 1 has a high Medicaid volume of $800, while Hospital 2 has a low Medicaid volume of $200. Each hospital pays a 6 percent tax on revenue, generating $120 in tax revenue. The state uses $80 of this revenue as its share to draw down federal matching funds.

With a 60 percent FMAP, the federal government contributes $120. The resulting $200 is distributed proportionally based on Medicaid volume, with Hospital 1 receiving $160 and Hospital 2 receiving $40. The net impact is that Hospital 1 pays $60 in tax but receives $160 in increased payments for a net gain of $100. Hospital 2 pays $60 but receives only $40 for a net loss of $20. Provider taxes can be used to redistribute resources within the health system for states.

These maps show the prevalence of provider taxes

throughout the U.S. All states except one, Alaska, have at least one provider tax in place as of fiscal year 2024. Thirty-eight states have at least one provider tax over 5.5 percent, approaching the safe harbor threshold of 6 percent.

This figure shows the national distribution of Medicaid financing for different types of Medicaid payments in 2018. You can see that about 68 percent of states' overall Medicaid spending was financed by state general funds. However, disproportionate share hospitals, or DSH, and non-DSH supplemental payments are more likely to be financed by providers through taxes or IGTs.

Next, we'll review how states distribute Medicaid payments to providers.

Base payments are the standard payment rates for services delivered to Medicaid beneficiaries, and they are typically fee-for-service rates set by the state. Supplemental payments, which we'll discuss further on the next slide, are additional payments beyond base rates to certain providers. They allow states to target payments for different purposes.

Directed payments allow states to direct managed

care plans to pay providers according to specific rates or methods. Many directed payment arrangements are similar to supplemental payments.

Historically, supplemental and directed payments exist because base rates don't cover provider costs or address policy objectives like ensuring access, supporting safety-net providers, or incentivizing quality.

This table lists some of the different types of payments and how they're used to address various policy objectives based on the intent of the payment implied from the federal rules. For example, the upper payment limit, or UPL supplemental payments, allow states to increase provider payments to what they would have been paid under Medicare.

For disproportional share hospital, or DSH payments, states are required to make additional payments to certain hospitals that serve a high proportion of Medicaid beneficiaries or other low-income patients. DSH payments can be used to cover the unpaid cost of care for uninsured individuals.

As shown, states use supplemental payments across a variety of providers. Supplemental payments were 53

percent of the total fee-for-service payments to hospitals and 46 percent of the total fee-for-service payments to mental health facilities.

The extent to which states use provider taxes and local government funds to finance their supplemental payments varies. GAO found in state fiscal year 2018 that, on average, 66 percent of DSH supplemental payments were financed by provider taxes and local government funds. Twenty-two states and D.C. financed between 80 to 100 percent of their non-DSH supplemental payments with provider taxes and local government funds.

Similarly, in our analysis of states' directed payment arrangements, we found that states also used directed payments to increase payments across various provider categories, with the most payments going to hospitals.

We also found that 53 percent of directed payment arrangements to hospitals in 2024 were financed in part by provider taxes. Overall, about half of all directed payment arrangements were funded in part by state general funds, which means that about half of directed payment arrangements were primarily financed by provider taxes or

local funds, such as IGTs.

As shown in this figure, Medicaid supplemental and directed payments are a large share of Medicaid payments to hospitals, making up about 40 percent of total hospital spending. 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.

Rural hospitals are a critical source of care for rural communities, but they often face financial instability. Many states use supplemental payments as a way to target additional funds to rural hospitals.

In total, we identified 15 states that explicitly targeted UPL or Graduate Medical Education, GME, payments to rural hospitals based on the narrative information reported to CMS or in 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 Medicare because they are often the sole provider in their community.

Using provider-level data on non-DSH supplemental payments 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 targeted critical access hospitals distributed the highest share of non-DSH spending towards rural hospitals.

Next, we'll discuss Medicaid's effect on providers. While supplemental and directed payments do increase provider revenues over what they would receive through base payments, it is important for stakeholders to also recognize that provider financing of the non-federal share ultimately affects the amount of revenue the provider has to cover the cost of providing services.

The Commission has done prior work on the need for data and transparency on the sources of the non-federal share. The federal government does not collect information on the sources of non-federal share in a comprehensive

manner. Last year the Commission supported a recommendation for transparency around the non-federal share.

The cost of health care-related taxes and local government contributions to the non-federal share can reduce the net payments that providers receive. To illustrate this effect, this figure shows how taxes and contributions from local governments reduce the net payments that DSH hospitals received in 2011.

While gross DSH payments reported on Medicaid audits in 2011 exceeded hospitals' costs for Medicaid payments, we estimated that taxes and local government contributions effectively reduced these payments by 11 percent, resulting in net payments to DSH hospitals that were below their costs of care for Medicaid covered patients.

Here's another example showing the impact of financing mechanisms on gross and net payments under managed care. For this example, we are using data for a Texas hospital. Texas collects and makes public Medicaid financing data at the provider level, similar to what we outlined in our recommendation.

This illustration is valuable because it is a provider-specific example of many of the concepts that we've discussed here this morning.

For this Texas public hospital, gross payments from the managed care plan were 128 percent of Medicare rates. However, after accounting for the cost of health care-related taxes and local government contributions, net payments fell to just 82 percent of Medicare rates.

In summary, Medicaid is a federal-state partnership that is supported by a complex set of financing structures that have been built over time. Many of the payment structures that states use to address particular policy goals are tied to how states have financed those payments.

The amount providers pay in taxes, IGTs, or CPEs can be seen as an additional cost that effectively reduces gross payments. It is important to analyze how both gross and net payments when developing payment policy and assessing how these payments are linked to the goals of access or quality.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Holly and

Chris. This was really great and really put into perspective.

I am going to open it up to the commissioners for questions and comments, AND I will start with Angelo and then go to Tim.

COMMISSIONER ANGELO GIARDINO: Thank you very much for walking us through a super complicated aspect of the health care ecology.

I wanted to just make one comment. It is really complicated, and I don't think anybody is doing anything wrong in using the levers and mechanisms that legislators and regulators have provided them over the decades of this system developing. It really reminds me of when you buy your starter house, and then, as your family expands, you add an addition, and then as your interests change, you might actually add a different addition. Then after about 40 years, you look at your house and you say, geez, it doesn't look as great as I thought, but it has really served its purpose. And I think you've really illustrated to us just how complicated this is.

A number of the hospitals that you've talked about also serve the entire community. So I just want to

make the point that many of these hospitals that are using these mechanisms are our regional trauma centers, and if you're driving on one of our roads in this great nation and you have a car crash, we need those hospitals to be fully functional.

The leaders of those hospitals have worked within this ecology to develop all of the services that all of us need, and Medicaid pays for the portion that it's supposed to and all the other systems contribute to that.

Again, I don't think anybody's doing anything wrong. This would not have been the way I would have developed this system. But we bought a starter house in 1965, and then we had other things that happened over those four or five decades, and we've put additions onto the house. You always have the option of demolishing the house and rebuilding one, but that usually ends up being a very, very expensive proposition.

So I appreciate you demonstrating to us all the different pieces to this house that supports all of us.

CHAIR VERLON JOHNSON: Thank you, Angelo. I love the idea of turning that house into our dream house now without demolishing it. That's great.

Tim, I'll turn to you.

COMMISSIONER TIMOTHY HILL: I like the analogy. We're going to have to work on that one.

Holly, I'm glad they didn't give you a complicated topic to start with. You did a nice job.

Can you go to Slide -- I have two questions and then a general comment -- 12, which was like the overview of the taxes. And I just want to be sure I understand the hold harmless provision in Slide 12.

Yeah. And so is the way we're supposed to think about the hold harmless is if the tax is less than 6 percent of patient revenue, it's okay to have a direct guarantee that you're going to get the money back? Is that the way to think about that?

CHRIS PARK: You cannot have a direct guarantee. The 6 percent means that it passes the indirect guarantee test, which means that providers are getting some portion of their tax revenue back, but there cannot be an explicit direct guarantee that they would get all of their money back.

And so you can't specifically make the payment tied to the amount of tax that a specific provider

contributed. So if the provider contributed like $10 million in tax revenue, you can't just say we are making a supplemental payment for $10 million back to you.

COMMISSIONER TIMOTHY HILL: Right. So the way to think about it is there's always a prohibition on a direct guarantee. If it's below 6 percent of patient revenue, we're going to assume that that is the case. Is that what that means?

CHRIS PARK: Well, it's the indirect guarantee part of it, so that if it's tied back to utilization, patient days and it's like $50 per day that you would get that hospital, so they could potentially get all of their money back. But it's not explicitly tied to the amount of tax that they paid. It would be tied to providing care to Medicaid individuals.

COMMISSIONER TIMOTHY HILL: Right. And then can you go to Slide 9 on the error rate? I think it can't be said enough in the current environment, that in many ways we are hoisting ourselves on our own petard here, which is Medicaid is an incredibly complicated program with incredibly complicated documentation requirements across eligibility and payment. And I'm all for auditing, and I

think we ought to be sure that people are complying with those requirements. But that 74 percent insufficient documentation rate really is to me a measure of complication of the program more than it is a measure of somebody trying to rip us off. Somebody's gotten a service. They were eligible. They were in the program, and they just missed something on the documentation. And I think it's important to keep reiterating that, particularly in the context of fraud and abuse in Medicaid and kind of like this is running away.

It's still a lot of money. I'm a former CFO. It should be right. We should document what we're doing, but we should also not mischaracterize what it measures in a way that can serve a purpose to go a direction in a policy front.

And then the last thing I would say -- and it kind of goes to Angelo's point but not as eloquently with the house -- I do worry about the fact that I've seen many times that a lot of the conversation around particularly provider taxes and financing is masking a conversation around people don't like what the state's spending the money on. It's not that provider taxes themselves are bad.

It's we don't like the fact that there's a lot of indirect payments going to manage care plans or a particular state has put together a 1115 waiver that meets the requirements of the statute, but we don't like the fact that they're paying for uncompensated care for immigrants or whatever it is that the state's paying for.

So I think it's important to point it is a legitimate source of revenue in financing in the state. There's going to be -- there are instances where consultants or others are really pushing the envelope on inappropriate schemes, if you will, and we should kind of root those out, but the notion that in general provider taxes are a fraud or something that's leading to an outcome that we don't desire I think is unfortunate and wrong, and I think in many cases, as I said, masks a -- I hate to say ideological, but a more policy-driven conversation about what it is the state's doing with the program rather than the actual imposition of the tax, if that makes sense.

Thanks.

CHAIR VERLON JOHNSON: Thank you, Tim.

Let's go to Carolyn and then Heidi and then Bob.

COMMISSIONER CAROLYN INGRAM: Thank you.

I wanted to also look at Slide 12, so just to probably make the point further of my fellow Commissioner.

As long as a state is following the items here on Slide 12 and these rules when they're setting up their tax programs, they're legitimate taxes. They're legal programs, correct?

HOLLY SALTRELLI: Correct.

COMMISSIONER CAROLYN INGRAM: Okay. So they're not considered gimmicks or schemes or loopholes. They're actually allowed right now under the federal government?

HOLLY SALTRELLI: That's right.

COMMISSIONER CAROLYN INGRAM: And a lot of them going I think -- back to your hospital slide, I think it was Slide 21. maybe, showing the support for the hospitals. I think it's there maybe. Maybe not 21. Yeah, showing all of the different payment mechanisms that hospitals have to have in place to stay afloat.

In many of the rural communities that Angelo was talking about, these payment mechanisms are put in place in order to make sure that the hospitals are able to provide services to the whole community, correct? Not just to Medicaid individuals?

CHRIS PARK: Yes. So it may be tied to specifically Medicaid utilization, but certain payments like DSH or uncompensated care pools can also go to support care for the uninsured. And if the hospital is largely Medicaid patients, then the majority of revenue would be coming from Medicaid that supports the hospital system overall.

COMMISSIONER CAROLYN INGRAM: So that makes sense, and thank you for providing that clarification.

I come from a very rural part of the United States where there's not a lot of services, and people rely on those hospitals, not just for emergency car accidents but also just to deliver babies and to have access to services when their kids have an infection, where the fever is really high. And there's no other place for care in that entire part of the state, leaving us with if these were to close, leaving us with you know severe deserts in terms of being able to access care.

And I know one of our charges is to really look at those issues around accessing care. So I appreciate you bringing this forward and showing us how important it is to those rural communities and hospitals.

I mean, I was born in one where it was the only hospital around to my mom to have a C-section in, so I could be here at this meeting today. So I really do support that money and those infrastructure going to those rural hospitals and find it really interesting is what's happened over time, as Angelo and others have talked about since we created this program in 1965, states have figured out ways to support those rural hospitals in our communities so they can continue to grow and thrive and be there and continue to be the source to deliver folks who are needing those services and access to care. So thank you for bringing that forward.

CHAIR VERLON JOHNSON: Thank you, and thank you to that hospital and your mom for making sure you were at this meeting Carol. We appreciate you.

All right. Heidi.

COMMISSIONER HEIDI ALLEN: I just wanted to go to Slide 8 really quickly, and thank you both so much for this work. It's really helpful reminders for us.

Maybe that was -- is that the right one? One of the things that I think is just like really so important and all of the information kind of both sides of what you

presented today -- one is the way that the federal-state partnership with Medicaid works, and then two is how the state comes up with their share. But the federal-state partnership is critical for the redistribution of wealth that would make the Medicaid program able to meet the needs of states that are both low income and have high proportion of people on Medicaid because of that low income.

Yeah, that's what I was wanting to look at. It is the FMAP, 7 I'm always one slide off.

So looking at that and thinking about, you know, without the federal government stepping in to redistribute wealth from wealthier places to more low-income places, the Medicaid program itself would be a penalty to say that you have to cover these populations and these services. And if you happen to have more of those populations and less revenue, you would be in a lot of difficulty.

And I think that we often think of that in terms of eligibility, like just the sheer number of people that you're serving as a proportion of your population, but it's also important to recognize that high-poverty areas also come with higher acuity meaning their populations have a higher burden of chronic disease, higher rates of mental

health needs, higher rates of disability, and higher rates of social needs. And so I think it's just important to take that 10,000-foot view of what the federal government is doing by redistributing wealth in that way.

And then there was another slide that looked at -- that showed how provider taxes work, the one with the hospital example, and it seems like -- right, yeah -- that also it's a way that states are able to redistribute wealth from places that hospitals and facilities that might be generating more revenue to places that are under resourced like rural hospitals. And so that both of these are kind of functioning as a way of making Medicaid work, that it wouldn't work if it was changed in a significant way without taking into consideration that lower resource place have a higher burden of people that they need to resource.

So thank you for showing that. It was, like, a very clear -- we've been talking about supplemental and directed payments for years, and this is like the best I've understood it, as I appreciate the very simple presentation.

CHAIR VERLON JOHNSON: Thank you, Heidi.

Let's do Bob and then Tricia.

VICE CHAIR ROBERT DUNCAN: Thank you, Chairwoman.

Again, great presentation. I like to try to simplify things in my own mind. So if you could go to Slide 9, please?

So when we look at this and we take the calculation of 579.7 billion plus the proposed improper payments of 31.1 billion, we come up with about 611 billion total spend in Medicaid, correct?

HOLLY SALTRELLI: Federal spend.

VICE CHAIR ROBERT DUNCAN: Yes, federal spend.

HOLLY SALTRELLI: Yes.

VICE CHAIR ROBERT DUNCAN: Okay. Out of that, we understand that 74 percent was in insufficient documentation. One of our Commissioners talked about that of the improper spend, the 31 billion. Really when we get down to the 16 percent of ineligible benefits, that becomes down to actually about 5 billion. Now, 5 billion sounds really large to us. I think we'd all like that. But in proportion to the total federal spend, that actually comes out to less than 1 percent. Am I correct in my thinking on that?

HOLLY SALTRELLI: You are.

VICE CHAIR ROBERT DUNCAN: Okay. I just wanted to make sure. I like to simplify, because we put big numbers and percentages, it looks different.

But at the end of the day, we're talking about less than 1 percent would be considered improper payments -- or not improper but about $5 billion.

HOLLY SALTRELLI: Yes.

VICE CHAIR ROBERT DUNCAN: Okay. Thank you. I appreciate that because I think that's important to know.

The other is if you go to Slide 27, and as you highlighted how the gross payments and then the net payments look at. So you said that's about 82 percent of the net payments. So this is based on for every dollar a hospital, it costs a hospital to provide the service, they're actually only getting 82 cents in reimbursement.

CHRIS PARK: Actually, to clarify this, because we didn't necessarily have their costs. This was based on information from the -- you know, the pre-print information that related it to a share of Medicare.

VICE CHAIR ROBERT DUNCAN: Okay.

CHRIS PARK: So this means that the net payments are 82 percent of what Medicare would have paid.

VICE CHAIR ROBERT DUNCAN: Thank you for that clarification. I want to make sure that was understood. Thank you.

CHAIR VERLON JOHNSON: Thank you, Bob.

All right. Tricia and then John.

COMMISSIONER TRICIA BROOKS: Thank you.

And, again, another great presentation.

Could you go to Slide 6, please? And just I wanted to make a point here because I think that eligibility workers who run the systems doing enrollment and redeterminations are reimbursed at 75 percent. So general administration is 50 percent, but the eligibility piece of it is 75, and you might want to break those out or clarify.

CHRIS PARK: Yeah. Sorry. We just, like, did a selection of various categories, because the list was too big, but we can certainly clarify that in other materials.

COMMISSIONER TRICIA BROOKS: Okay. Thank you.

And could you go to -- let's go to Slide 12 before we go back to 9. I just -- I loved Angelo's analogy of the house. I want to use a different one here when we talk about provider taxes.

I pay taxes when I fill up with gas and put tires on my car, and that is to pay for my roads. So is that legal? Yes, it is legal. We do it all the time. We target areas, and people use services in order to do that, you know, the payment.

So I just think it's really important to point out that it's not unusual for us to target a specific industry with taxation that then benefits the people who take care of those services. I get the service of driving on the road and the bridges, and they don't hopefully fall down.

And let's go back to Slide 9. There's a lot been said about this slide, but I want to make another comment, and that is on the insufficient documentation, there are new rules. We have not clarified in rules what the documentation requirements are since 1986. It's almost 40 years. No wonder we're making a bunch of mistakes in documenting eligibility and documenting claims.

So we need those rules, and yet those rules are actually one of the things on a menu that the House of Representatives is considering for cuts to Medicaid, and so I think it's really important to highlight that that rule

will have significant impacts. It improves coverage, removes barriers for children. It also removes barriers and red tape for disabled populations.

People who are in what's called the non-MAGI groups, which are your disabled and your elderly seniors, currently have stricter rules and have to renew their coverage twice a year as opposed to once a year, and it's a burden. It's a burden on the individual. It's a burden on the state.

So I think it's really important to point out that these rules -- and another rule that's being targeted is the access rule which is to improve network adequacy across the country. And so there are things that we have to consider when we look at something like this and say "Ooh, that insufficient documentation, we've got a fix for that, but let's get rid of the fix" doesn't make any sense at all. So thank you.

CHAIR VERLON JOHNSON: Thank you, Tricia.

John?

COMMISSIONER JOHN McCARTHY: I want to go back to Slide 5. When we talk about FMAP, I think one of the things that comes up often is we talk about that formula

like it came down from the mountain was set in stone, and I think if you look at it and you say if we were to look today -- and this is more of a statement than a question, guys, so you don't have to answer it. But if you look today, we wouldn't probably base it on per capita income.

I was just talking to a former Medicaid director in Nebraska, and we were talking about this. And his joke was, well, if Warren Buffett just moved out of Nebraska, that would increase the FMAP by so much that they get, which is true because that's how it's calculated on that basis like that.

So I think that's one of those things of looking at how do we even come up with this formula, and what changes could we look at, and how is it better to measure that? Because when you're looking at states and you're looking at the burden on states of what they can actually afford, this has a huge impact on them, just the formula itself, not even taking into account that it's a fact that it's a three-year rolling average, so that when you do have a recession, it takes a while for it to catch up on those things. And so states are left behind, and you get Congress then talking about having to do enhanced FMAPs

then during a recession.

So really there is more that we could do looking at that formula to make sure that it is a more timely formula and also probably matches what state burden is better.

CHAIR VERLON JOHNSON: Thanks, John.

Let's go to Carolyn and then Jenny.

COMMISSIONER CAROLYN INGRAM: John, to that point, I recently was teaching a class at GW, and I told them that everybody likes to pick on you at MACPAC. And they all thought that was pretty funny, so just want to pick on you. And if Warren Buffet really did move out of that state, then what would happen to some of their economy and all the jobs that he provides there? I'm not sure that that's what they really want. So I think there's a lot more to consider in terms of how the FMAP gets put together than those types of things. And that's just a shout-out to those folks at GW who wanted to make sure that somebody called you out during the meeting.

CHAIR VERLON JOHNSON: Thank you, GW.

[Laughter.]

CHAIR VERLON JOHNSON: All right. Jenny.

COMMISSIONER JENNIFER GERSTORFF: I want to go back to Slides 26 and 27. While you're flipping there, we received a public comment from Valley Medical Center which is a disproportionate public 330-bed hospital in Renton, Washington. And I just wanted to highlight something that they mentioned in their public comment.

Their payer mix is they have 64 percent of their patient population are on Medicaid or Medicare, and they participate in both the DSH program and directed payment programs with the state of Washington. And their estimated annual payments they were expecting to receive from their directed payments were $80 million, and they're very concerned they won't receive that at this point, which for their general income is difficult compared to their cost.

And coming back to Slide 26 here, I wanted to point out your chart is very helpful showing the total revenue and how from gross revenue to net revenue compares to cost, but it's from 2011, which I know with the DSH lags, it's very difficult because we don't have the transparency of that data.

And then to Slide 27, how meaningful that makes this slide and the transparency that we have in Texas and

what they've implemented there being able to look at a provider level at their gross versus net payments and how that compares. Even if it's not to cost to that benchmark of Medicare payments would be great if we had that nationally.

CHRIS PARK: So we are underway on a project to try to -- we did this -- some work a few years ago, trying to estimate what Medicaid pays for inpatient hospital admissions and comparing that across states but also to some external benchmarks like Medicare. And we are in the process of updating that, and we are, to the extent possible, where we can link the provider-specific payment information to hospital cost reports to get an estimate of cost, you know, we will try to kind of update some of these figures in terms of what the cost coverage may be.

COMMISSIONER JENNIFER GERSTORFF: I love that. Thanks, guys.

CHAIR VERLON JOHNSON: Thank you.

Let's go to Mike, then Dennis, then Tricia.

COMMISSIONER MICHAEL NARDONE: Thank you.

So thank you for this presentation. This is such an incredibly complex topic, and my head always hurts after

I have to go through a presentation like this, but it's really instructive, and I really appreciate your hard work on this.

So I just wanted to highlight Slide No. 14, which is, you know, states with provider taxes in place. So, I mean, I think what this slide really demonstrates pretty visually is just the extent to which the provider taxes are ingrained in the basic landscape of Medicaid financing, and so, you know, as ways are looked at to maybe constrict these or go in a different direction, understand that this is going to have reverberations across the country and in rural states as well as urban states.

I come from a state and was Medicaid director during the Great Recession and was involved in implementation of a hospital tax in the state, and just a couple of points that I think are, you know, reflected in some of the other comments that you made, Holly and Chris.

I mean, first of all, I think we work very closely with CMS to ensure that, you know, our program was consistent with what the federal statute said, also, you know, abided by the statutory requirements that as we understood them in implementing the tax. So it was

something that was available to us legally to basically increase resources to the state program.

We also -- you know, in constructing it, we did provide a substantial portion to hospitals. However, it had to go through a process where we showed that it was redistributive so that people weren't getting back their taxes. But that was going based on Medicaid, by the Medicaid requirements.

And also, that the funding that we received, that we provided to hospitals -- and this was demonstrated on one of your other graphs -- did not fully fund the costs of Medicaid at those hospitals. So we, I think, estimated that we were getting up to around 90 percent of costs, with the provisions that we put in place with respect to the hospital payments. And that, for us, didn't also account for the lower rates that we were paying for outpatient services. This was just on the inpatient side.

And then also, the tax revenues were not only used to fund hospitals, but they were also used to fund other Medicaid services. And I think there's some perception that, you know, where do these funds go? I mean, they were -- at least from my experience --recycled

into other services and actually helped us to maintain coverage during a period where there was a recession that was going on in the larger economy.

Also, just in thinking about this and provider taxes, significant number of provider taxes -- I think it's in the near 50 -- are for nursing home services. And again, you know, the revenues that come in, at least from my experience, have not only gone to nursing homes but also have gone to fund other services like HCBS. So it's just important I think to just make a point about how important these are to Medicaid as well as to the providers that rely on Medicaid to help fund some of those costs.

So I just want to reflect on my own personal experience in terms of -- and how this relates to, I think, some of the considerations that are going on right now.

CHAIR VERLON JOHNSON: Thank you, Mike.

Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks.

For me, it would be really helpful to see a simple slide that says, on the left side, this is fraud, and on the right side, this is system complexity, and then deal with system complexity as it is and just, you know,

everything people have discussed, but be able to differentiate in a very clear way what fraud is and then to deal with what system complexity is, and then how do you address system complexity on its own, standalone from getting conflated with what fraud is.

I think the hospital down the street from me, it's an urban hospital, but they don't choose who comes to the door, and everyone comes through that door. And I don't think what we do -- if you don't talk enough about underinsured people, we always, you know, say uninsured. But a vast number of the people, so many people, they're underinsured, and they just -- their insurance is not going to cover the bills. And so hospitals have to absorb that as well. And so how do we make sure that we're talking about the system complexity and all the hospitals have to do to retain all the things, all the folks who walk through the door, and just folks who are -- folks who are immigrants, whatever they may be, but also those underinsured folks as well, as well as the uninsured.

I don't think we'll be able to do that and not do that, the difference between underinsured and uninsured. It's a huge issue.

CHRIS PARK: Yeah, certainly, you know, certain Medicaid payments can be used, like DSH, to, you know, deal with uncompensated care for both uninsured and underinsured.

COMMISSIONER DENNIS HEAPHY: Distinguish between underinsured and uninsured. Just to give folks a sense of what a high percentage of folks in this country have insurance, but it doesn't cover what they need. And therefore, it's being covered by Medicaid.

CHRIS PARK: I'm not sure. I'd have to, like, go back and see if there are any data on if people have estimated underinsurance. I'm not fully aware of that at this moment, but there might be.

COMMISSIONER DENNIS HEAPHY: Thank you.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Tricia?

COMMISSIONER TRICIA BROOKS: Thank you.

And Dennis brought up the word "fraud." There's been a lot of talk that there's significant fraud, waste, and abuse in the Medicaid program, and I think this is an area where MACPAC could spend some time investigating program integrity efforts, what kind of recovery we make

when there is fraud identified.

We know that the majority of fraud are bad actors in the provider community, and there's negligible evidence of individual fraud. And so we need to better understand this to really, you know, dispute the fact that there are billions and billions or trillions of dollars in fraud, waste, and abuse.

Are there inefficiencies? Absolutely. We've grown the house by adding additions, and we forgot about that hallway we needed to get to the room. So there are things we could do to improve Medicaid.

One other point, something came up about outcomes and quality and additional work that could be done to remind people of the impact on health, but not only on health, but also on financial stability for our low-income families and the ability to work. So those are all outcomes that come from Medicaid.

In fact, there's a tremendous amount of evidence that children who have Medicaid in childhood are healthier as adults, they do better in school, and they end up being more productive workers and earn higher wages later in life. So it's an investment in our future, and it's an

investment in trying to tackle those chronic diseases that are rooted in childhood. So I think those are two areas where MACPAC could add more value to the field.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Tricia.

Let's go to Patti and then Mike.

COMMISSIONER PATTI KILLINGSWORTH: Thank you so much.

Three, I hope, quick points. If you can go back to the slide on the PERM error rates and percentages. Not to minimize the importance of ensuring that Medicaid payments are appropriate, I think we all agree that that's critical.

But as someone who's sort of overseen people who are a part of this PERM audit process, when we talk about a lack of documentation, it is oftentimes a lack of access to that documentation in a timely way. And again, we're talking about sort of administrative complexity in terms of what you need to collect in order to prove that a payment was appropriate. So the amount has to be appropriate or units of service. The coding has to be accurate, so diagnosis code, procedure code, all of that. Medical

necessity has to be documented, which may include a history and physical. It may include a plan of care. It may include physician's orders. And all of these, you're trying to obtain from that provider who delivered that service within a specified time frame.

Specifically overseeing PERM for home- and community-based services, it oftentimes required that the service documented the person who delivered the services and the tasks that were performed during the course of that service. So we're talking about pretty detailed information that has to be obtained. Oftentimes, it's not that the service didn't happen. It's that long after the fact, it was very difficult sometimes to obtain in a timely way that documentation as proof. So the fact that the rate is as low as it is, I think it's a success.

I would also say, just to be really practical, right, if these payment mechanisms that states have long relied upon were to go away, the net impact is not, oh, states will pick up those costs, because they can't, right? Most states are operating under their own balanced budget requirements. They don't have the resources to be able to pick those up, which means one of a few things.

It almost certainly means that provider rates will be significantly reduced and with all of the implications that go along with that in terms of capacity to deliver these services to this population and to other populations who need it. But it may also well mean even more direct impacts to Medicaid beneficiaries.

So you have three levers, right? You have what you pay, who you provide it for, and what you provide for them.

In Tennessee, for example, the hospital assessment fee, in part, covers what would otherwise be a reduction of physician visits as well as inpatient and outpatient visits available to adult Medicaid beneficiaries, right? So if that assessment fee were to go away, those benefit limits would likely have to go into place, which would immediately reduce access to certain services for people, and we just need to be aware of that.

Ultimately, the third lever is who you cover, right? And so if you run out of options on the other two, you have to begin to look at the optional populations that you're covering under your program.

So as an entity focused both on payment and

access, you can't look at the two in isolation, right? And so I just want us to pay attention to that as this moves forward.

The third thing I'll say is just a quick statement. I, too, was born at a rural hospital, which is now closed. So those are just the real things that happen.

Thank you.

CHAIR VERLON JOHNSON: Thank you.

Mike?

COMMISSIONER SONJA BJORK: Thanks, Patti, for -- appreciate those comments. You always say it more articulately than I ever can about the impact of these payment programs.

I just wanted to just ask around the directed payments, and I'm just trying to refresh my memory on this, because there has been a substantial growth in these payments. And I'm wondering, do we have the ability to look behind the overall numbers to see what percentage of directed payments are for rates-related, for instance, to bring payments up to 95 percent of Medicare, what percentage of those payments are for quality, some of the quality improvements, because I think it's just important

to note that, you know, directed payments always get tied with provider taxes, but it's not always directly tied to provider taxes, right? Directed payments represent payments that are made through the managed care mechanism, system of delivery.

And then I guess the other question I have is -- and this is all in the interest of transparency -- is do we have a sense of how much of the directed payment shift or the increase in directed payments represents the move to more managed care in terms of the increase? And I'm just not sure we have -- I don't know if we have a view into that, Chris and Holly. I'm just -- but I wanted to ask that.

CHRIS PARK: Yeah, certainly. when directed payments first came about, MACPAC had done some work on the topic, and during some of the state interviews, they did indicate that this was a way to kind of shift more into managed care and take the supplemental payments that were making fee-for-service and kind of continuing them in managed care. So definitely some portion of that, you know, if managed care went away, they would still be making some portion of those payments in fee-for-service under,

like, the UPL program based on those historical kind of interviews.

We do have some ability to know what proportion of the directed payment arrangements may be just paying up to Medicare or other benchmarks. But that information isn't always provided on the preprints. Sometimes they may say that we're using Medicare or average commercial rates (ACR) as the benchmark, but they don't clearly specify this is 100 percent of ACR or 90 percent. You know, they just may be saying -- you know, demonstrating that it's below the ACR but not with a specific percentage amount.

With the managed care rule that went into place last year in 2024, CMS will no longer require a preprint if the state is just making a minimum fee schedule that requires the plans to pay 100 percent of Medicare.

So in the future, we may not know specifically if the states have that kind of minimum fee schedule arrangement in place.

COMMISSIONER MICHAEL NARDONE: Thank you.

Kind of argues for some of the points that have been made, I think, previously around transparency, around the directed payments, but I appreciate that.

CHRIS PARK: Yeah. On the flip side, I will say the managed care rule also puts into place more requirements of reporting directed payments into T-MSIS, and so, hopefully, once that gets implemented, there will be more transparency into -- at least even if the directed payment isn't specified directly, specifically in the claim, you know, we would at least kind of know the total payment made.

CHAIR VERLON JOHNSON: Okay. Dennis.

COMMISSIONER DENNIS HEAPHY: I've been adding oranges to the apples and oranges conversation, but we spent a lot of time on directed payments in the hospitals.

And what I'm wondering, I'm sure MACPAC has done this part maybe before my time, and that's looking at upcoding by payers and looking at denial of services that folks are actually eligible for under the Medicaid in this state and looking at, like, what does that look like? I mean, I just look at so many lawsuits, the AG's office in the states filed against payers because of denial of access to services.

We're on the behavioral health side. So I was wondering, have we looked at that side of what fraud versus

complexity of the systems looks like? I think it's a topic I want to bring up and see is that something that we have looked at in the past and to what degree. Chris, you would probably know better than anybody else.

CHRIS PARK: I'm trying to think if we've looked at that specific issue.

Certainly, you know, we have done different projects on access and -- you know, I'm just thinking about like last year, a couple years ago, kind of looking at the prior authorization process and denials and appeals and to what extent there are information like on what might be getting denied and what processes are in place to kind of understand how beneficiaries could appeal and go through the grievance process to get access to those services.

We haven't specifically looked at upcoding per se, but we certainly can think about ways to -- you know, it's been mentioned by Tricia as well, like to incorporate some more program integrity type of things into our work.

COMMISSIONER DENNIS HEAPHY: I'm just thinking if it's the same thing we've been doing here. One column says fraud, one says system complexity, and look into both and just investigate them and see. This is not fraud that's

been committed by the MCO, this is system complexity, or this is fraud, and that's like what we're doing -- yeah, across the system.

Probably glad I brought that up.

CHAIR VERLON JOHNSON: I think so.

All right. Any other? Okay. Jami? Thank you, Jami.

COMMISSIONER JAMI SNYDER: Hi. I just had a quick technical question. And, Chris, you just alluded to it with the managed care, the finalization of the managed care rule last year. They did say set the payment rate for state directed payments at the average commercial rate. It sounds like -- well, I guess my question is, have we done an analysis on the impact to states if it was set at Medicare? It sounds like based on what you were talking about earlier that maybe that's not possible at this point, given the lack of detail in the preprints. Is that right?

CHRIS PARK: Yeah, I think we do have some information about what states have identified that they're using the ACR as the benchmark, but we don't necessarily know always at what percentage that is.

Yeah. So I think there may be ways within

certain states and arrangements we could kind of back of the envelope do that, but, you know, it's also kind of hard to know specifically what the underlying service mix is as to like what Medicare would have paid for those particular services.

But there are various -- like, I think CBO has aggregated information of studies on how much ACR is compared to Medicare, and certainly, you know, it's a pretty significant amount above Medicare.

CHAIR VERLON JOHNSON: One last time?

[No response.]

CHAIR VERLON JOHNSON: All right. Well, clearly, this was very interesting and helpful for all of us, and we appreciate you and Holly. You did a great job. Welcome, and we're glad you're here.

All right. So, with that, I'm going to turn it over to Bob.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman. Again, I want to echo the thanks and sentiments to both of our groups this morning on Medicaid and the facts and figures.

Next, we're going to talk about one of those

populations that this program covers, and that's our children and youth with special health care needs. And this is a follow-up to the work that's been taking place over the last couple of years as we look at transitioning into adulthood.

The team has looked at the feedback we've given over the last several meetings. They're coming forth with us today to walk through four recommendations. They ask, as you look, to make sure that our feedback was incorporated, because we'd like to bring this back to the group tomorrow as a vote on a package of all four recommendations.

And with that, I'll turn it over to the experts, Linn and Ava. Thank you.

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

* LINN JENNINGS:

Well, good morning, Commissioners.

Today Ava and I will review our draft chapter, which includes four recommendations that the Commission will vote on tomorrow morning as a package. And so since we've presented these materials before, the chapter review

will focus on providing high-level overview of each section in the chapter and highlight key information related to the recommendations.

I also want to note that in past meetings, Commissioners have raised a number of specific issues to be addressed in the chapter and recommendation rationale, including the importance of identifying adult providers, prior to transitioning out of pediatric care, the challenges with navigating multiple, simultaneous transitions, and questions about data availability and gaps in data collection related to the transition of care process and the health outcomes. And so all of these issues may not be addressed in our high-level presentation, but they are addressed in the chapter text and in the recommendation rationale.

So we'll start with a brief background, and then we'll highlight current federal requirements and the state Medicaid and Title V rules in supporting these transitions, and then we'll review the challenges before turning to our recommendations.

Almost one in five children have special health care needs, and almost half of these children are covered

by Medicaid. Children and youth with special health care needs can also receive services and supports from Title V agencies.

And as children and youth with special health care needs approach adulthood, they need a transition from pediatric to adult care, and this is a multi-step process that often begins several years prior to transitioning. And research shows that individuals who receive structured transitions, which includes a transition of care plan, have better health outcomes.

However, findings from our analysis of the National Survey of Children's Health indicates that many of these children do not receive transition services or a transition of care plan. And although there are these known challenges with this process, there are few data sources that collect information about this population, and even fewer that collect consistent and comparable data for assessing the size of the transition age Medicaid covered children and youth with special health care needs population, those who have a transition of care plan, how many transition to adult providers, and their health outcomes and service use after the transition to adult

care.

Medicaid statute and its implementing regulations do not include requirements for children and youth with special health care needs transitions from pediatric to adult care. There are, however, expectations for states to provide transition planning for beneficiaries enrolled in Section 1915(c) waivers with age limits.

There are also certain provisions of the managed care rules that address issues related to access to care for beneficiaries with special health care needs across the lifespan, but these provisions don't directly relate to child to adult transitions of care.

CMS has also published some guidance related to these transitions. For example, recent EPSDT guidance specifies that care coordination and case management can be used to facilitate the development of a plan to outline the transition process to appropriate providers and services.

And state Medicaid and Title V agencies both serve children and youth with special health care needs, and they are required to coordinate with each other. Each state Medicaid agency must describe a cooperative agreement with the state Title V agency, called an interagency

agreement, or IAA, and the IAAs must specify certain information related to the roles and responsibilities, but there aren't specific requirements related to the roles and responsibilities with the transition of care for this population.

State Medicaid agencies have the flexibility to define their own transition of care strategy, and in these next couple of slides, I'll highlight some of our key findings from our state policy scan and state stakeholder interviews.

State Medicaid agencies and MCOs both have a role in identifying and notifying those approaching transition age and specifying who is responsible for providing these transition services. Almost all states include some information about transition planning and their age-limited waiver applications, but the transition planning procedures vary in their specificity.

Many states include provisions in MCO contracts related to transitions of care for this population, but few include provisions to specify who is responsible for the transition of care and the development of transition of care plans.

There are no federal restrictions on states covering services to support transitions of care, and these services may be provided through a state plan or waiver authorities. However, states may not always be aware of how to cover them through these existing authorities or which existing CPT codes may apply.

CMS doesn't require state Medicaid programs to collect or report data related to transitions of care for children and youth with special health care needs or their health outcomes, so most states do not. However, some state agencies and MCOs may collect quality data that captures some information related to this population.

And state Medicaid agencies are required to establish IAAs, as I said earlier, and are not required to specify specific roles related to the transition of care. In our review of all IAAs, four states included information related to the transition of care.

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

First, there's no federal requirement for states to document or publicly communicate their transition of

care strategy for children and youth with special health care needs, and findings from our family advocate interviews and beneficiary and caregiver focus groups indicated that beneficiaries and their families found this process confusing and frustrating because they were often not provided with clear expectations about their transition of care. They were unable to locate state resources or documented state strategy with explicit steps and were unaware, in many cases, of who was responsible for supporting them through this process.

Second, there's no federal requirement for states to develop a transition of care plan for each child with special health care needs, although research does show that these plans are important.

Beneficiaries and families that did have transition of care plans shared that these plans were helpful if they laid out specific steps, including addressing how to identify adult providers, and if these plans were updated as the child aged and their needs changed. However, many did not have transition of care plans, and even some of those who did have a care plan said that their plans did not address many of these steps.

Third, there's a lack of guidance to states on coverage of services to support the transition of care, and through our work, we found that some states do cover transition-related services using existing authorities, but there was a lack of awareness by states in how to use these authorities.

Additionally, there's a lack of data collection on transitions of care. There's no federal Medicaid requirement to collect these types of data, and state Medicaid agencies generally do not collect data about children and youth with special health care needs and their transitions.

And findings from our work indicate that there is a need to collect these types of data to understand how state transition of care strategies serve this population, if there are gaps in access and services, and the effect of transitions on health outcomes.

And finally, there's a lack of cross-agency coordination between state Medicaid and Title V agencies, and due to this, few state agencies coordinate on transitions for this population, and there aren't always clear expectations around which agencies are responsible

for supporting them through their transition.

And I'm going to hand it off to Ava to present the recommendations.

* AVA WILLIAMS: Thanks, Linn.

I am going to go over the recommendations and rationale. The recommendations and accompanying rationale and implications are largely the same as they were from our last meeting. So I'll be highlighting what the chapter discusses.

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 of care plan, time frames for the transition, and making the state strategy publicly available.

This recommendation has a minimum population that includes children enrolled in Medicaid through SSI, the Katie Beckett eligibility pathway for children with disabilities enacted under the TEFRA authority, those enrolled in a Katie Beckett waiver, and those 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 the children, youth with special health care needs population, delivery system, and program design. The chapter notes several considerations for states when developing their strategies, such as expanding on the minimum population detailed in the recommendation; leveraging existing frameworks for transition, for transitions as a foundation for their strategies; engaging and soliciting feedback from stakeholders, beneficiaries, and their families when developing their strategies; the importance of engaging adult providers in the transition process as well as reviewing and updating the care plans on a routine basis.

As a reminder, the implications for each recommendation are largely the same as they were in our February meeting. The Congressional Budget Office does not estimate there will be a direct effect on federal spending. 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 need -- sorry. Beneficiaries and their families would have a better understanding of the state's transition strategy and expectations for their own transitions. Plans would have a better understanding of the state's transition strategy and expectations for how they should support this population during their transitions. 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 states on existing authorities to cover transition of care-related services for children and youth with special health care needs using the same minimum population as in the first recommendation.

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 TCM and the EPSDT benefit.

The chapter also notes that CMS should consider addressing how states can cover warm handoffs, same-day

visits between pediatric and adult providers, and other activities that facilitate transitions.

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 and would need to make payment policy changes.

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 and engage with children and youth with special health care needs earlier in the transition process.

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 experience with transitions of care.

This recommendation is focused on improving data

collection and reporting related to the transition of care process, including 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.

The chapter includes considerations for CMS in implementing this recommendation. For example, CMS should solicit input from stakeholders, including beneficiaries and their families, on what information would be most meaningful to collect to better understand this population and their transitions of care. CMS should also leverage existing data collection activities to prevent duplicative efforts and consider collecting information related to the adult system after the beneficiary's transition.

Additionally, the chapter acknowledges that evaluating health outcomes for this population is challenging, and more work is needed to develop meaningful health outcome measures that capture information about the experience during and after the transition to adult care. There would be no direct effect on federal spending.

Depending on the extent to 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 and their families' experience with transitions and, in turn, how to improve transitions.

Similar to the state implications, depending on to the extent current data collection is leveraged, plans may not have to make changes to their collection efforts, and providers may have new reporting requirements related to the receipt of an individualized transition plan and gain a better understanding of this population and their transitions.

The last recommendation states that the Secretary of HHS should direct CMS to require that state Medicaid agency IAAs with state Title V agencies specify roles and responsibilities for supporting children and youth with special health care needs transition from pediatric to adult care and that the state Medicaid agency role described in the IAA should reflect the state's transition strategy.

This recommendation focuses on requiring state Medicaid agencies to specify in their IAAs with Title V which agency is responsible for providing which 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 and collaborating with other agencies that provide services and support to children and youth with special health care needs, such as departments of developmental disabilities and education agencies.

While most implications are the same, the plan implications were updated. 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. Plans may need to collaborate with, collaborate and coordinate with state Title V agencies on services and supports for this population's transitions, and providers may experience changes to their roles in supporting children and youth with special health care needs during their transitions.

Today we welcome Commissioner feedback on the

draft chapter, and with that, I'll turn it back to the Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Ava. Thank you, Linn. Again, appreciate the great work that you've done in taking our feedback.

Now I'll open it up to my fellow Commissioners. So I'll go to Angelo and then Patti.

COMMISSIONER ANGELO GIARDINO: Again, I'm just so thrilled that you've taken this initiative on, and as someone who has been in pediatrics for 35 years, it's just wonderful to see health care transition from pediatrics to adult care really moving from an initiative and a project to really viewing this as an element that's essential to optimal care.

And as a pediatrician who loves the children that I take care of, we never want them to just stay in the pediatric setting because that's not right for them. You know, we want them -- in all the domains of their life, we want them to make the transitions they're supposed to make.

So to me, it's like essential to do this because of the investment that we've made in the child, and now they're ready to take that next step. So if you've ever

done any gardening, you know that you may start the seedling in the greenhouse. Yes. But you would never keep the plant that you started early in the season in the greenhouse throughout the summer, because it would be constrained, and ultimately, it would not do well. And it's really important when the time is right, you pay attention to the weather, but then you do move the little plant that you started in the spring to the flower bed, and then in the summer it flourishes. And that's what this is about.

And this is not a cool project. This is part of essential, optimal health care, both in the primary care and specialty care. The problem is, a lot of us don't know how to do this, and we don't know how to do it systematically. And what you're proposing is kind of the structure that we need in this phase of our development to move it into regular practice so that it happens for all the kids that we're taking care of and not just the ones that are lucky enough to live in a state or a community that is invested in health care transition individually or independently.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo. I appreciate now with our dream home, we have our little gardening, and Linn and Ava have laid out the gardening plan. So thank you.

With that, Patti.

COMMISSIONER PATTI KILLINGSWORTH: Linn and Ava, thank you for your excellent work, and the draft chapter is very good. So I appreciate that so much.

I am not nearly as skilled as my fellow Commissioner, Angelo, in coming up with great analogies, but I do think this is an area where an ounce of prevention is worth a pound of cure, right? And being on the front end of really doing this well will have significant impact, not just on the experience of care, but I believe on the health outcomes and the ultimate cost to the system as well.

So it is moving from good idea to good project to really good policy, right? And how do we take everything that we've learned and really make it a part of how we do things going forward?

The only comment I'll make with respect to kids in 1915(c) waivers, while I appreciate the fact that there

is an expectation, a requirement that they talk about transition when those waivers have age limits, as a practical matter, given the fragmented nature of how those waivers are typically delivered sort of by entities separate and apart from who is responsible for physical care and behavioral health care, that coordination rarely takes that continuum of needs into account, rarely provides for meaningful coordination and continuity of those physical and behavioral health care services. So even for those kids, there really is a need for a much more comprehensive strategy.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks.

Thank you very much for the recommendations. These are awesome.

I just think something that may be striking in the chapter is how the next step is really to look at how well prepared the system is for these children.

And, you know, Angelo would not put those little plants out if there were tornadoes every day or there was

not enough sun or whatever, that he'd keep those plants in that greenhouse. And I'm thinking of a two I know with hydrocephaly, and one, because I had the original shunt put in in a Children's Hospital, was I would go back as an adult and get that done, get a surgery and have it done again. The other person, though, she had to go to another hospital, and the folks don't have the level of expertise that the folks in the Children's Hospital have. And so the shunt was put in place. It just seems to be fine, but the symptoms are still continuing, and there's no one for her to really talk with who understands the trajectory of hydrocephaly and what happens with shunt over time.

And so I'm just saying, like, as we're looking at this, we also have to look at how do we strengthen the adult system to ensure that it's actually got the capacity and the interest in providing services for this population.

And the last thing I'll say about this is, I know a woman who's got a couple of kids with disabilities, and they're not major disabilities, but the doctors, the pediatricians, don't want to go near them. Kid has got a cold, and the pediatricians, no, take them into the Children's Hospital. No, no, no, like, the kid's got a

cold. He doesn't need this. And so how do we ensure that providers, in their training or whatever it may be, understand that they're actually -- they're treatable, all adults, regardless of what kind of disability they may have or don't have.

So it's all great that we're doing and putting this in place, but make sure there's something there for them to go into, because I think is the next step.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Madam Chairwoman?

CHAIR VERLON JOHNSON: I just really like you calling me that. Thank you so much.

I just have to say thank you both for really getting us to this point. I really feel like our recommendation is very strong. I mean, it really covers all the different areas that we wanted it to. I think it's very thoughtful, it's multi-level in terms of intervention. The structural part is taking care of operation and all of that, and so just wanted to say thank you for really helping us to really get to a place where we think that we can actually move the needle a lot on some of these issues here.

And the other piece of it too is that you brought us some caregivers, we heard their voices, and I can definitely see that reflected in the chapter and just want to say thank you for that as well.

So I am very excited about all the work that you've done, that you've helped us to get here on this and voting on this tomorrow. So really appreciate your work.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman.

And back to you, Dennis.

COMMISSIONER DENNIS HEAPHY: Yeah, I apologize if I missed some of the chapters.

There's emphasis on disparities in the transition planning process, and I know the schools do a great process and the families are really engaged. They're educated and understand what the rights are, and then you go to a low-income school and primarily minority school, and parents who are not speaking English or they're working. The complexities of engaging the transition plan and understanding the rights is very challenging, both of the kids are on Medicaid and should be on Medicaid, but the family context is so radically different.

And so I think as you're looking at this, is there a way for us to actually track disparities that may occur both in the transition planning process and in the outcomes?

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Carolyn?

COMMISSIONER CAROLYN INGRAM: I just have one technical question that I just keep getting stuck on when we cover these things so you'll have to clarify for me. Are they called the "Katie Beckett pathways" in the CFR? Why do we use that language? I'm not familiar with it in states that I work with, but if it's actually federal terminology, I understand keeping it in there.

LINN JENNINGS: Yeah. So I think my understanding is states use a variety of different terms. So there was like Katie Beckett prior to TEFRA, and so some states I think have kind of continued to use that terminology. And so some states may still have kind of a Katie Beckett waiver prior to TEFRA, but most transition to a state plan option, but some transition to having kind of what they call like a Katie Beckett-like waiver, which is a 1915(c) waiver that emulates, I guess, the Katie Beckett

eligibility pathway. And so some states may call it a TEFRA program or a TEFRA waiver or Katie Beckett. And so I think we, in the chapter, tried to emphasize that there are a number of different ways that this is named, maybe by states, but that's kind of the historical context on that.

COMMISSIONER CAROLYN INGRAM: Yeah, the states that I've worked with, they just call them "home- and community-based waiver services, and so that's where I guess I struggle with keeping Katie Beckett in there. But if that's what others use, I guess it's fine to do that.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you.

Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: If not, I echo the sentiments of the great job you've done on this. I appreciate it. Look forward to bringing this back tomorrow for a vote on all four recommendations.

And with that, I'll turn it over for the Madam Chairwoman to open this up for public comment.

CHAIR VERLON JOHNSON: Okay. so with that, let's go ahead and open it up for public comment. We do invite

everyone in the audience to raise your hand if you would like to offer comments. Please make sure you're introducing yourself and the organization you represent, And we do ask that you keep your comments to three minutes or less, please.

So with that, let's see if we have any comments.

All right. So it looks like Richard.

PUBLIC COMMENT

* DR. RICHARD ANTONELLI: Yes. Can you hear me?

CHAIR VERLON JOHNSON: We can hear you, yes.

DR. RICHARD ANTONELLI: Hi. This is Richard Antonelli, a general pediatrician with four decades of experience taking care of children and youth with special health care needs, medical director of Integrated Care at Boston Children's Hospital.

In my clinic, I see 30- and 40-year-old people. They're there not just because I'm handsome or especially smart. It's because getting these folks with complex needs across the bridge to adult care is challenging, and so I serve in that humble capacity.

I want to commend the Commission and in particular the staff that put this chapter together, this

draft chapter so far, for your bold vision, for your dedication to making this journey more safe, more efficient.

None of this has to be blue sky or aspirational. In fact, I think paying attention to the folks that are crossing that bridge from child to adult care, we already have a really good idea of what needs to happen. Some of the barriers that exist around knowledge of the care teams, the ability of patients to advocate for themselves, we need to do better.

I appreciate Angelo's gardening metaphor, but I also agree with Dennis Heaphy's knowledge. On the adult side, it's challenging for everybody, especially if you have complex needs. So I view this set of recommendations as a great next set of steps.

I'm an advocate for measuring what's important, and I would love to be able to watch this continue to evolve. So my sincerest gratitude to the staff and in particular to the Commissioners for taking on this issue. I see this as a start, and then I look forward to see what's coming next. So thank you very much, everybody.

CHAIR VERLON JOHNSON: Thank you so much,

Richard.

We'll see if there's any more comments.

[No response.]

CHAIR VERLON JOHNSON: All right. Seeing none, I do want to remind you that you can submit any additional comments to our MACPAC website at any time

With that, we will go to lunch now, and we'll return at one o'clock. Thank you.

* [Whereupon, 12:02 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

VICE CHAIR ROBERT DUNCAN: All right. I'd like to welcome everyone back for round two on this Thursday.

We have Tamara here to talk to us about timely access to home- and community-based services. So she'll provide a background on the level of care determination and has been doing some environmental work and interviews with stakeholders, and so she's going to share that. We ask that the Commission think about feedback on that and areas of exploration as we move further in this work.

So it's all yours.

TIMELY ACCESS TO HOME- AND COMMUNITY-BASED SERVICES (HCBS): LEVEL OF CARE DETERMINATIONS AND PERSON-CENTERED SERVICE PLANNING PROCESSES

* TAMARA HUSON: Well, thank you, and good afternoon, Commissioners.

So I am going to present an introduction to our follow-on work to timely access to HCBS, which is focused on aspects of level of care determinations and person-centered planning processes.

Today I'm going to take you through some

background on these two processes as well as some preliminary findings from interviews that we conducted with state officials.

I'm sure that this slide looks familiar to many of you, but I do want to spend a few minutes talking through the eligibility and enrollment process for individuals that are seeking HCBS, since this work focuses on different areas than the first phase of our timely access work.

For an individual that is newly seeking Medicaid coverage for HCBS, the first step in the process is for the individual to complete a Medicaid application. And while for many groups of Medicaid beneficiaries, such as children, pregnant women, or parents, eligibility is determined using Modified Adjusted Gross Income standards, or MAGI standards for counting income and household size, eligibility for individuals that are seeking HCBS is more involved and has additional requirements. Such individuals are part of what we call "non-MAGI groups," and they have to meet both financial eligibility and functional eligibility criteria. Financial eligibility for these non-MAGI groups includes both income and assets. Also,

individuals seeking HCBS must be functionally eligible, which is determined using an assessment tool. Functional assessment tools are sets of questions that collect information on an applicant's health conditions and functional needs. There's a range of different assessment tools that states use, and MACPAC has previously published work on these tools.

I also want to clarify for this presentation that when I refer to the assessment, I will call it both a level of care assessment and a functional needs assessment, but this is the same thing, and these terms are interchangeable.

Okay. So then the second step in the process is for the state Medicaid agency to make the eligibility determination, which again is based on the person meeting both the financial and functional eligibility criteria that is set by the state. States have up to 90 days to make an eligibility determination for non-MAGI populations. Then if the person is approved, they can be enrolled in an HCBS program, which is step three. However, as you know, there must be a person-centered service plan in place, or a PCSP, before the enrollee can start to receive services. And

then, finally, I'll just note that there is an annual reevaluation of financial and functional eligibility and a review of the PCSP.

The two inputs for today's presentation are from our environmental scan and from interviews. As you'll remember, we contracted with the Lewin Group to conduct an environmental scan of all approved Section 1915(c) waivers, Section 1915(i) and (k) state plan amendments, and Section 1115 demonstrations for all 50 states and DC, as well as other relevant resources. Part of the scan captures how states administer their level of care determinations and develop PCSPs.

We did present last April of 2024 on the findings from the scan, and we also published it and an accompanying policy in brief on our website in August of 2024. Today I'll be reiterating some of the findings from the scan.

Then the second part of today's presentation draws from interviews that we conducted last summer with officials in seven states.

So let's start with level of care determinations. To be eligible for HCBS, individuals generally must need a level of care equivalent to that provided in an

institution. So that could be a nursing facility, a hospital, or an ICF/IID. States specify the required level of care criteria in each of their HCBS programs, and this commonly differs by population.

For example, programs serving older adults typically require a nursing facility level of care, compared to programs serving individuals with intellectual or developmental disabilities, which typically require an ICF/IID level of care.

The level of care determination, which includes both conducting and approving the functional needs assessment, may be made directly by the Medicaid agency or another designated state government agency. And so this next slide shows what type of entity conducts and approves a level of care assessment for at least one HCBS program in a state or in D.C.

In some states, two different entities will conduct and approve the level of care assessment, while in others it's the same entity, and a state Medicaid agency may delegate the authority to determine eligibility to another state agency or entity, as long as it exercises appropriate oversight over the eligibility determinations

and appeals decisions.

Level of care assessments can be conducted in person, by phone, virtually, or by record review. So of the 47 states and D.C. that reported an assessment method in our scan, all states offer in-person options, 19 also allow phone or virtual options, and 32 use record review in one or more HCBS program. And record review is always combined with another assessment method.

States are also required to reassess participants no less frequently than annually, and they have to demonstrate through annual reporting that this requirement is being met for at least 86 percent of enrollees, but I will note that the access rule increases this to 90 percent.

Sorry. My slides got messed up here.

Okay. Moving on to person-centered service planning processes, all states use PCSPs to identify the services and supports that a person needs to live in the community. The purpose of person-centered service planning is to empower individuals to build a life they choose or aspire to at any age across their lifespan. PCSPs, among other purposes, are intended to identify the individual's

goals and desired outcomes and reflect the services and supports, paid and unpaid, that will assist the individual to achieve them.

For example, PCSPs may document the supports available for an individual's goals around employment, community engagement, and wellness. They should also reflect the individual's strengths and preferences, as well as risk factors and measures in place to minimize them.

Requirements for the person-centered planning process are described in regulation, and I've listed them on this slide and on this next slide for your reference, but I'm not going to read through all of them right now.

States set their own timeline requirements for completing the PCSP. Our scan found that most states require the PCSP be completed within 30 to 45 days of enrollment. Again, there are no federal timeline requirements for completing an initial PCSP, but CMS does require that states demonstrate that they're monitoring PCSP development in accordance with their state policies, and that they report annually on this measure in their CMS-372 reports.

States are also required to review and revise as

appropriate the PCSP at least every 12 months, which is what most HCBS programs do. Some states have shorter time frames, such as six or even three months, and ten states use other timelines.

Again, I'll also note that the access rule requires that states review and revise as appropriate the PCSP at least every 12 months for no less than 90 percent of individuals continuously enrolled in the waiver, and this applies to all Section 1915 HCBS authorities and will be effective beginning July 2027. And states will have to report annually to CMS on the percent of beneficiaries for which the PCSP was updated.

PCSPs should be developed at times and locations convenient to the individual and should include any other individuals who have been invited by the participant. With the exception of two states that did not report an assessment method, our scan found that all states use in-person meetings and half of states also allow phone or virtual options.

A number of different types of professionals are responsible for PCSP development, such as case managers or nurses, and states frequently allow more than one type of

professional to lead the PCSP development. There is no federal requirement that medical professionals must be responsible, but sub-regulatory guidance states that their qualifications should be reflective of the nature of the program's population.

PCSPs must be signed by the enrollee and the providers responsible for its implementation. This may be done using a written signature or an electronic signature. Our scan found that 33 states permit the use of e-signatures.

Now we're going to turn to findings from our interviews, and we'll start with level of care determinations.

State timelines for making level of care determinations largely depend on the state's policy decisions and operational practices. Among the seven states that we spoke with, timelines ranged from 2 days to 60 days. In some states, shorter timelines were in place for individuals in emergency or crisis situations or for individuals transitioning from specific settings.

Programs serving individuals with complex needs and high acuity may have longer timelines, such as 30 or 60

days, to allow for time to collect and review medical records and other documentation.

Most states said that they are generally able to complete their determinations within the stated timelines. The majority of state officials said that an adequate workforce, so having enough case managers, social workers, or nurses, is a key reason that states meet their timelines.

Two state officials also noted that sometimes they're waiting for information from doctors' offices or they need to do follow-up calls with the individual's medical provider or with the individual or their caregiver.

In some programs as well, states require a physician's signature, and that can delay the determination, and then in a few select state programs, there's also a slight delay because of a two-step review process in which one entity conducts the level of care assessment and another entity then reviews and approves it to make the final determination.

But despite all these potential barriers, state officials generally conveyed that they complete their level of care determinations timely.

State officials agreed that virtual level of care assessments are an appropriate alternative to in-person assessments in some circumstances and for some populations but generally preferred to do assessments in person. Officials expressed a number of reasons for using virtual assessments, including use in crisis situations, in rural areas, and when the individual or other household members are sick.

Some officials also spoke about virtual assessments being less intrusive and disruptive and how for specific populations, doing it virtually may allow for greater comfort and flow of conversation.

One official also noted that virtual assessments led to a reduction in rescheduled appointments in their state.

However, state officials noted that doing assessments in person is considered the best person-centered practice. A number of officials noted it can be hard to assess ADLs and IADLs without seeing the person in their physical environment.

Officials also said assessing health and safety risks is easier to do in person as well as the need for

services such as home modifications. A few state officials also noted that beneficiaries do not have universal access to or are comfortable with technology or might have internet access.

Finally, while state officials agree that in-person assessments are best for the initial level of care assessment at the time of eligibility, some states allowed for reassessments and monitoring to be done virtually. And then, finally, the states we spoke with all had a clear understanding of federal level of care policy and guidance. States have long established practices and procedures in place for conducting their level of care assessments.

Now turning to findings around person-centered service planning processes. Similar to the level of care timelines, state timelines for completing the initial PCSP largely depend on the state's policy decisions and operational practices. Most states that we talked to had a timeline of either 2 weeks or 30 days, and they talked about how information from the level of care assessment flows into the PCSP, which helps to expedite its creation.

The PCSP, however, requires additional information, such as the specific services and amount of

services authorized for the individual and information related to the person's preferences and goals.

Also similar to the level of care assessment timelines, we heard how the amount of time it takes to complete the PCSP depends on the available workforce and on the enrollee schedule. State officials likewise noted that PCSPs are generally completed within the stated timelines or sooner.

The states that we spoke with that have the shortest timelines tend to be those that complete the level of care assessment and PCSP, or begin working on it, together at the same meeting. An official talked about how it can be very difficult to separate the two pieces when meeting with the individual and how the level of care assessment ties into the development of the PCSP.

States had very similar practices for using virtual meetings to develop the initial PCSP as they did for the level of care assessments, stating that the preference is to conduct meetings in person. States used virtual meetings during the PHE and continue to do so in a limited capacity, such as for emergency situations or when members are sick.

Three states, however, noted that they use virtual or phone options to update the PCSP annually or throughout the year.

State officials were also generally supportive of using e-signatures on their PCSPs, as it has improved efficiency for both states and enrollees. Six of the seven states that we spoke with used e-signatures. In one state that's been using e-signatures since 2015, they shared that nearly 100 percent of PCSPs are signed this way, and they saw an improvement in efficiency. Then the one state that is not currently using e-signatures noted that they discussed the option, but that it would require an investment in technology, and they had other competing state priorities.

We asked the states that do have e-signatures about the investment in technology, and two states noted that they had to make an initial investment to implement its use, while two other states said they were able to leverage existing technology and licenses.

Finally, states noted that not all populations may be comfortable using e-signatures or have the technology required for its use. And then, finally, again,

similarly to level of care, states largely understand the flexibilities available to them to design their person-centered planning processes.

Again, states have longstanding policies and procedures in place dictating how the PCSP is developed. However, two state officials noted particular areas in which they would like more guidance. One state official spoke of a need for additional guidance on remote versus in-person monitoring requirements, and then a different state official said they would like some more guidance around e-signatures.

I'm going to wrap up with some next steps. I'm happy to answer any questions on the material that I just presented. It would also be helpful to hear if there are particular areas that you would like to see explored in our upcoming interviews this summer with experts and federal officials, and then we will return in the fall to present findings from those additional interviews that we conduct over the summer.

With that, I will turn it back to the Vice Chair. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Tamara.

All right, Commissioners. Patti.

COMMISSIONER PATTI KILLINGSWORTH: So, Tamara, thank you so much for this work. I think it's really important.

Can you go back to Slide 4 for me, please? Because there's just some things I want to be sure we sort of understand at a very practical level.

If we look at that lovely little diagram, I want to point out that step one has two parts and that those two parts are typically linear, at least in terms of the eligibility determination, because in order to apply institutional income standards so that people can qualify when they're receiving home- and community-based services, they have to meet the level of care requirement and will be actually enrolled into an HCBS program upon that financial eligibility determination. So there's kind of like two parts there, each of which has their own timelines associated with it.

For my own edification -- I hope for the edification of others -- I try to apply a timeline to this little diagram, and so here's what that timeline would look like using the numbers that are provided in the deck.

Honestly, I used the max, right, because we all know that when there's a max, people tend to go to the max, and states were also really honest in saying, well, most of the time we meet it if we have staff capacity and if providers respond timely and all of that, but sometimes it's even maybe longer than that.

Step one, which would really kind of begin before you approve anything, is 45 days to complete the assessment process, and then to approve the assessment, another 30 days. Those were on Slide 9, I think.

Step two would be the financial eligibility determination which, as we've talked about before, states have up to 90 days to do that financial eligibility determination for people with a disability or people who are seeking long-term services and supports.

Then step three would be 45 days from Slide 14, again, the maximum time that they talked about for developing the PCSP.

Total all that up, and we're now at 210 days. That doesn't include actually implementing the services that are in the person-centered support plan which, from my experience, depending on the kind of service, can take

anywhere from 30 to 60 days or more if it's a complex service like residential services where you have to sort of set up a place for the person to live and hire the staff and all of those things.

We're talking about a group of people who by definition need an institutional level of care and, quite frankly, can go into the nursing home tomorrow and get retroactive coverage back to the date of admission once determined eligible. How many people are we losing in this lengthy process of making people eligible for home- and community-based services and in a way that, consistent with long-standing institutional biases in the regulation, does not allow the same standard to be applied to a person receiving home- and community-based services as is applied to a person seeking institutional placement?

One is retroactive to the date of application. The other won't begin until there's a plan in place for that person at the conclusion of this, maybe 210 days, maybe longer, right?

So, if we want to think about access here, we had a big problem, and it's not a problem that we're going to solve with kind of a few little tweaks around the edges.

It's just a massive problem when it takes more than half a year on average to get from, oh, I need home- and community-based services to I can actually have them in my home.

And I would love to tell you that my own experience bore out that that happens a lot faster, but I think some of those things don't happen a lot faster. Some of them can. Some of them quite frankly don't.

As you do the interviews with states, I think it would be super helpful to have a better understanding of what does their real experience look like if we go from date of application all the way to "I got a service," so that we really understand, because a lot of those pieces of data aren't transparent to us. When you look at claims data, I can tell from the date of eligibility or enrollment into the program to the date of the first service, but I don't know anything that happened before that and how long that process actually took.

So kind of understanding what that looks like, I think would be really helpful, understanding what are the barriers that keep this stuff from happening faster. Why does it take 90 days to make a financial eligibility

determination for someone? Once you've determined they meet the level of care criteria, why does it take so long to make that financial eligibility decision? How could we speed that up and really just focusing in on those opportunities to, again, not just make tiny little changes but to really make this entire process function much more efficiently?

Thank you.

VICE CHAIR ROBERT DUNCAN: Michael?

COMMISSIONER MICHAEL NARDONE: I just wanted to thank you, Tamara, for this.

I kind of wanted to follow a similar vein, but taking a little different way maybe where Patti was headed is I was trying to understand, just from my experience, what were -- and I think -- what were the real barriers to getting people approved for HCBS services? In my experience, the financial eligibility piece, the sorting through all the income and assets really is the more -- is really, at least from my experience, one of the aspects of this that really takes a lot of time. So I think understanding if that's the case from the state perspective -- I mean, I think kind of Patti's comments about what is

the real-world timeline and understanding, like, what does this look like on the ground would be really helpful in trying to understand that.

I was under the impression that the financial eligibility and the functional eligibility could proceed at the same time, and I thought that's the way we did it in our state, in PA, but I think trying to understand that a little bit better is whether or not that actually is what's happening, or is it the sequence process? Because I think it's important to understand where you want to focus your energy in terms, of if we want to expedite this process, where is it that we want to put our energy, because last time we talked about expediting the PCSP, the provisional plans of care. And that's one tack, right?

Then the question is, well, what are the other real barriers and what are the steps we need to change those, and where do we really have to work and where should we put our priorities in order to shrink this timeline? So I think kind of understanding that would be really helpful.

The other just question I had -- and maybe this is for some of your discussions with the states -- where you have a two-step process where the level of care gets

approved by a second entity, kind of understanding why. Is it a kind of -- is it a kind of perfunctory process that, you know, they're just like -- you know, it's like a one-day and it's just they're checking a box, or is it a real, like, kind of what are they actually doing in that period of time? Or is it like they got the financial eligibility, have a functional eligibility, and now they're just making a check to say, okay, this person's approved? So understanding it kind of at a real ground level where the place is where this gets kind of hung up.

And I would think that one of the things that hampers the financial eligibility is a piece that is around, like, assets and kind of understanding are people inappropriately transferring assets to get LTSS? I mean kind of going through that whole process.

But, anyways, I think the real-world examples would be helpful along that line.

VICE CHAIR ROBERT DUNCAN: Thank you, Michael.

Dennis, then Patti.

COMMISSIONER DENNIS HEAPHY: Thank you.

I want to pull off a little bit of what Patti and Mike said, and I think there's a difference between the

eligibility determination and the planning. The planning can't be done in just that perfunctory way. You may be able to determine eligibility with a one-time visit, but to really understand what the person's needs are, it's more than just one. It's a process.

Obviously, you need to get the person set up for services right away. Like Patti pointed out, this timeline is just ridiculous, but what does it actually mean to create that plan of care? I think that's really important.

And I think it's also understanding the person's disability in the context of their environment, the international classification of functioning, what do you mean to actually assess a person's needs, because are they living in an inaccessible location, where they're going to need more services than they might need if they were in an accessible place? Are they living in a place where there's no access to transportation? All these different things are really taken into consideration.

There's often a push, I think unduly, on folks to know who exactly is there that will be available as an unpaid caregiver, and that seems to put a burden on other folks in the family that may actually not be appropriate or

fair.

Then just to sort of broaden it, if someone's been doing these assessments on a yearly basis for 25 years, do they really need to go through that assessment every year, or should it only be every two years or something, only based on whether or not the person's life has changed? It seems like it's really an administrative burden for the state to do these assessments, as frequently as they do them, and for the person.

So those are my initial thoughts. I have more. Is it only using a medical model in terms of determining what the person's needs are, or are they using an independent living framework as well, looking at what the person's goals are, their aspirations, and what do they actually need to achieve those things?

And then another one is folks may have a combination of mental health diagnosis and a physical disability, and maybe their symptoms may change at different points. So, with fibromyalgia, they may be having a really good day when that nurse comes to visit, but then the fibromyalgia comes in, and they can't get out of bed for three days. So, actually, what are they

assessing? The person at that moment? The person over time? What does that actually look like?

And then I'm looking at Tricia and saying the needs of kids, too, are very different than the needs of adults, and so how does that take into consideration?

CHAIR VERLON JOHNSON: Thank you, Dennis.

Patti.

COMMISSIONER PATTI KILLINGSWORTH: Just one point of clarification, Mike, to the extent it's helpful. The entirety of those processes in terms of eligibility determinations don't have to be linear, but the actual eligibility determinations do, because oftentimes -- I would say most of the time -- people who qualify financially for LTSS won't qualify for Medicaid in another way. They're not eligible for Medicaid unless they need home- and community-based services, which then allows the institutional income standards to be applied, a higher level of income, or to set up a qualifying income trust. It gives them a pathway to Medicaid that wouldn't be available to them otherwise.

So you can't -- you could determine that they don't meet all of the other categories, and that may be

happening simultaneously, but you can't determine that they do meet, right, or that they would qualify under the institutional requirements until you know that they meet the level of care requirements.

And I think as a practical matter, that's -- as you point out, it's not an easy process. So I think most states -- and I think this would be interesting to know in our conversations with the states -- don't go through that whole process of asset verification and all those kinds of things until you know level of care is met, and then they'll do the additional work to actually see if they qualify financially under that higher income limit and, you know, verify all the assets and look at transfers and all that kind of stuff.

So the determinations have to be linear. Some of the processes don't have to be.

COMMISSIONER MICHAEL NARDONE: I think just understanding that better would really be helpful, though.

COMMISSIONER PATTI KILLINGSWORTH: Yep, agreed.

COMMISSIONER MICHAEL NARDONE: I think that's to your point earlier.

COMMISSIONER PATTI KILLINGSWORTH: Agreed. Thank

you.

VICE CHAIR ROBERT DUNCAN: Dennis, back to you.

COMMISSIONER DENNIS HEAPHY: I think back to Michael's point about perfunctory, is there a perfunctory process in the assessment itself, and is it done by -- is it done by an AAA? Is it done by an independent living center? Who actually does that, the assessment, is really important. So it'd be helpful to know, how do they determine who's doing the assessment? Is it contracted out? Who do they contract it out to?

TAMARA HUSON: Yeah. So, in the environmental scan, we do have information on who's doing the assessment. So it's most often like case managers, nurses, social workers.

COMMISSIONER DENNIS HEAPHY: Where the nurse comes from may make a difference. So I understand the different skill levels, but where they're coming from makes a huge difference in how the lens they're using in determining what people's needs are.

TAMARA HUSON: Yeah. So, in the states that we spoke with, it was a mix. There were some states who contracted out with case management agencies, but then we

also had a number of states who actually had state staff. So they had nurses that were on staff, and those people were the ones doing the assessments.

COMMISSIONER DENNIS HEAPHY: Thanks.

CHAIR VERLON JOHNSON: Thank you. Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: So, Tamara, do you feel like you've got enough feedback to start exploring a little deeper?

TAMARA HUSON: Yes, I do. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you.

With that, I'll turn it back over to Madam Chairwoman.

CHAIR VERLON JOHNSON: Thank you. That was great. Appreciate it.

All right. So Melinda is making her way up, and we're going to turn our attention to turn our attention to MOUD and Medicaid. And we've been talking about this for a couple of months now, which has been really great, and so we know that Medicaid pays a substantial amount of treatment for OUD as well. We have a draft checklist coming up. So Melinda's going to walk us through that

draft chapter, and I caution all of you all to listen intently and to provide any feedback that's necessary or questions.

So over to you.

ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER (MOUD) IN MEDICAID

* MELINDA BECKER ROACH: Thank you, and good afternoon, Commissioners.

Today I'll be walking through a descriptive chapter on access to medications for opioid use disorder and Medicaid, which we plan to include in the Commission's June report to Congress.

MACPAC undertook efforts to examine access to MOUD in light of Medicaid's role as a major payer and source of coverage for individuals with opioid use disorder as well as persistently high rates of overdose death related to opioid use.

The draft chapter presents findings from that work, drawing on stakeholder interviews and an analysis of Medicaid claims data and identifies areas for future Commissioner consideration. It starts with background on MOUD, followed by a discussion of recent Medicaid and non-

Medicaid policies that have affected access to MOUD.

Next, we discuss MOUD coverage and present estimates of MOUD use, including how the benefit mandate -- and specifically additional coverage for methadone -- affected utilization.

We then discuss three barriers to MOUD as identified through our work. These include social stigma, provider availability, and utilization management practices, such as prior authorization.

The chapter ends with a discussion of the Commission's plans to further investigate the use of utilization management practices and how they affect Medicaid beneficiaries' receipt of timely and effective care.

The FDA has approved three types of MOUD: methadone, buprenorphine, and extended-release injectable naltrexone. These medications 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.

There are important distinctions between the different types and formulations of MOUD as well as varying

federal rules for prescribing and dispensing each medication. For instance, methadone, when used for the treatment of opioid use disorder, can only be dispensed at federally regulated opioid treatment programs, commonly referred to as "OTPs." Typically, patients must travel to an OTP to receive their medication on a daily or near-daily basis.

In contrast, buprenorphine and naltrexone can be prescribed or administered, in the case of injections, in a variety of settings, including by office-based providers.

Congress and federal agencies have pursued a variety of policies to improve access to MOUD in recent years. Those specific to Medicaid include the requirement that Medicaid programs cover all forms of FDA-approved MOUD and related counseling and behavioral therapies beginning October 1, 2020. When the requirement was passed as part of the SUPPORT Act in 2018, it was really only methadone that wasn't covered by every state. Stakeholders we interviewed generally expressed positive views of the MOUD benefit mandate and congressional action to make it permanent.

Coverage is an essential component of access, and

therefore, the benefit mandate was an important step toward better access to MOUD for Medicaid beneficiaries, particularly in those states that added methadone coverage to comply with the mandate.

While coverage of all forms and formulations of MOUD is required, states and MCOs can still use various strategies, such as prior authorization, to manage utilization.

The chapter highlights several other recent Medicaid policies and initiatives that have sought to improve access to MOUD, including Section 1115 demonstrations to improve the continuum of care for beneficiaries with substance use disorder and to provide reentry services to beneficiaries nearing release from incarceration as well as a state plan option through which states can expand access to short-term residential and inpatient substance use disorder treatment.

The chapter also discusses a number of policy changes not specific to Medicaid but which affect access to MOUD more broadly. For example, there have been changes to methadone access both during and after the COVID-19 public health emergency.

At the start of the pandemic, SAMHSA relaxed restrictions on the use of methadone take-home dosing, which minimizes the need for patients to make daily trips to OTPs. Those flexibilities remained permanent in a final rule that SAMHSA issued last year.

Similarly, there have been policy changes aimed at improving access to buprenorphine, such as by expanding the use of telehealth and removing certain requirements for buprenorphine prescribers.

The chapter also discusses the importance of non-Medicaid grant funding, much of it administered by SAMHSA, in allowing states to expand and sustain access to MOUD. States described using these funds in a variety of ways, such as to purchase vans for mobile clinics that can bring MOUD to areas where treatment is otherwise hard to access or to pay for services like peer supports that may not be covered by their state's Medicaid program.

Moving on to coverage of MOUD, the chapter highlights a recent SAMHSA study on coverage of MOUD in Medicaid based on a review of publicly available information. It identifies some remaining gaps in coverage for methadone and the extended- release injectable

formulations of buprenorphine and naltrexone and several instances in which researchers were not able to identify a state's coverage policy.

With the exception of states with provider shortages who are not subject to the MOUD mandate, every state has amended their state plan to comply with the law, meaning that MOUD are technically covered even if they are not listed on publicly available documents like the state's preferred drug list or an MCO formulary.

However, as we previously noted, states can still limit their use, the use of MOUD, through prior authorization and other utilization management tools. For a variety of reasons, documented coverage does not necessarily mean that access to or use of medications is widespread, particularly when it comes to methadone and injectable products, and this is something we'll see in the next section of the chapter on utilization of MOUD.

The findings in this section are the result of our work with Acumen to analyze data from the Transformed Medicaid Statistical Information System, or T-MSIS. We found that the share of beneficiaries receiving MOUD has increased in recent years from 63 percent in fiscal year

2017 to 71 percent in fiscal year 2022.

Access to MOUD was likely affected by several factors during this period, including federal and state opioid response efforts and the onset of the COVID-19 public health emergency in early 2020.

Our findings are generally consistent with those of other studies using T-MSIS data to analyze MOUD use among Medicaid beneficiaries with opioid use disorder. However, I think it's notable that they are considerably higher than MOUD treatment rates observed in studies using data from the National Survey on Drug Use and Health, which are commonly cited, and this is largely due to the fact that the NSDUH relies on self-reported data rather than diagnoses or claims for opioid use disorder-related services and therefore tends to identify more beneficiaries with opioid use disorder.

While the share of Medicaid beneficiaries with OUD receiving MOUD has increased in recent years and is relatively high nationally, there is considerable variation across states, ranging from 42 percent in Iowa to 84 percent in Vermont in fiscal year 2022.

The chapter also provides insight into the

specific types of MOUD that beneficiaries are utilizing. In our analysis, beneficiaries with OUD most commonly received an oral formulation of buprenorphine followed by methadone, extended-release injectable naltrexone, and extended-release injectable buprenorphine.

While use of extended-release injectable formulations is low overall, it is particularly low in certain states, which is something that readers will be able to observe in one of the tables in the chapter, which shows the use of MOUD among beneficiaries with OUD by state and medication type.

Commissioners will likely recall that we examined how the likelihood of receiving any form of MOUD varied across demographic groups and found significant disparities when comparing utilization among younger versus older beneficiaries and non-White versus White beneficiaries. In FY 2021, White beneficiaries were more likely than any other racial or ethnic group to receive MOUD. Rates of MOUD use were lowest among Black and Asian American and Pacific Islander beneficiaries.

Young adults age 18 to 24 were roughly two to three times less likely to receive MOUD than other adults

under age 65.

The last piece of the claims analysis presented in the chapter looks at how the MOUD benefit mandate affected utilization of MOUD by evaluating the main outcome associated with the mandate, the addition of methadone coverage in states that had not previously covered it. We found that the addition of methadone coverage increased overall MOUD use and narrowed the gap in treatment rates between states that previously had not covered methadone and those that had.

The chapter identifies several key factors that create barriers to MOUD. Stakeholders reflected on the persistence of stigma and misinformation surrounding the use of methadone and buprenorphine, which are stigmatized sometimes as replacement drugs because they are opioids and controlled substances. This stigma can contribute to policies that discriminate against individuals taking MOUD and reinforce restrictive zoning laws and other structural barriers, particularly for methadone.

The chapter also highlights federal rules that contribute to stigma and make providers more hesitant to offer MOUD.

Beyond stigma, there are a host of other factors that contribute to the limited availability of MOUD providers, which is a significant barrier to MOUD access for Medicaid beneficiaries. The chapter discusses some of these factors, including the general behavioral health workforce shortage, a lack of training and support for providers, low provider reimbursement rates in some instances, and laws that limit the availability of methadone providers.

The stakeholders we interviewed discussed strategies for addressing 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.

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 and emergency departments prescribe MOUD and make warm handoffs to other providers who can offer ongoing treatment.

The chapter discusses how states and MCOs can use

utilization management strategies to promote appropriate care, control costs, and reduce the risk of fraud, waste, and abuse. We focused in specifically on the use of prior authorization and daily dosage limits.

Many of the 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.

Interviewees emphasized the need to capitalize on every opportunity to engage individuals in treatment, given the potential that patients waiting for medications will overdose or not reengage once their treatment is authorized.

Some expressed a 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 withdrawal.

Several stakeholders also took issue with the use of daily dosage caps for buprenorphine, which can be problematic for patients who are using fentanyl or have a long history of opioid use disorder and need higher doses of buprenorphine to stabilize.

Some state Medicaid programs 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.

The chapter closes by noting the need for continued efforts to address barriers to MOUD and highlights the Commission's interest in more closely examining the use of utilization management for MOUD and Medicaid.

That ends our overview of the chapter. As we prepare the chapter for publication in the June report, we'll be making revisions to incorporate any feedback that Commissioners would like to provide today. Thank you.

CHAIR VERLON JOHNSON: Thank you, Melinda. I appreciate that.

All right. I'll open the floor up to the Commissioners.

Jenny.

COMMISSIONER JENNIFER GERSTORFF: Melinda, thanks for this work. I thought you did a tremendous job of pulling together all of the extensive research that you and the team have done into the draft chapter.

I have a couple of themes that we've discussed at previous meetings that I'd like to see incorporated with more emphasis. I have a few questions and then a few considerations for future work.

The themes that we've discussed that I'd like to see more of in the chapter, one is that opioid use disorder is a chronic medical condition. I didn't see that called out specifically. I think a lot of stigma against people with OUD comes from a perspective that addiction is more of a weakness than a physical disability.

People who are dealing with addiction to drugs like illicit fentanyl are incapacitated when it comes to everyday kinds of things, and with treatment, they're able to get back to contributing to society, and everything changes.

You've also mentioned mortality concerns quite a bit from opioid overdoses, but there are several other important outcomes from effective MOUD treatment that I think we should highlight, things like reductions in emergency department utilization, inpatient hospital stays, reductions to justice involvement, and homelessness.

Now I'll go to my questions. It looks like on

Slide 8 you mentioned grant funding, and I was wondering if you have a sense of whether discontinued federal grants or the impending federal budget cuts could affect the progress that we've seen in MOUD treatment.

MELINDA BECKER ROACH: I mean, the recent efforts by HHS to rescind some of the COVID-era supplemental funding, some of which states and localities have been using for substance use disorder prevention and treatment recovery services, that certainly comes to mind. I think the fate of those efforts is still in question.

And then I think at this point, you know, we're sort of waiting to see what other policies emerge and take shape that could affect some of the work that states are doing with respect to this population.

COMMISSIONER JENNIFER GERSTORFF: If you flip to Slide 9, I was wondering what the situation might be where fee-for-service covers extended-release buprenorphine in 40 states, but managed care plans don't cover it in two of those states?

MELINDA BECKER ROACH: Yeah, as I mentioned, this is data from a report that was commissioned by SAMHSA, and they were sort of taking the perspective of a patient who

was trying to seek information about their state or MCO's coverage policies, and so I think in many instances where we see gaps in coverage or an inability to identify coverage, it's possible that that just reflects sort of the difficulty of accessing that information.

And as we note in the chapter, some of the publicly available sources that were used in this study, like state-preferred drug lists, those are not exhaustive lists of the medication -- of the outpatient medications that a state may cover, and so I think some of that may be reflected here. That's a good question. It's something we've been thinking about a lot and try to address with some additional language in the chapter.

COMMISSIONER JENNIFER GERSTORFF: That's helpful.

And then just some considerations for the future work on this. I really liked Slide 13 and that chart that you're including in the chapter, and I'd love to kind of expand on that to study success rates by type of MOUD for metrics like medication compliance, reductions in inpatient stays, reductions in emergency department utilization, and reduced overdose deaths, and then maybe some longitudinal studies to see if we can measure things like reduced

justice involvement, gainful employment, or people able to obtain alternative health coverage. I think all of those things would have cost offsets. So we're spending a lot of money on this treatment, and I think we can get a lot out of it. Studying that would help to show that and any evidence that we might be able to study with offsetting costs of covering MOUD.

And then one other thought is just a deeper dive into some subpopulations that are affected by OUD: Indigenous communities, pregnant people, and dual eligibles.

CHAIR VERLON JOHNSON: All right. Thanks, Jenny.

Doug?

COMMISSIONER DOUG BROWN: Melinda, thank you for the update of this presentation. You've incorporated some of the comments and feedback that we've given you in previous meetings, which is great to kind of see this coming through.

Let's go back to Slide 9 again. It's much of what Jenny just iterated. I want to hit on, too, just to make sure that we're all level set on this, and that is that under the Medicaid program, if a manufacturer

participates in the Medicaid drug rebate program, these drugs have to be covered at the state level. Realizing that this is a search of publicly available information and if it's not publicly available, then it was deemed to be not covered.

I think it's misleading to say it's not covered. Maybe it's not found, not published, but I think not covered is not the right way to say it in here, because someone that's just glancing through this, when this report goes to Congress, is going to think that there are states and places that don't cover the drugs, and that's not true. They're covered, but they're not available at the time that this survey was done in a public format, and maybe that's changed now since this is three years old.

The other piece that I have is a challenge with some of the data and some of the comments around the very low utilization. I guess you can go to Slide 13, where we talk about low utilization of injectables, and maybe it was even further up in the presentation, where we talk about the injectables and the very low utilization in some states.

There are challenges in getting to some of this

data, especially when you move to injectable products, where if you have bundled services and the drug is included as part of the bundled payment, you may miss the drug.

In addition to that, if drugs are paid for through 340B, you won't see those drugs in the rebate system in the reports of the rebate file, because states can't invoice for that if it falls in the 340B side, so they're excluded.

I do not know in the T-MSIS data whether those drugs come through so that you can see those drugs in the T-MSIS data, and I know that on the CMS website where they publish all state utilization, they suppress utilization of less than 10 units, and so you could have utilization going through. And I think there needs to be some connection between low utilization and perhaps numbers of providers that prescribe the injectable form of the drug in those states.

So that's my kind of general concern about some of the data there that points to lower use of the ER products or extended release or injectable products.

The other thing you have to consider with this is that physician reimbursement for the service of providing

the injectables or buy and bill of the injectable drug may lead physicians not to want to use those products. You highlighted that in the chapter, and that's in print. But there may also be insufficient reimbursement, not only that the patient isn't coming back, which I think was what the example was, but just if there's insufficient reimbursement, physicians aren't going to buy and bill that drug to begin with. And I think my recommendation would be to -- as you do primary research, to dig in a little bit on the reimbursements across some of the states with very low utilization for that.

The other piece of this is that once patients are stable on oral therapy, many of them won't move off of oral therapy, and physicians won't want to change it. It's going to be physician's choice, picking the right patient to do that. Injections can be painful. You've got not only the injection site, but you've got the wheel that's created underneath the skin when you inject the volume of fluid or the drug under the skin.

From a primary research perspective, kind of next steps, I think you should talk to prescribers of MOUD to kind of investigate some of the things that I just

highlighted there. I think it would be worth it to talk to a manufacturer or two of MOUD drugs to find out what their challenges are and uptake of their product, would give you insights into what they see are the barriers to access into moving patients from oral to long-acting injectable products.

And finally, state officials that have knowledge of pharmacy reimbursement. Sometimes we talk to state officials at the Medicaid director level, but they don't have the working knowledge of some of the finer details of how the pharmacy program is and the reimbursements and things that go there. So I'd recommend that you include those types of folks in your next -- in your follow-up interviews.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Doug.

Let me go to Dennis first and then Carolyn and then John.

COMMISSIONER DENNIS HEAPHY: Some of my comments build off of what was said by Jenny.

One other thing is I was reading around about disparities in folks with disabilities engaging in MOUD,

and so I'll send that to you at the end of the chapter to see if there are people who are less likely to engage up front in MOUD and also are more likely not to continue with MOUD.

MELINDA BECKER ROACH: Yeah, thank you for highlighting that. I think we can absolutely incorporate some of those findings.

COMMISSIONER DENNIS HEAPHY: Thanks.

MELINDA BECKER ROACH: Great call-out.

CHAIR VERLON JOHNSON: Carolyn?

COMMISSIONER CAROLYN INGRAM: One other question I had is, did you look at the amount that Medicaid is reimbursing to IHS and Tribal 638s for dispensing MOUD, or was that included in any of the data?

MELINDA BECKER ROACH: We didn't look at payment rates as part of this work. We were really focused on utilization specifically.

COMMISSIONER CAROLYN INGRAM: Yeah, just to clarify, I shouldn't have said paid for because they're paid an encounter rate, so it's all the same, but meaning the utilization. Was that data, the utilization data included?

MELINDA BECKER ROACH: We did not. Actually, I would have to go back and double-check because we did -- as I mentioned, we did look at -- we did do some comparison across racial and ethnic groups to understand how utilization varied.

COMMISSIONER CAROLYN INGRAM: That would be interesting to see if we could find anything. In my experience, because IHS and Tribal 638s are paid an encounter rate, it's sometimes hard to track actually what was covered and paid for in that encounter around these, and maybe Doug has some ideas about how to find that or dig into it. Maybe it's a process of also talking to the providers at IHS or Tribal 638s about how it's billed back, but I have a feeling from what we see in our data that it's not accurately tracked, and so that there's actually maybe more dispensing going on in that area but that we don't know about it. And so it would be interesting to see if that's true, if it's underestimated in the data.

Thanks.

CHAIR VERLON JOHNSON: Thanks, Carolyn.

John and then Sonja.

COMMISSIONER JOHN McCARTHY: Melinda, you just

answered my question that I had, which was I was looking at the slide that had the -- what is it? Twelve, I believe. Yeah, Slide 12 where you're looking at the share of Medicaid beneficiaries receiving it, and I was going to ask you if that -- because I brought this up at another meeting -- is what are the payment rates in those states, but you had said earlier that we didn't really look at payment rates.

I think the one issue that I have with that is that the title of this chapter is "Access to Medications for Opioid Use Disorder," and if we're not looking at payment rates -- it is looking at access, but if you're leaving out the look at payment rates, that is a big -- we're not going to be able to pick up some different things around that, so I don't know. Are you planning to look at payment rates in the future, not for this chapter but for a subsequent chapter?

MELINDA BECKER ROACH: Yeah, we don't have any plans at the moment. It's something we can take back and consider.

The next phase of work, which we're getting ready to launch, is going to be sort of diving in deeper into

some of the utilization management issues that emerged in this phase of the work.

CHAIR VERLON JOHNSON: Sonja?

COMMISSIONER SONJA BJORK: I sure like the chapter. Thanks for everything that went into it.

For future work, is there an aspect that can be looked at that has to do with rural, the ways patients are able to access care if they have limited transportation options? So I know in the region that I work in, if you live in the city, then, of course, you can take public transportation, but for the very rural areas, our health plan is providing a lot of rides to different types of treatment. And I just wonder if there's any way to look at is that an effective way to make sure that more people are able to stay consistently on track with their program and if that happens to be a factor or not.

Thanks.

CHAIR VERLON JOHNSON: A good call-out as well.

Any -- oh, there we go. Mike. Mike and then Jenny again.

COMMISSIONER SONJA BJORK: Sorry. Just picking up on John's point, I wonder if in looking at the slide

that you have up around the share of Medicaid beneficiaries by state, I just wonder if there could be a little deeper dive into what the reason is behind the variation just from an understanding point of view, and I wonder if in that exploration whether or not rates would be the issue that kind of came up or if it was some other factor. I think it would be helpful to understand that variation.

The other thing I was just wondering, I just had a question about, is are you able to -- I'm wondering about the expansion population and the extent to which, you know, the ability to get Medicaid basically increased their ability to get these services, and I'm thinking about some of the comments that were made at last month's session around, you know, states' progress in terms of developing their 1115s and their process of developing a continuum of services. I mean, this is also part of that continuum, and I think one of the comments we heard from at least one of the other participants -- at least one of the state participants was the importance of expansion, the importance of expansion to kind of continuing with the progress that they're making in terms of their OUD continuum. So I just wanted to reflect on that.

Thank you.

CHAIR VERLON JOHNSON: And Jenny.

COMMISSIONER JENNIFER GERSTORFF: Sonja actually reminded me; I had flagged one of the other public comments that came in to highlight. It was from the VP of Operations at Sonara Health, and she wanted to just make us aware of a digital health solution that they have that provides remote observation of take-home methadone for people with OUD, which is really serving people in rural communities to expand access. And she mentioned some pilots in New Jersey and also Ohio with the CareSource plan there, looking at reductions in non-emergency medical transportation costs and so some of the cost savings and offsets to pay for expanded access. So that could be something to keep an eye on as well.

CHAIR VERLON JOHNSON: Okay. Any other questions?

[No response.]

CHAIR VERLON JOHNSON: Melinda, anything else from you? Did we give you what you needed?

MELINDA BECKER ROACH: Yes. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you so

much for the work, and we appreciate that.

All right. So we're going to switch gears a little. We're going to go into PACE. Brian and Drew are going to join us and walk us through the presentation and the draft chapter that we have in store.

[Pause.]

UNDERSTANDING THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) MODEL

* BRIAN O'GARA: All right. Good afternoon, Commissioners. Drew and I are here to provide you with a brief overview of our even briefer draft chapter on the program of all-inclusive care for the elderly, or the PACE model that we'll be including in our June report to Congress.

So like the draft chapter, this presentation will begin with a brief background and description of our analytic approach in this work, and then we'll discuss several elements of the model and discuss key findings both from our review of research and our stakeholder interviews. And we'll end by looking ahead.

So just a brief recap, the PACE model is a fully integrated Medicare-Medicaid program that serves adults

ages 55 and older who qualify for a nursing facility level of care but can remain safely in the community.

PACE providers receive a monthly blend of capitated payments from Medicare Parts A, B, and D and also state Medicaid agencies.

Most PACE participants are dually eligible, dually enrolled in Medicare and Medicaid, and as of March 2025, there were more than 82,000 PACE enrollees across 33 states and the District of Columbia.

To better understand this model, we contracted with the Center for Health Care Strategies to help us understand the model design, the administration of the PACE model, and state and federal oversight of the model. We conducted a literature review, but of course, we also interviewed stakeholders in five states and the District of Columbia. And stakeholders at the state level included state Medicaid officials, PACE organizations, one state PACE association, and consumer advocates.

And we also spoke with stakeholders at the federal level, including officials from CMS, the Office of Assistant Secretary for Planning and Evaluation at HHS, and staff from the national industry association for PACE.

Some of our first key findings are around eligibility and enrollment. As we discussed earlier, PACE is for a subset of the population who is ages 55 and older, who meet their state's nursing facility level of care criteria, but can also remain safely in the community.

PACE organizations that we spoke with shared that most enrollment comes from word-of-mouth referrals. Some stakeholders raised concerns that individuals may be institutionalized while waiting to complete eligibility determinations and enroll in PACE, and we also heard from some providers that states may not always include PACE in options counseling for beneficiaries when discussing HCBS.

States are responsible for determining the criteria by which PACE organizations evaluate if an individual can live safely in the community, and this came up with one state Medicaid official we spoke with and some consumer advocates who raised concerns that PACE organizations may selectively enroll participants they believe to be less high cost and high need. And then once enrolled, a participant in PACE remains enrolled regardless of their changes in health.

To become a PACE organization, expand a service

area, or add an adult day center, an entity must submit a complete application to CMS. These included assurances from the state Medicaid agency and the proposed service area. We heard -- sorry -- PACE centers then enter a three-way agreement with CMS and the state Medicaid agency that described the federal requirements for administering the model, and we heard from providers that there were several challenges in starting up these programs and throughout the application process, which they described as lengthy and expensive.

PACE organizations mentioned that, for example, there are four days per year when they can submit an application to CMS. They can only submit one application to either open a new day center or expand the service area at the same time and other challenges that we heard.

And although states differed in their approaches to procuring providers, most state officials expressed interest in further expanding PACE in their states, particularly into rural areas.

So service delivery. The PACE model requires an interdisciplinary team, or IDT, of at least 11 mandated providers. These providers develop the person-centered

care plan for PACE participants and provide any and all necessary medical and non-medical care to enrollees. These are without the typical benefit limitations, such as scope, amount, and duration that you may find in other Medicaid programs. And PACE organizations must operate an adult day center from which the IDT coordinates and offers most but not all services. Providers can also offer services in the participant's home or at an alternative community site.

And interviewees we spoke with largely agreed that the PACE model as designed provides enrollees with a broad and comprehensive benefit and an all-inclusive benefit package.

And consumer advocates, however, did raise some concerns that the double-sided nature of this benefit is that some PACE programs may offer fewer home-based services compared to other MLTSS or HCBS programs, simply because there is no federal floor for services that must be offered in the home under PACE.

States we spoke with -- PACE organizations are required to have formal written processes for grievances and disenrollments as well as appeals. States we spoke with all use different processes for monitoring PACE

enrollee complaints, appeals, and grievances. Participants can voluntarily disenroll from the PACE program at any time for any reason, or they may be involuntarily disenrolled for certain reasons such as moving outside the service area of an organization, disruptive or threatening behavior, or failing to pay any associated premiums with the benefit.

States actively monitor their PACE programs for voluntary and involuntary participant disenrollment through a variety of methods. We heard from state and federal officials that participant death and relocation out of the program service area were the most common reasons for disenrollment, and although some officials acknowledged that voluntary disenrollments often do occur when a participant transfers to a nursing facility, stakeholders noted that these appear to reflect enrollee preference, and stakeholders largely were not concerned that PACE organizations may try to avoid paying for institutional care by disenrolling participants.

And now I'll pass it over to Drew.

* DREW GERBER: Thanks, Brian.

As we discussed in January, federal and state entities share oversight responsibility of PACE as a

Medicare-Medicaid program. Federal oversight spans several divisions and offices within CMS, but it's primarily led by the Center for Medicare, using the same infrastructure used to oversee the Medicare Advantage Program.

Both federal and state oversight primarily consist of auditing PACE providers, and through reviewing data these providers are required to report.

PACE organizations are required to report some utilization data to CMS, including 23 medical and non-medical elements, in addition to certain Medicare encounters, largely those provided by contracted providers outside of the IDT that would generate a bill.

While states may include additional reporting requirements through two-way contracts with PACE organizations, we heard in our interviews that these contracts are relatively pro forma and without substantial new reporting requirements.

Reporting Medicaid encounters also poses challenges for PACE providers and for states, as the PACE model does not lend itself to the reporting structure used for other Medicaid managed care.

Federal officials and providers said that

identifying and collecting Medicaid encounters would be difficult for most PACE organizations, and only one state in our study requires some level of Medicaid encounter reporting, though several officials did express interest in adapting encounter reporting to work with PACE.

For fiscal year 2023, combined federal and state Medicaid spending for PACE totaled $3.9 billion. Most PACE participants are dually eligible, and therefore, in addition to Medicaid payments, PACE programs receive payments from Medicare as well, which we describe in greater detail in the chapter.

Most states set Medicaid payment rates for PACE as a percentage of the amount that would otherwise be paid, or the AWOP, if the participant were not enrolled in PACE. This is a statutory requirement for PACE. Statute sets that AWOP amount as the cap for PACE payments, and states have some flexibility in how they both develop their AWOP and the subsequent rate cells used to pay providers. These are developed depending on the comparison population used by the state and the different data sources that they're able to use.

One state in our study, in particular,

California, does pay PACE providers based on experience data, but they are still limited by this AWOP cap on spending.

States vary in how regularly their rates are reviewed and updated, and the process is often dependent on state legislature budget priorities. Of course, capitation payments also vary by state. For example, among states in our study, the capitation payments for full-benefit dually eligible individuals ranged from approximately $2,800 per member per month in one state to $7,700 per member per month in another.

Looking ahead, we're looking to hear your feedback on this draft chapter today, which is slated for publication in the Commission's June report to Congress. We plan to return with additional work on the PACE model as well in the near future.

I'll turn it back to the Chair.

CHAIR VERLON JOHNSON: All right. Thank you both for that. It was very helpful.

Let me see. We have a couple of hands up. Patti, start with you.

COMMISSIONER PATTI KILLINGSWORTH: Yeah, thank

you both for the draft chapter, lots of really great information in there.

I do want to reiterate that I think PACE is a best-in-class integrated care model in terms of integrating financing, integrating benefits, the very comprehensive interdisciplinary care planning and coordination approach. It's what we think care should really look like in terms of many of those aspects.

I don't think we have in the Medicaid program, at least not that I'm aware of, any other HCBS model or duals integrated care model that is granted the kinds of flexibility or relief from quality oversight and reporting that PACE organizations enjoy. And so it's always hard to sort of say, yay, I love these things, but are these things only possible because we don't apply the same level of administrative requirement that we require of other integrated care programs?

It is a very small program relative to other integrated care models, 82,000 beneficiaries compared to 72 million who are served in managed care across the country in Medicaid.

One of my questions is, is if we look at that

cost $3.9 billion to serve 82,000 beneficiaries, we come up with a cost of about $47,551.70 on average per beneficiary. So how does that compare to comparable cost of care serving comparable populations? And by that, I don't mean people in nursing homes. I mean people who meet institutional level of care, but are served in other kinds of home- and community-based care programs. Is it a cost-effective model in that sense, not just looking at the cost of what it would be if all of these folks were in nursing homes?

I do say I continue to have concerns and want to be sure that we call out the very different requirements for these organizations around accountability and transparency, around network adequacy, around the appropriateness of payments that are being made to them, around quality requirements and oversight. And there's a lot of sort of talk in the chapter about how to expand PACE and barriers to expansion, but at the same time that we're talking about expansion, we have to be looking at all of these other sort of things that typically apply in the Medicaid program that don't apply in the PACE program and if those kinds of adjustments are important in order to ensure that we're getting the same level of access and

quality in the PACE program.

CHAIR VERLON JOHNSON: Thank you, Patti.

Yeah, I'll just say too, just for the points that you're making there for me, as I think about the PACE program, how it's evolved, just really kind of think a little bit more about how does it fit into our broader conversations around access, addressing disparities, rebalancing away from institutional care. But it just doesn't seem like it's very scalable, and so I think that's getting to your point. And so if we can get more into -- more -- I guess dig a little bit deeper on how we could do that, that would be more helpful, but it just seems a little bit more challenging, given the differences with the requirements and all of that.

With that, Dennis, let me turn it to you.

COMMISSIONER DENNIS HEAPHY: Thanks.

I agree with all the points that have been made, and also, I just don't understand why they can't be held to the same standards. Days that, like -- was it 30 days return to the hospital, all-cause hospital stays, or returned to emergency room utilization or HEDIS or CAHPS or NCI-AD? What makes this population so unique, or the PACE

program so unique, that those metrics don't apply to them?

And then I'm also concerned about the cherry-picking, and if people actually move out of PACE into nursing homes by choice, or is it because the PACE program doesn't feel like they're able to actually meet the needs of that individual anymore within the program? Because it's a very isolated, very insular program, and so it's hard to know exactly what goes on inside of it. Like the IDT, how that functions, and who determines what kind of -- HCBS people receive. And so -- and the access, the reduced access to HCBS, why is that reduced?

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

Let's see. We have Jenny and then Mike and then Carolyn.

COMMISSIONER JENNIFER GERSTORFF: Can you flip to Slide 12? I have some just nuanced language that I noticed on your slides and in the draft chapter that I'd like to propose an alternative.

So it says that "Rates are not required to be actuarially sound." I would propose something like "Federal regulation does not require PACE rates to be

actuarially sound."

So you've mentioned a few times that many states use actuaries to set their rates, and actuaries are bound by the profession to follow actuarial standards of practice, and that is one other small thing. It's not in the slide, but it is in the draft chapter. It says "generally accepted actuarial principles," which is more of kind of an accounting term. So we would say that we have to follow our actuarial standards of practice.

CHAIR VERLON JOHNSON: Thank you.

Mike, then Carolyn, then Heidi.

COMMISSIONER MICHAEL NARDONE: Yeah, just picking up on Jen's point. So I would actually ask a further refinement, which is it's not federal regulation. It's actually federal statute that sets how PACE rates are set in Medicaid.

So AWOP is a legislative requirement around how states can pay for PACE, and so I guess my point -- I guess the point I would like to make -- and I think you guys in doing this chapter, yeah, I think tried to find the right balance, like, between some of the concerns that Patti raised as well as kind of some of the positives about the

model.

You know, in Pennsylvania, we found it to be a very important tool for better integrating services for people who are dual eligible, so have found it to be a very good model. Would it be -- you know, it isn't as -- it's difficult to take to scale because of some of the things that -- you know, some of the requirements around PACE, some of the administrative costs, the fact that, you know, it is community-based, some of the requirements. But I think -- you know, I think as a group, I think we should be looking at, well, what are the -- you know, what are some of the things we might want to recommend going forward in terms of, you know, getting PACE on a more level playing field with the MCOs around quality metrics? I think that's something we should be looking at.

I think we should be looking about how rates get set. You know, we might -- you know, if we go to an actuarial standard, it'd be interesting to explore, you know. That might -- for some states, that actually might require an increase of costs and kind of understanding that a little bit better because, you know, some of the way AWOPs are developed aren't actuarially sound. So I think

that -- you know, going forward, I think that would be, you know, maybe some of the areas where we can -- you know, I think we've had a lot of comments from the Commissioners around some of the areas where we might want to look in terms of making some sort of recommendations to Congress or to CMS going forward.

I think one of the interesting points -- and I don't know if you have any more on this from your work to date -- is that there's been an increase in people who are Medicaid-only PACE, and so I'm wondering, is that -- I'm just -- this is much smaller than a broader point I just made, but I'm just trying to understand who those people are. Are they people who are 55 to 65 who don't -- aren't eligible for Medicare yet? In which case, I think that's interesting to note because I think there's been a significant increase in that population over the last five years who were part of PACE.

BRIAN O'GARA: Yeah, we can't say for sure why, you know, that distribution has shifted a bit towards Medicaid-only growth.

We did speak with one PACE organization that served primarily -- I think most or all of their program

was individuals under 65, so who were Medicaid-only. So I'm -- you know, that shows that there is a need among that population for a program like PACE, but we didn't hear anything about, you know, why nationally that shift may be occurring.

DREW GERBER: Yeah, I would also just add, I think we heard across some of our interviews, but in particular, a provider in one state had noted over sort of the 10 years or so they've been running their program, they have seen the age profile of their participants shift younger. So there may be a trend there.

CHAIR VERLON JOHNSON: Thank you.

Carolyn.

COMMISSIONER CAROLYN INGRAM: Thank you.

Just a few qualifying questions I wanted to make sure to clarify. So in the documents we received, you talked about how eligibility works, and I want to make sure I understand. There's no standard tool for eligibility to get in. The PACE site is actually making the determination if the person can live safely in the community?

BRIAN O'GARA: Yes. According to federal regulations, the program is -- or the state outlines how

the programs can determine the specific aspect of being able to remain safely in the community, and that's where we've seen -- we've heard about some leeway with how providers may determine that factor.

COMMISSIONER CAROLYN INGRAM: Mm-hmm. So the person that's getting paid also gets to make the determination about whether or not you can live safely in the community? That seems like a pretty big conflict of interest that doesn't exist in our other integrated programs. So I think that's worth noting.

I have to agree with Mike and I think Patti in terms of the quality standards. It sounds like there aren't defined outcomes by the states in terms of holding these entities or the federal government really to inequality standards. Is that true in what you found?

BRIAN O'GARA: Beyond the 23 measures that are reported through the health plan management system and maybe the occasional Medicare encounter claim data, there aren't really any comprehensive quality metrics required now.

COMMISSIONER CAROLYN INGRAM: Okay.

And then in terms of encounters, you noted that

they can't really provide encounter data for the services they're providing. I didn't quite understand why that is. Can you explain that a little bit better?

BRIAN O'GARA: So the model is set up and the benefit design is set up so that someone can go to the day center and get any and all care they need from any of the providers there. They may see their PCP in the hallway. They may take a left turn and see their physical therapist. And it's designed, from my understanding, to be a benefit that doesn't generate claims for each service, that you can just go and receive any and all services that your providers determine necessary.

And so I think coming from that approach, services delivered through the PACE benefit don't generate claims. That seems to be design choice.

DREW GERBER: I would also --

COMMISSIONER CAROLYN INGRAM: If you were -- oh, go ahead.

DREW GERBER: I would also just add, I think we did hear that one of the elements of the PACE model that at least some of the providers and, I think, consumer advocates we talked to appreciated was sort of the

flexibility of those in the model, the providers to provide additional services. For example, someone providing transportation back to the home from the day center, that person may then go in and help arrange groceries or organize the home or help in a different way with the participants. So there's maybe a little more ambiguity in some of the roles that these different providers are playing.

COMMISSIONER CAROLYN INGRAM: Mm-hmm. I guess I get that. I mean, you know, certainly, there's some aspect or some portion to helping people to live in the community, but I would think if you're running a business, and these businesses are for profit, you have to be able to track what money you're spending on things. So what money are you spending on doctors? What money are you spending on transportation? You wouldn't be able to run a business and not be able to track some of that information.

Likewise, if we were building a plan of care for somebody, we want to know, are they getting the services in the plan of care inside managed care companies? We keep track of that. Like, did they make it to their physician visit? Did they get transported, you know, in order to

make sure we're meeting the plan of care? And I would assume that they're keeping track of that to meet the plan of care. So I don't understand why they wouldn't also be held to providing that encounter information.

And then, likewise, I don't see how you would set rates if you're not getting that encounter information, and I think that's one of the things that makes it so difficult to determine whether or not the rates are sound that you're providing them or appropriate, or is it costing too much for the service if you can't track the encounters? So I think that's something that would be good for us to look at in terms of a recommendation.

There's got to be a form or method for tracking. I don't think there's anywhere else in the Medicaid program where we don't track what services people get. You know, we go out of our way to do that in lots of different ways, especially if we're trying to show outcomes in somebody's plan of care.

DREW GERBER: So I can briefly respond to that --

COMMISSIONER CAROLYN INGRAM: Okay.

DREW GERBER: -- and Brian may have more to add.

I would say that we did hear that the ability for

PACE providers to report some of these encounter data does depend both on the size and sophistication of the PACE provider site. Some PACE providers we heard do actually have this data and some quality data that they're both reporting either to their nonprofit leadership for grant purposes or to their state PACE association. But, you know, there's a huge variety in the type of organization running a PACE center. So I think the capacity to do this has differed and the ability to report it out in a way that fits with the state encounter system has been a challenge.

I think I'll let Brian jump in if he has something to add.

BRIAN O'GARA: I would just add there are federal requirements. Providers do need to obviously track and monitor what services are delivered and if that's in line with the personal care plan.

We heard from states and federal officials that during the audit process or other oversight activities, they will go into the organization and pull records to make sure that, you know, the organization is tracking care as delivered and what's in the care plan. So there are some requirements around monitoring service delivery.

And then going back to your earlier question, because it spurred a thought, I think part of the reason why claims are not generated is that one of the key elements of the model in the original statute is that the capitation must represent all payment from the state to the program. So states can only pay for the services through the capitated rate, and so I wonder if that may be part of why, you know, providers aren't billing for individual services. That monthly rate has to represent the entire payment from the state for the benefit.

COMMISSIONER CAROLYN INGRAM: Yeah, that's interesting. I mean, managed care companies get a capitated rate, but we have to report back encounters. Even if we're paying a provider a value through a value-based purchasing agreement and sub-capping to somebody, we still have to report those encounters back. So I think it's at least good to hear that they're tracking those, but we expect, you know, mom-and-pop provider organizations who are providing home- and community-based waiver services in the community to bill us and track those encounters. And some of those providers are pretty small. So if they can figure out the sophistication around it -- there's free

software. There's other things I would think that these PACE sites, some of them having a lot of backing, should be able to figure that out.

The next question I had was around the network and the monitoring in your documents that you provided us. I think it said, talked about how there aren't standards around making sure that the network is adequate, and I just wanted to have you explain that a little bit more. Maybe I misunderstood it.

BRIAN O'GARA: I would have to double-check on network, provider network adequacy generally. We did confirm there are no network adequacy requirements for nursing facilities. So when folks transition to institutional care, I would have to check on the other general requirements around network adequacy.

COMMISSIONER CAROLYN INGRAM: Wow. That's something I think we should dig into. I mean, we're the Commission that looks at access to care and want to make sure that people have access to it, and I find it hard to believe that we have a program in Medicaid that we've left behind and not required some network access requirements.

All that being said, I find it really hard to

figure out how as a state you would set rates for this. I appreciate my colleagues and the Commissioners talking about that they have to be actuarially sound, but if you're not getting encounter data, you don't have access to care requirements. You don't have public reporting about your quality and your outcomes. It's a really hard program to set rates for. So I understand why it's so hard to figure those out.

I think we need to think about making some recommendations around those things that we've been talking about for such a long time, that we require integrated programs be brought to this platform as well in order to be able to get some of those outcomes and to be able to get the rate setting. Almost feels like we left, you know, a whole entire program behind and just because there's not very many people in it and didn't really take into account considerations that we've pushed for a number of years across the rest of the Medicaid program for this population.

So I'll pause there because that's probably enough. Happy to discuss more later. Thanks.

CHAIR VERLON JOHNSON: All right. Thanks.

Heidi and then Dennis.

COMMISSIONER HEIDI ALLEN: So I'm like the opposite of the last three or four people who've spoken because I think that it's not a HIDE SNP, it's not a FIDE SNP, it's not a D-SNP. It's not a plan. It's not a delivery system. So it's not a nursing home. You know, it's both, and it's not for everybody. And so everybody that's like, well, they're cherry-picking and they don't, you know, accept -- like, in Carolyn's -- and so, you know, what Carolyn was saying is, like, that why would the person who makes money doing the evaluation made it sound like they're incentivized to bring everybody in? And I think the accusation has been that they're more selective because not everybody does well in a day center model.

But that doesn't mean that a day center model is not a good model for a significant number of people, and for us to say, well, it should be good for everybody or it's not good doesn't make any sense, because some people do better at their home when people are bringing services in, and some people do better in institutional care, and some people would do better in a day service model. And so comparing apples to oranges to bananas and then saying the

banana needs to look like an apple doesn't make any sense to me whatsoever.

And we want to move away from these counting widgets of, like, how many times did you -- you know, let's say you spent 15 minutes with this person and then you did -- you know, you talked to them about vitamins, and then you talked to -- you know, you did this and, like, this check box of let's get charged for everything. And we want to move into relational care, which is what the PACE program does is it puts them in a living environment with all of their providers, and their providers see them all day. And I don't want the provider having to pull out something and say, well, I talked to Heidi for five minutes about her nutrition, so I should mark that down as a nutritional educational thing.

And it's so funny to me that, like, this level of scrutiny that we're all talking about in the one program that people love. We have Medicaid advisory committees and surveys where people talk to us about the problems they have with access and the problems that they experience, sometimes the quality, and then we have this program that everybody wants more of and all these people want to get

into and they can't. And we're like, we really need -- you know, 23 measure outcome measures are not enough. We need more outcome measures, or how terrible is it that they might need to go to institutional care, and they should be punished if people are going to institutional care. Well, no, like it's a different model.

And we have -- I don't want to -- like, I don't think as a Commission our job is to say, you know, one size fits all for people. This may be a model that's just good for a small number of people. This may be a model that's difficult to scale. I would love to do recommendations that help us think about how a popular model that -- everybody we talk to was so enthusiastic about. I'd love to think about how we scale that, if it's scalable, and in some places, it may not be scalable, but, like, to think about how to basically contort it so that it looks like all the models that people aren't happy with and that people are not getting the care that they like. And that's -- I'm not as excited about that.

So I agree with Dennis. Like some of them, you know, like, you know, hospital readmissions or, you know, emergency department use, those kinds of models seem to

make a lot of good sense, but trying to compare on number of primary care visits or number of, you know, specialty visits, like, if it's really good at what it's doing, they might need -- they might have less specialty visits. That doesn't necessarily mean they have less access to care.

And I guess if this were one of the many things that we talk to people, like, when we talk to people about their dental benefits and they express a lot of concern, then we'd be like, yeah, let's really -- we really need to dig down and figure out where this access problem is. But when we've talked to people, they really love it. So I assume that, you know, that that actually speaks well.

So I guess I just don't want the record to be that all of these -- you know, three or four people on the Commission feel like this requires such heightened scrutiny and how did this get away with us. I think that, you know, we need to obviously be responsible, which it sounds like the states have really tried to do a lot to have oversight. They interview people when they leave. They interview people when they voluntarily disenroll, but I don't know that we necessarily need to put them at the same standard as an MCO or, you know, some other kind of delivery system.

CHAIR VERLON JOHNSON: Thank you, Heidi.

Let's go to Angelo and then Dennis.

COMMISSIONER ANGELO GIARDINO: Dennis was before me, so I don't want to jump ahead.

CHAIR VERLON JOHNSON: So Dennis and then Angelo and then Carolyn.

COMMISSIONER DENNIS HEAPHY: So I agree with much of what Heidi said, and I also think it's important to -- can you say more about the three-way contract between the states and the Feds.

BRIAN O'GARA: Yeah. You'd like us to say more on this?

COMMISSIONER DENNIS HEAPHY: Yeah.

BRIAN O'GARA: Yeah. Essentially the three-way contract outlines federal requirements. The PACE program agreement, it's called, you know, PACE participant rights, services, payment, oversight activities, and some states we spoke with do use additional two-way contracts between just the state and the provider, but from the states we spoke with, they didn't seem to have many substantive additions.

But the three-way contract is kind of -- sorry. The three-way agreement is the governing contract for the

model.

COMMISSIONER DENNIS HEAPHY: So it's an agreement, and there's confusion about oversight, if I remember correctly. And so how does -- so then how do -- I guess part of me is just jealous because we had a demonstration of a plan where the folks enrolled in dual-eligible plans as a three-way contract between the state, the Feds, and the plan, and it would seem to work really well because there was a really close oversight model. And now we're moving away from that integrated two-way contract into separate contracts, and so I'm just a little bit jealous of the way -- the way PACE programs do it.

But I'm just wondering, like, with the oversight, actually who's watching the shop if the Feds and the state don't know?

BRIAN O'GARA: That's a great question. Many divisions of CMS have specific oversight functions for various processes, eligibility, service delivery, kind of trial and audit periods, and states that we spoke with do hold various oversight activities. And the states we spoke with tried not to duplicate what CMS does, but states primarily also rely on audits for their oversight

activities.

COMMISSIONER DENNIS HEAPHY: And then my last question is, PACE is a provider model, not an insurer model. Is that correct?

BRIAN O'GARA: The PACE organization is the provider in the plan. I don't know if that answers.

COMMISSIONER DENNIS HEAPHY: It does. It does.

BRIAN O'GARA: Okay.

COMMISSIONER DENNIS HEAPHY: But its primary focus is to be its primary responsibility is as a payer, and the activity as an insurer is to me -- it's the method they use to be that provider of services. Is that right?

BRIAN O'GARA: Sounds right.

COMMISSIONER DENNIS HEAPHY: Maybe you could clarify it in the chapter.

BRIAN O'GARA: Yeah, we can take that back.

COMMISSIONER DENNIS HEAPHY: Yeah, because there's a very big difference about being a provider group, providing services, and using the insurance arm of the vehicle to make that happen, and being an insurer that contracts with providers.

Thanks.

CHAIR VERLON JOHNSON: Okay. We're getting a little short on time. So Angelo?

COMMISSIONER ANGELO GIARDINO: Okay. I'm going to be really quick.

So I'm almost positive that there are no children in PACE. Envision me then as someone from Mars, and I'm popping in, and I'm hearing that this is an idealized, best-in-class program that can serve a group of patients really well. I guess from a policy perspective, I'm interested, as you do further work, these 82,000 people that are served, how can they be characterized? Why are they ideal for PACE? And if PACE disappeared, where would they be served? And what would be met, and what wouldn't be met? But I'm the first to say innovation is important, and you should allow programs to have some flexibility around meeting standards, but usually, you can characterize the group that's getting the standards. And why are they different, and why aren't they the same?

And if that's great, then ultimately, what I'd love to hear is, there's 82,000 people being served now. If you can characterize that group, what should the right size be for the United States? You know, should it be

160,000? Should it be 240,000? And if so, then what would we do to let everybody that should be getting PACE get PACE? Because that's what I'm interested in. I'm not interested in hurting PACE. I'm not jealous of them. I just would like to know, how do you figure out who should be in a PACE model, and then what's the right size for the United States? So that's my policy question.

Thank you.

CHAIR VERLON JOHNSON: All right. Jenny.

COMMISSIONER JENNIFER GERSTORFF: I just wanted to add to the conversation that because many of these programs are so small, even if we had complete encounters from them, it could be hard to rely on that encounter data to set actuarially sound capitation rates, because we'd have credibility concerns. So you'd still be looking at the cost of care for similar enrollees, which is what the amount that would have otherwise been paid kind of gives us as a benchmark, is what kind of care are people receiving in other settings, and you know, capping it there.

And then one other clarification I wanted to make for the record is the new PACE rate-setting guidance from CMS that was effective January 2025, it requires actuarial

documentation and certification for soundness if the rates are developed by an actuary. So I just wanted to make sure I said that out loud.

CHAIR VERLON JOHNSON: Okay. All right. Carolyn and then Mike.

COMMISSIONER CAROLYN INGRAM: That's very helpful information and context.

I just want to clarify that the reason -- for the Commissioners is the reason you're hearing concerns from four people on the side of the table.

An example of that. So, my parents, my grandparents were living in the community, and I tried to get them into PACE programs in an urban setting. They were both denied and because they were seen as too high need. They continued to live in the community for several months and then eventually both died in nursing homes.

So I think saying, you know, we want to hold PACE to a standard and not have it have bias about who gets in or gets enrolled and make sure that it has quality outcomes and make sure that its network is adequate so it can't just deny care from people when they feel that they're too high risk or when they feel that they need to then move back

into a nursing home and they get left behind, that's why you're hearing kind of some of the concerns. So I think it's based on real experience.

I'm not discounting that there are people in the PACE program who find it to be a great program, but there's some work that we definitely need to do.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Carolyn.

Mike.

COMMISSIONER MICHAEL NARDONE: I was just going to say just there are, quickly -- the indicators, there are -- I just want to point out that there are 23 indicators that PACE does have to report on. Those -- some of those are some of the measures that we recognize, like emergency utilization, hospitalization, you know, not the level of HEDIS, right? But they have been able to be used in some of the national studies to demonstrate, you know, what is the effect of the PACE model during COVID, you know, some of the analyses that you pointed out in the chapter. So I just want to kind of put a pin on that, that there is some data. It's not as robust as we would like, but there is data around the quality.

And then just also put a point in the fact that the states set the rates for PACE, right? The requirement, as the way I understand it -- and you tell me if I'm wrong, Brian and Drew -- that it's like the requirement solely is it's less than the average cost of what they would be if they lived otherwise. And that AWOP would include, for instance, what -- you know, as states are moving forward with managed care, managed long-term services and supports, that should include the data from the MLTSS programs in terms of what would be the cost for those folks if they are, you know, in the MLTSS system.

And so I just want to kind of make sure that -- like, there's a lot of concerns being raised, but I just want to make sure that we understand that there are some data that's collected, not as robust as we would like, and states do have flexibility around the rates.

And finally, I think what's just interesting to reflect on is, you know, thinking about the history of the dual-eligible programs and SMACs, right? You know, there is the ability to do two-way agreements with the PACE programs, and I wonder if that is in a direction maybe more states could go in in order to kind of achieve some of the,

you know, improvements that they might like to see or some of the things they might like to see. And, you know, the SMACs started out where they were pretty pro forma, and over time, they really evolved to be more robust documents.

So areas for future work.

CHAIR VERLON JOHNSON: All right. Thanks, Mike.

And then I'm just going to close it out with Heidi.

COMMISSIONER HEIDI ALLEN: So thank you for that, Carolyn. I think that one of the things that strikes me, though, is, like, in managed care, you think of cherry-picking as, like, they try to dissuade high-cost patients from going into their managed care company because they don't want to spend more money, whereas with PACE programs, I think that the limit they're setting is they have a certain type of patient that they feel like isn't served well in their model. And that may be somebody who has higher needs, and they feel like they can provide in a day service model.

And my question is, like, can't that be okay? Can it be okay to say, this model actually isn't for everybody? Because it's more like an educational setting

saying this isn't the best learning environment for people -- you know, like saying, you need to be in a special classroom because this classroom isn't going to be able to meet your educational needs and not the same thing as saying we don't want to spend money on you. So it's like cherry -- it's a different way of thinking about cherry-picking.

And I think that we should, like, not conflate the two, that to say that this model may not be for everything isn't cherry-picking in the way that we think of it -- or for everybody is not cherry-picking in the way that we think of it as a managed care company trying to get away with not serving people that cost a lot of money.

But I do -- I can imagine, you know, having spent time in visiting PACE programs that -- you know, that there would be people for whom, you know, a group environment like that in a day center, that they would not be able to give that person enough attention or support, and they would worry that they would be happy -- not be happy there. And that's just like -- so I think that those kinds of things really should be teased out when we think about our recommendations about accountability for who was selected

to be in those and who aren't.

CHAIR VERLON JOHNSON: All right. Thank you. Thank you both for that.

COMMISSIONER CAROLYN INGRAM: I'll just briefly respond.

CHAIR VERLON JOHNSON: How brief?

COMMISSIONER CAROLYN INGRAM: You know, maybe we agree to disagree, but when you have somebody determining the enrollment who's also getting paid and having to make the expenditure out, I think that's a huge conflict, and I think it does present a problem there.

I'll stop there.

COMMISSIONER HEIDI ALLEN: But they're also the ones to --

CHAIR VERLON JOHNSON: Guys, okay, let's stop here, okay? We can have many, many more conversations about this. We have a lot more issues to get to today.

Thank you both for all that you've done today. We appreciate you.

All right. Next up, going to the Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you very much.

As we make the transition and bring Kirstin up --

all right. You ready? Okay. We'll get started on self-direction for Medicaid home- and community-based services.

SELF-DIRECTION FOR HOME- AND COMMUNITY-BASED SERVICES

* GABBY BALLWEG: Thank you, and good afternoon, Commissioners.

So today, I'm going to be presenting on our draft chapter for self-direction for Medicaid home- and community-based services. This will be included in the June 2025 report to Congress, and the chapter incorporates an overview of self-direction for home- and community-based services, or HCBS.

I've presented on this at the December 2024 meeting, and then we also discussed the interview findings at the February 2025 meeting. So this presentation is going to follow an overview of the chapter which is reflected on this slide.

I'll begin with some background primarily which includes Medicaid coverage for self-direction and key stakeholders in program administration. Next, I'll discuss some of the state design considerations followed by a discussion of state administration of self-direction and

those considerations. Lastly, I'll wrap our conversation up with some next steps.

And with that, we'll get started on the background.

So the chapter begins with the description of Medicaid coverage for self-direction, and as a reminder, self-direction is a beneficiary-controlled home- and community-based services delivery model that allows the beneficiary to choose their service providers and to have control over the amount, duration, and scope of services that are outlined in their person-centered service plan (PCSP).

It's important to remember that although there are these flexibilities in the self-direction program, they do operate within the existing HCBS framework. So self-direction is not fundamentally changing the level of care determination process or what the state or a third-party administrator deems as the appropriate level of support for an individual in a community.

The Centers for Medicare and Medicaid Services, or CMS, requires several components that all self-direction programs must include. These are the person-centered

planning process and person-centered service plan, or PCSP; information and assistance in support of self-direction; financial management services, or FMS; a system of continuous quality assurance and improvement; and an individualized budget.

In each state, an array of different players interact in a complex system to offer self-direction, as you can see on this slide. The state Medicaid agency administers the model, but the Medicaid agency can designate program administration to 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 assistance support roles, which can include managed care organizations when operating in a managed care environment to help beneficiaries better self-direct and to resolve any

issues as they arise.

The beneficiary interacts with information assistance professionals like case managers and support brokers so that they can effectively and safely self-direct their home- and community-based services.

The beneficiary may also select their FMS agency when there are multiple in a state and interact with the 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 instances. This worker will provide HCBS as outlined in the beneficiary's PCSP.

The HCBS worker is enrolled with the FMS agency so that they may receive payment for approved services, and each self-direction program may establish their own network of supports for the beneficiary. That means that this graphic is really a general model, but there can be variations by state or even by a program within a state.

Following this overview, the chapter moves on to a discussion of state design considerations based on what we heard in our interviews.

When designing their programs, states choose the Medicaid authorities to use for self-direction and often do so based on their policy and programmatic goals and on the authorities that are already in use in the state. Among the HCBS authorities, most states use Section 1915(c) waivers to provide self-direction.

State officials also identified a broad array of populations who self-direct. Interviewees shared several considerations regarding the level of supports necessary for beneficiaries to effectively self-direct their HCBS. They noted that some individuals such as those with dementia or limited English proficiency may need additional supports.

Interviewees also shared that beneficiaries with strong natural supports, such as individuals with adult children who live nearby, may need fewer additional supports in order to effectively self-direct their services.

State agencies must also consider the HCBS available for self-direction. These services can vary by program, and our case study states frequently offered self-direction for many different services including respite,

personal care, and equipment, technology, and modifications.

For each service in the self-direction program, the state agency must determine whether to allow beneficiaries to have control over their service budget, or what we call "budget authority," or to have control over employing their HCBS workers, or what we would call "employer authority," or both. State agencies choose to offer employer or budget authority by service in a program. For example, in one self-direction program, the agency could choose to offer both employer and budget authority for personal care services but may select to only offer budget authority for equipment, technology, and modifications.

Another flexibility many state agencies offer is the option to hire family caregivers. Interviewees noted that the option to hire family caregivers can help to address the HCBS workforce shortage, increase access to HCBS in hard-to-reach areas such as rural areas, and help provide more culturally competent care.

After outlining the state design considerations, the chapter continues with a discussion around state

considerations for program administration. State agencies must establish the roles and responsibilities for their staff and third-party entities that provide information and assistance supports. Some states rely on entities that beneficiaries are already familiar with to provide these supports. States usually have multiple information and assistance entities operating within the program, and their roles can often overlap, which may be difficult to clearly distinguish from one another both within and across states.

For example, among the case study states we interviewed, the support broker role was often not very clearly defined according to interviewees, and some other information and assistance entities may have provided some support broker services.

Lastly, interviewees, especially information and assistance entities and FMS agencies, emphasize the importance of collaboration across third-party entities in a state to effectively support self-directing beneficiaries.

State agencies can also take different approaches to administering FMS. They can contract with multiple FMS agencies, a single agency, or provide FMS in-house. State

agencies can also take different approaches within a state. For example, one state in our case study provides FMS in-house for some of its programs but also contracts with multiple FMS agencies for other self-direction programs in the state.

The different approaches that state agencies take to providing FMS represent some trade-offs between minimizing the administrative burden with fewer FMS agencies to oversee or maximizing some beneficiary choice by having more FMS agency options available.

Lastly, the chapter discussed the quality reporting, monitoring, and oversight in self-direction. To conduct these activities, states rely on information and data from contracted entities. According to subject-matter experts at the federal level, these experts can't always identify the total spending or enrollment data specific to Medicaid self-direction. Researchers noted that the CMS does not require personal identifiers for beneficiaries self-directing their HCBS in the Transformed Medicaid Statistical Information System (T-MSIS).

At the state level, interviewees cited poor data systems infrastructure and interoperability among entities

as key barriers to program administration. Primarily, they noted that data systems are not always set up to handle self-direction specific information, like variations in HCBS workers wages for the same service or to share beneficiary data across information and assistance entities and state agencies.

Lastly, state officials noted that the CMS final rule on ensuring access to Medicaid services may support some state quality monitoring of self-direction programs. Specifically, they noted the provision that requires states to report the time it takes for a self-directing beneficiary to receive services from the day that they were enrolled in the program.

Now I'll move on to our next steps. At this time, we're looking to obtain any additional Commissioner feedback and specifically feedback around our draft chapter, and we're also happy to address any outstanding questions. As a reminder, this chapter is planned to be published in the June 2025 report to Congress.

And with that, I will turn it back to the Vice Chair. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Gabby.

Thank you, Kirstin.

All right. Commissioners, any thoughts on the chapter and feedback? Patti.

COMMISSIONER PATTI KILLINGSWORTH: You did a great job of explaining a very complicated subject. So I appreciate your work.

I am -- a comment and then a question. So the comment really relates to the impacts of the public health emergency. We know that during that time, I think there was a fair bit of growth in self-direction in the use of family caregivers to -- and the payment of family caregivers to deliver services, a lot of new flexibility that states chose to grant some of it temporarily, specifically around legally responsible individuals. I'm curious, when you think about your case study states, if any of those states sort of voiced -- I know they talked about benefits, right, in terms of improving access, in terms of culturally competent care. Did they voice any concerns with regard to utilization or with regard to conflicts of interest or any of those sorts of things? I think I saw the mention maybe around reporting of critical incidents being a potential concern, but just kind of

trying to understand sort of what did we learn from that and then did those case study states talk about their intent with regard to those flexibilities going forward. Is that something they're going to maintain, or are they sort of rolling it back to where they were before?

GABBY BALLWEG: Yeah, that's a really great question.

So kind of going back, you noted the PHE. So you're right on base there. We heard from our case study states, particularly, one of them had a massive amount of growth. It was over, like, 200 percent in their self-direction program during -- I think it was the 2019 through 2023 period. I'll have to go back and check that data point. It's in the AARP scorecard focused on self-direction. They have some state-by-state data, but they did mention that the large growth in the program has made it a little bit difficult to have such a large growth in the number of enrollees in a short amount of time. So that's definitely one point.

Your point on utilization as well, a separate case study state did note comparing utilization, and self-direction, they just kind of gave us an estimate to

regular, more traditional -- I guess I should say more traditional HCBS delivery models. They did note that the utilization was higher in self-direction. They didn't expand as much on why that is.

There's some research out there around this topic, but generally, our understanding is utilization is generally higher of HCBS in self-direction than the general HCBS model. So that did come up. It didn't sound like a concern of the states that shared that with us but definitely something that they are aware of.

In terms of the conflicts of interest, I think we do talk about that a little bit. There can be -- and we do discuss this a little in the chapter as well -- sometimes a conflict of interest when the person who you are paying to provide a service is also a family member. So there is some balance there.

It wasn't, in terms of what we heard from state officials, a large concern from state officials, but definitely something we touch on in the chapter, and I'm happy to go back to our notes as well and make sure we've really fully fleshed that out. Yeah.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

Dennis?

COMMISSIONER DENNIS HEAPHY: Thanks for the chapter. It's really good, and I'm still perplexed by it somewhat, and I'm sorry. I'd almost like to see a second, like below the chapter title, "the Cash and Counseling model," because I think that's what we're actually talking about is Cash and Counseling, and because there are lots of different self-direction models usually employer, like consumer-employer models. But that's a subset of what this larger self-direction Medicaid home- and community-based services is really talking about, because I don't have -- I mean, I have -- I have control over the PCA to hire and fire them, but I don't have control over the dollars. I want to have control over the dollars for wheelchair and any of those sorts of things, and so I think like just clarifying and making it clear that this is a comprehensive understanding of self-direction.

And I think you just mentioned that there are times where when someone may only be permitted to have self-direction over certain aspects of their of their services. Is that correct? Like DME and --

GABBY BALLWEG: Like, so people are only

permitted to provide self-direction for certain services?

COMMISSIONER DENNIS HEAPHY: Yeah, yeah.

GABBY BALLWEG: Yes. So it varies by authority. I think, like, what you're saying Dennis, like, some authorities are specific to self-direction. So every service in that authority is self-directed, but other states will actually offer some services within the authority to be self-directed and others not. So is that what you were --

COMMISSIONER DENNIS HEAPHY: I think it'd be helpful for me if you could bring that out more in the chapter, just saying how different each -- how different -- how differently each state implements this and that some states are -- like, only provide Cash and Counseling for this service or that service. And I'm assuming based on what I read that these are all Cash and Counseling services.

GABBY BALLWEG: Yeah, we did -- we spoke to a range of states. So, like, for example, we heard about, like, the Massachusetts personal care assistance program, and that one is -- you don't have budget authority. You only have employer authority. So like you're saying,

Dennis, more -- I don't want to say restrictive, but they -- it's very selective in what the authority is for the beneficiary in self-direction which may be different, a different experience for the beneficiary if they are in a different program where they manage both the budget and employer authority.

COMMISSIONER DENNIS HEAPHY: But I think bringing up those differences in the chapter would be really helpful.

GABBY BALLWEG: Yeah, we can do that. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

We have Michael, then Heidi.

COMMISSIONER MICHAEL NARDONE: Thanks, Gabby, for trying to synthesize all this work. It's obviously a fairly complex area, and that's actually my question. You know, the one thing that I'm struck by as I read through the chapter is the amount of variability that there is in these programs and how they differ from state to state and just how much flexibility the individuals get with respect to employer authority versus budget authority. And I'm just wondering when you -- when you talked to the states, did they feel there was enough guidance and technical

assistance available to them as they were developing these programs? Are there some best practices that that states have found or that need to be kind of -- that would be helpful to other states as they design these programs? Particularly, as you know, there has been a significant expansion during the COVID period.

So that was really where I went with this as I read the chapter. It was helpful to hear all the different points, but I just was wondering if states felt supported enough in the development of these programs.

GABBY BALLWEG: Yeah, I think we heard -- it was a bit of a mix there. Some states felt like, you know, they've had these programs for a while now. They think we -- they know what they're doing, and they're implementing it. So I think there was that side of things.

There are some states who maybe they were trying something new, maybe they were trying self-direction for children, for example, which was one thing we heard, and that's a little bit more complex, a little bit different. And so, in those instances, maybe more guidance could have been useful.

But, in general, states felt that they did have

the appropriate level of guidance from CMS. We did, as a part of our literature review, also look at CMS guidance documents as well, so we kind of have an idea of what's out there for self-direction. But it's definitely something we'll keep looking into as we're going into phase two of this multi-cycle project and kind of keep thinking about. Does that kind of help answer your question?

COMMISSIONER MICHAEL NARDONE: Yes. I mean, I think that there some really basic -- you know, the role, I mean, I'm thinking about some of our -- you know, some of the programs in Pennsylvania. You know, the information and assistance function is -- as you pointed out in the chapter, is provided by different entities for different waivers, and so I guess I'm just -- it's just interesting about how this has evolved over time, and I just wonder just understanding that a little bit better and whether or not there is some information that could be provided to help states in the development of these programs.

GABBY BALLWEG: Yeah, definitely. And I will also note I forgot to add states were really interested in the topic as well and interested in the work that we're doing here, so we're definitely reaching back out to some

of our interviewees to share what we found so far.

COMMISSIONER MICHAEL NARDONE: Great. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Gabby. Thank you, Michael.

Heidi, you have the last part of this.

COMMISSIONER HEIDI ALLEN: Finally. No, I'm just kidding.

So you mentioned utilization, that some states reported that utilization was higher. Is this the one state that tracks utilization, or was this broader than that one state?

GABBY BALLWEG: So states generally look at utilization reports for beneficiaries. That's part of a lot of their quality monitoring and oversight processes. Generally, states kind of have an idea of utilization in terms of the states, some states noted to us -- I think where we were talking about the data challenges -- that they sometimes struggle in terms of understanding how many people are in self-direction versus people who are in a general HCBS model when they're looking at the data. So kind of disaggregating between those two groups can be challenging, and then at the national level as well, we

don't have a consistent data that we're able to say for Medicaid-specific self-direction. Does that kind of clarify?

COMMISSIONER HEIDI ALLEN: Yeah. And I just think that, like, just understanding utilization, like, as a concept would be -- like, are we talking about total costs? Are we talking about hospital utilization, emergency department utilization, outpatients, prescription? Because some of -- some utilization to me would be an indicator of higher quality, like you would want people to be getting care that we think they should be getting, like having a primary care visit every year and getting preventive immunizations, things like that. And then some care, we would look at as concern that maybe somebody is not receiving the care that they need in their home, like if they had higher emergency department visits or readmissions to the hospital after hospitalization. So I think that, like, really figuring out what they mean when they're talking about utilization, or is it total costs because total costs could be either they're getting really good preventative care and it's so expensive or else they're getting the higher acuity care, and it means that -

- you know, it's like just trying to tease through that intersection.

GABBY BALLWEG: Yeah, in that context, they were talking about HCBS utilization so they weren't specifically talking about, like, emergency department utilization, for example.

And in terms of service utilization, if that's more specific, not so much on the cost side.

And then I guess one other maybe data point, this is a little older, but so in the Cash and Counseling demonstrations, they did evaluations there, and they also looked at -- I believe in that, like, emergency department utilization as well. I'd have to go back to it. I think it's from around 2007 when they published that report, but it's another great data point out there for self-direction.

VICE CHAIR ROBERT DUNCAN: Okay. I was just kidding. So Carolyn's going to get the last one, a very short one.

COMMISSIONER CAROLYN INGRAM: I'll be very quick, and you don't have to answer it all today. But just in your data or your interviews, were you able to tell what states are doing to protect individuals who are self-

directing to make sure they actually get a service? I understand EVV is being used to prevent fraud and abuse of somebody saying, "Oh, I'm at McDonald's working, but I'm also over here working." But are states doing anything to ensure somebody who's self-directing is actually getting a service and even on top of that making sure they're not abused in that regard?

GABBY BALLWEG: Yeah. So I think that goes kind of back to our comment on, like, utilization reports, for example. One of the things that we heard states do is they are monitoring the use of services that are outlined in the person's PCSP, and so, for example, if a state sees that someone's not, you know, using as many services as they think that they should be within a given time frame based on their PCSP, then that would kind of trigger additional steps to check and make sure that person is getting the services that are outlined. And also, vice versa, if they're, you know, blowing through their services really quickly, that would maybe indicate, oh, the beneficiary doesn't quite understand how to manage their services, maybe they need more education, or maybe there's something else is going on. So that's one thing we heard.

Another piece we heard was check-ins. So sometimes the FMS representatives have check-ins with the beneficiary.

Another example we heard were, like, case managers having to do check-ins. The frequency is different, but one state said they do it every year. One state said they do it more quarterly. I think it ended up being around three per year. So I think there's different approaches that we heard from states but definitely also something we can continue looking into as we move into phase two. Yeah.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn. Thank you, Gabby.

Kirstin and Gabby, do you feel like you have enough to finalize the chapter for June?

GABBY BALLWEG: Definitely. Thank you.

VICE CHAIR ROBERT DUNCAN: All right. Thank you.

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

CHAIR VERLON JOHNSON: Thank you.

All right. So we are inviting all of you in the audience to raise your hand if you'd like to offer

comments. Please make sure you introduce yourself and the organization that you represent, and we do ask that you keep your comments to three minutes or less.

And with that, Katie Pahner, I believe, you are up.

[Pause.]

CHAIR VERLON JOHNSON: Katie, can you take --

PUBLIC COMMENT

* KATIE PAHNER: Yes. I'm sorry. I just saw the prompt. Apologies.

Good afternoon, everyone. My name is Katie Pahner, and I'm with the National PACE Association.

The National PACE Association represents all 184 PACE organizations that operate in 33 states and the District of Columbia, serving more than 82,000 participants across the country.

We appreciate the Commission's interest and focus on PACE as well as the thoughtful approach that MACPAC has taken to gain a comprehensive understanding of the PACE care model and its role as an integral part of the landscape of integrated care.

PACE is widely considered the most fully

integrated care model, providing comprehensive medical and social services to older Americans, most of whom, as was noted today, are dually eligible for Medicare and Medicaid, with the goal of keeping them living safely in their communities for as long as possible.

Respectfully, I would like to take the opportunity to address some comments made regarding the lack of traditional managed care network adequacy guardrails in PACE. PACE organizations are held to broad network adequacy requirements that ensure that participants have a right to a choice of health care providers within the PACE organization's network that is sufficient to ensure access to appropriate high-quality health care. Federal PACE regulations also specifically require that PACE organizations ensure participants have reasonable and timely access to specialists, as indicated by the participant's health condition and consistent with current clinical practice guidelines.

Notably, CMS does delineate specific requirements in the federal regulations to ensure that participants' reasonable and timely access to medical specialists, requiring PACE organizations, in fact, to execute and

maintain contracts with a minimum of 26 commonly used medical specialties in PACE. That's the minimum floor.

Regarding beneficiary enrollment considerations, it really is important to note the unique health and social needs of PACE participants relative to their ability to live safely in their homes and communities. The average PACE participant is 76 years old and has six or more chronic conditions, and nearly half of PACE participants are living with dementia.

The criteria that PACE organizations use to determine if an individual can safely live in the community are established and must be approved by the state. If it is determined that the prospective PACE participant's health or safety would in any way be jeopardized by remaining in the community setting, the PACE organization must deny enrollment.

The state provides oversight of the PACE organization's administration of the criteria, and any associated enrollment denials based on the application of the criteria. In those select situations where a participant is denied enrollment, the PACE organization must notify the state and CMS.

We understand the state may not have the capacity to closely monitor every denial, but if there is a PACE organization that routinely denies enrollment and there are concerns of cherry picking, we would truly hope that the state would address those cases and engage the PACE organization on the issue. We take this issue seriously.

In closing, we know the firsthand promise and potential of PACE, and we do not want PACE to be the best-kept secret anymore. To enhance access to PACE and to sustain the quality of care for participants, we do support wholeheartedly CMS's development of a uniform set of PACE performance measures that are both important and actionable for the PACE population without overburdening PACE organizations to ensure that that will help sustain the quality of care for participants.

NPA encourages CMS to work with states and PACE organizations to develop thoughtful and targeted national PACE standards for service delivery and performance data sources and metrics. Please feel free to reach out to NPA at any time with questions or if you need additional information. We welcome the opportunity to further discuss some of the questions and concerns raised today.

Thank you again.

CHAIR VERLON JOHNSON: Thank you, Katie.

All right. Camille?

CAMILLE DOBSON: Good afternoon, Commissioners. This is Camille Dobson, your frequent-flyer commenter today. I'm the Deputy Executive Director at ADvancing States, and we represent the state agencies that serve older adults and people with physical disabilities in delivering high-quality home- and community-based services.

There was a lot on the agenda today about HCBS. So I'm going to dial back to the first presentation from Tamara about eligibility processes, and I really applaud Patti's -- sorry -- Commissioner Killingsworth's summary of the long time it takes to get an individual from when they present needing HCBS to when services are actually delivered.

We have increasingly gotten requests for technical assistance from our members around the issue of financial eligibility. That seems to be the biggest sticking point in terms of speeding the process along.

Some of that is a factor of who is actually doing financial eligibility in many states. It has been

delegated to the typical -- and I say this in quotes -- "welfare agencies" that are doing social service public benefit program eligibility, and this, of course, is challenging because you need a lot of specialized knowledge to do financial eligibility.

We have been informally surveying some of our members, and we highlight those states that are able to do it in less than 90 days, and there are a handful of them. They have told us that they find access is speeded much more quickly when individuals come to the system already having SSI, because Social Security Administration has already done some of the resource and asset verification that would speed up the process and tends to be the longest drag to the financial eligibility process.

I would also offer that initially we thought, much like Patti, that functional eligibility would come first and financial would come second, but we are finding states that recognize that they are investing resources in functional eligibility determinations for individuals that may never actually qualify financially, and that now they are pausing and having individuals go through the financial eligibility process first. And when that looks like if

they have touch points that indicate that the person is very likely to be financially eligible, then they will deploy their assessment process, whatever it is, to do the functional eligibility. It is such a choke point, that I really applaud the Commission for undertaking this work, because it is very few experts in the states anymore, as retirements are hitting the eligibility system, who understand the nuances of financial eligibility in particular. So anything that the Commission can do to raise this issue would be appreciated.

And then pivoting quickly to PACE, I did want to highlight that while there are measures that the PACE organizations report to Medicare, none of them really address the home- and community based services aspect of the services that the PACE centers deliver so well, and we have found states that are participating in our national core indicators for aging and disabilities quality of life survey that is offered to individuals that are getting any kind of publicly funded services.

Four of our states participating do include PACE participants in that survey process, and so one of the benefits of doing this is that it is, in fact, a

standardized tool that can compare programs across the state system. So we've got a state that has MLTSS. They have PACE programs. They actually survey people in their nursing facilities as well as all of their waiver -- regular fee-for-service waiver participants and can really see what those indicators around choice and control, health and safety, access to the community across the different settings. And so we very much encourage our states, when we talk to them about who they'd like to survey, that they -- because of the growing nature of PACE and the expansion that's been seen in a number of states, that they include PACE participants in that survey, which would really give the states some kind of standard quality benchmarks on the HCBS aspects of a person's PACE experience.

And we'd be happy to provide that information to the Commission if that would be useful. Thank you.

CHAIR VERLON JOHNSON: Thank you, Camille.

Eric, you're up next. Eric Carlson.

ERIC CARLSON: This is Eric Carlson from Justice in Aging. I'm commenting on the timely access discussion, and this is expanding upon a point that Ms. Killingsworth made. She pointed out that in the nursing facility space,

generally folks are eligible to -- as a practical matter, they're able to get into nursing facilities immediately, today, tomorrow, whatever it may be. And I observed that that's not because the financial calculations are easier or quicker necessarily in a nursing facility setting or whether the level of care determinations are done more rapidly. It's because nursing facilities are willing, I think, to admit people and run the risk. I imagine it's because facilities are obviously operating in any case, and it makes sense to them to admit someone, knowing that they're still paying the nurses and nurse aides and the dietary and whatnot. And so there's not a huge exposure to admitting one more person.

That may be the same in some day settings as well, but it's not in an HCBS setting where there's a personal care worker, for example, who specifically is providing care to one person in his or her home. So I just make this observation.

I understand that the Commission has considered several of these related issues and that presumptive eligibility was just included in the most recent report, but I suggest that it's worth thinking about the totality

of those issues in this study, talk to some of the providers, get some sense of the decisions that they're able to make, because it's not about -- it's not necessarily about reducing the administrative time from three months to two months.

Ideally, it would be a matter of making changes that would allow HCBS to start immediately, the way that in many cases it starts, as Ms. Killingsworth notes, in nursing facilities immediately.

CHAIR VERLON JOHNSON: Thank you, Eric. We appreciate your remarks.

Teja?

TEJA STOKES: Good afternoon to the Commission. My name is Teja Stokes, and I'm the Deputy Executive Director for the National Association of State Directors of Developmental Disability Services (NASDDDS).

Our association is the members of all the state I/DD programs nationally. Our agencies oversee three-fourths of the nation's home- and community based services, spending and support more than 1.3 million people annually through home- and community based services, as well as institutional services, although be it to a lesser degree.

We are very interested in the Commission's work on self-direction and are happy to make a public comment about that today because, as has already been noted, we do see within our state I/DD programs an increased uptake of self-directed options. And while this does afford people maximum choice, autonomy, and flexibility, our members are seeing that they don't have direct lines of sight into service delivery, service quality, and/or adherence to approved plans of care. So we hope that the Commission continues to shine a light on these particular issues, identifying the challenges, the barriers, and potential solutions.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Teja.

Any other comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. Well, if you have additional comments, feel free to email, to submit those to our MACPAC website, and with that, we are going to go ahead and go right into our next session.

So could I have Emma and Katherine to the front?

While we're waiting, let me just give you an

introduction. We are doing a panel on AI and automation in prior authorization process. As you know, we started this conversation at our previous meeting. It's very timely, given all the information we're hearing about AI and prior auth, for sure.

So we are going to have Emma and Katherine to join us, and they will introduce the panel as soon as they are ready. Hi, everyone. You can hear me now.

[Pause.]

PANEL ON AUTOMATION AND ARTIFICIAL INTELLIGENCE (AI) IN THE PRIOR AUTHORIZATION PROCESS

* EMMA LIEBMAN: Hi, everyone. So we're just getting all of our panelists situated, but in the meantime, just to kind of introduce what we're doing here -- so it's great to be here. Katherine and I are returning today with a second installment of our ongoing work on automation in Medicaid prior authorization, and the focus of this work is on automation tools that supplement or replace human decision-making, including AI.

Last month, we provided an overview of findings from our literature review, including the policy framework, some of the uses of automation, and some potential benefits

and risks associated with these tools. And today we're moderating a panel to help deepen our understanding of the current and future role of automation in this space and to help guide our work going forward.

We're joined by three experts on automation in health care who bring expert -- extensive knowledge, rather, across a variety of perspectives. We are joined by Dr. Sanmi Koyejo, an associate professor in the Stanford University Department of Computer Science. Sanmi additionally serves as principal investigator of Stanford's Trustworthy AI research, which focuses on developing principles and practices of trustworthy machine learning across several arenas, including health care.

We are also joined by Heather McComas. Heather is a pharmacist by training and serves as the director of Administrative Simplification Initiatives at the American Medical Association. Heather brings substantial expertise in prior authorization and has fielded national surveys to better understand physicians' experiences with utilization management efforts.

And last but certainly not least, we're joined by Wayne Turner, who is a senior attorney with the National

Health Law Program. Wayne additionally serves as a consumer representative to the National Association of Insurance Commissioners, with whom he recently published a report on the use and regulation of AI in utilization management.

So thank you to all of our panelists for being here today. We're really looking forward to learning from you all.

As usual, with our MACPAC panels, Katherine and I will moderate discussion with our panelists first, and then we'll open up the floor to Commissioners to provide their own questions.

And just as a reminder, we have a lot of questions teed up for discussion today. So, to our panelists, if you could please keep your responses to no more than three minutes, and we can do our best to get through everything and hear all of your lovely insights.

With that, I'll jump into our first question, which is for Sanmi. As an expert in machine learning, can you give us a quick primer? What is AI? And from a technical perspective, how is AI used in health care, especially with regards to the prior authorization process?

* DR. SANMI KOYEJO: A real pleasure to be here today. Thank you for having me.

So "AI" is a term that I think has changed in maybe meaning over the course of many years. I think in 2025, AI seems to mean large-language models and things like ChatGPT, but really, it's a collection of tools that are trained with data and are used to either automate decision-making or solve various kinds of generative modeling tasks.

As mentioned at the beginning, one kind of AI tool are things like the language models and image generation models that have captured imagination recently as ways to create poems and things like that. But really, these are much more recent developments and, in some ways, related but I think take so much more attention compared to so much of where AI ends up being used and having a high impact on people tied to trying to scale up or automate various kinds of decision-making.

So these kinds of tools, a few years ago, would have been called machine learning tools, but these are tools that ingest data and try to replicate or sort of speed up various kind of prediction or decision-making

kinds of tools in ways that can be -- I guess I imagine is much more scalable than humans can do them.

So, within the health care, there are a variety of applications where AI has gotten used. I think in the early days, it was mostly imagined tied to prognosis and diagnosis kinds of questions, so, again, these kinds of decision-making tools. And the idea would be that you'd be able to observe various things about a patient and then use a tool to mimic what a physician might say in terms of decision-making.

I think nowadays there is much more maybe promise and so much more -- a variety of different ways that people are trying to use even these kinds of automated decision-making tools but also more broadly AI tools within health care and specifically within prioritization and tasks that look like these.

So these look like decision-making tasks. From an automated or machine learning point of view, the goal here is to make decisions faster about patient care or about care for various kinds of stakeholders, and so these tools will, again, take information about individuals and make some kind of prediction about some outcome.

And the goal here is to be able to do this quickly and ideally to do this accurately in a way that is both efficient but also effective for everybody, and I think this is where a lot of work is being done but also, I think, more needs to be invested.

In my group, we spend a lot of time thinking about the ways that machine learning tools can make predictions that don't work well for everybody and so can lead to equity gaps across individuals and across different groups and ways that we can improve the tooling, such that those happen less frequently.

Often the source of this is the data that the models are trained on, but the consequences can be significant because, again, the key artifact or the key property of these kinds of tools is that they can do this at scale efficiently. And they do this all the time. So there's no -- the scale and the sort of amount of decisions that it can make per unit time, I think much larger than most humans can do, even across large groups. And so the impact can be quite large, and so it's quite important to build these tools in such a way that they are equitable and then work for everybody.

And so I think that's a lot of where the frontier is within both the science but also the practice of building machine learning and AI tools is thinking through what it -- what equity and sort of good performance means in ways that works for everybody and making sure we can build these tools such that the outcomes that we want are the outcomes that we're getting.

EMMA LIEBMAN: Thank you so much. That's really helpful grounding, thinking about both the science and the practice. I like the way you said that.

So switching gears a little bit, I'd like to hear from our panelists about some of the ways that automation tools like AI can improve the prior authorization process for relevant stakeholders, so payers, providers, and importantly, beneficiaries.

Wayne, if we could start with you, can you share your thoughts on ways that automation tools, including AI, can be used to improve the patient experience and outcomes, specifically with regards to authorizing or paying for health care?

* WAYNE TURNER: Sure. And thanks so much for the opportunity to be here.

I mean, I think the main benefit for Medicaid beneficiaries and other health care consumers is that using AI for prior authorization and other utilization management can speed up the process to get decisions faster so that those consumers and those patients can get access to needed care faster. So that's a big plus.

I do also want to note that there's been a significant increase by insurers and Medicaid managed care plans in the use of prior authorization. So it used to be reserved just for kind of high-cost care, but our friends at the American Medical Association have some really compelling data on just how prior authorization has really exploded.

I do want to note also that HHS recent finalized the interoperability rule that establishes minimum timelines, seven days for standard prior authorization requests, 72 hours or less for an expedited request. And that's really helpful and important.

We're also going to see some data-reporting requirements. One of the exciting things, too, about that rule is that it applies on multiple kinds of plans, so Medicaid, CHIP, FFM plans, Medicare, so having that kind of

like harmonized regulatory framework is really helpful.

The data reporting kicks in in 2026. It's aggregated, though, so we don't have it broken down in terms of types of service. And also, notably, the interoperability rule does not apply to prescription drugs. Hopefully, we'll see further regulatory action on that front, but again, big benefits for consumers.

EMMA LIEBMAN: Thanks, Wayne.

Heather, the same question for you. What are some of the roles that you see for AI and other algorithms to improve the prior authorization process? And just given your perspective, if you could talk a little bit in particular about the context of providers.

* DR. HEATHER McCOMAS: Can you hear me okay, first of all? Okay.

All right. Thank you so much for inviting the AMA to have a seat at this table. Prior authorization is a huge concern for our members. So we're really glad to be part of the conversation here today.

I'm going to start with two quick caveats. The AMA and physicians certainly see the role of AI and other technologies to improve prior authorization, but it is not

the magical solution that's going to fix this problem. And I want to be really clear about that.

I think a good data point in that is the fact in 2018, the AMA, along with other health care professional associations, and insurer trade organizations released the consensus statement on improving the prior authorization process, and that document outlined five big areas of prior authorization reform. One of those five, 20 percent, was technology, but the other areas included things like - Wayne kind of alluded to -- reducing the overall volume of requirements, which is really important, improving transparency, and ensuring patient continuity of care.

So, again, I don't want any of us to have this magical thinking that AI is going to fix this huge problem. It's very complex and requires a lot of different angles in finding a solution.

Secondly, I want to be clear that the AMA and physicians, when they talk about AI, we're talking about augmented intelligence. I want to be really clear and guard against thinking of AI as a replacement for highly trained clinicians. It should always be a support, not a replacement, for human clinician judgment, really important

thing.

So tagging right on with what Wayne said, we definitely see the potential for AI to improve the process, certainly to reduce clinician burdens in this time of physician workforce shortages and high physician burnout, huge potentials to help AI to help pull data from the EHR to populate prior authorization requests.

Also, on the payer side, as Wayne was alluding to, definitely see the potential for this to improve efficiencies, critically to reduce care delays -- that's so important -- and also just to reduce paperwork in general. And we also would hope that AI would be used for things to reduce overall volume requirements, to identify services for which prior authorization is almost always approved, and get rid of those requirements because they're not really adding any value to the system.

So the bottom line is we see a lot of potential for AI to improve efficiencies and get us to get faster. We think that's great. However, we do see dangers -- and we'll talk about this more in a second -- of getting to fast notes. I think that's where a lot of the risk is around AI use right now for prior authorization. We've

already seen this in investigative journalism reports in the news, I'm sure a lot of you are familiar with, where we're seeing health plans using AI to lead to increased and fast denials, with no human oversight, really concerning.

There was one case where Medicare Advantage plans were using an AI algorithm to essentially discontinue prematurely post-acute care for severely ill patients. So that's certainly not how we want to see AI be used.

EMMA LIEBMAN: Thanks, Heather, and thank you for previewing the next question.

So, as you mentioned, there are some concerns about potential challenges and risks associated with the tools that we've been talking about.

I want to start with you again, Heather. Are there controls that you see as important in safeguarding patient data and patient care in an environment with an increasing AI presence and algorithmic presence?

DR. HEATHER McCOMAS: Yeah, sure thing. So I want to get back to this concern about increased denials. The AMA every year conducts a survey of 1,000 practicing physicians regarding their experience with prior authorization, and in this year's survey, 61 percent of

physicians expressed concern about AI increasing prior authorization denials. And I think this issue of concern about denials is particularly relevant for Medicaid.

I know that all of you are familiar with the 2023 OIG report of Medicaid MCOs that found that, on average, there was a 12.5 percent prior authorization denial rate. And for some of those MCOs, the denial rate was as high as 25 percent. Adding on top of that is the fact that a lot of states don't have appropriateness reviews or other methods to review adverse determinations. So there's a real risk there for patient harm.

And that's something also that's really highlighted by our survey results. Physicians over and over again report overwhelmingly that this process can lead to care delays. It can lead to negative clinical outcomes. It can lead to treatment abandonment, and most alarmingly, in our most recent survey, over a quarter of physicians reported that prior authorization has led to a serious adverse event. That's something like hospitalization, injury, or even death for a patient in their care, that's just really horrifying.

And then on top of that, this process obviously

adds burden, but denials can also increase that burden. Forty percent of our survey physicians indicated that they have staff who just work in prior authorization every day, all day. And a large part of that workload is fighting inappropriate denials.

And I think another part of this risk of using AI in prior authorization is getting away from the personalized medicine that all of us value so much. All of us in our care want to be treated as a unique person with our unique clinical characteristics, our unique social situation. We don't want to be treated as a member of a group and kind of boxed with other people. We want to get individualized care. So we obviously think that controls are really important.

First and foremost, we think that in any case where it looks like a machine is pushing a decision towards a denial, an appropriately qualified clinician needs to get involved and completely review the medical record. That is just key.

Transparency is a huge issue all the time, all the way up and down. Huge, huge issue. First of all, just in terms of payers are using AI in their prior

authorization determinations, Wayne just referenced the National Association of Insurance Commissioners' survey on AI use. And I think one important data point to pull out is that of the surveyed insurers, 23 percent said that they -- only 23 percent indicated that they are disclosing to physicians if they're using AI or machine learning. So that's obviously a huge black box there.

But beyond that, we need transparency regarding how the AI is being trained, what data are being used, what are the characteristics of the patients in that data set. Are there any protections to mitigate bias and discrimination? What clinical criteria are being used by the AI?

And it's also really important moving forward as AI is increasingly used by payers, how is the use of AI impacting coverage determinations? Are we seeing that AI is increasing prior authorization denials? That's obviously not something that we want.

And one final thing I'll throw out there. I think we've heard a lot of chatter in the health IT press in the past months and perhaps years about growing AI arms race between -- in one corner, we have provider EHRs. In

the other corner we have health plan systems. And we're going to battle each other and kind of keep on trying to one-up each other, and I would just say, I don't think that's a good use of our scarce health IT resources. There are better ways to spend our money than investing and just kind of outdo each other on AI.

EMMA LIEBMAN: Thank you so much, Heather.

Wayne, if I could ask you the same question, if you could just add your thoughts on what controls, if any, you see as important here.

WAYNE TURNER: Sure. So I just really appreciate Heather's comments, and she raises such great and important points.

I really do want to underscore, yeah, there are efficiencies, but, I mean, AI can really slow down or prevent access to necessary care through the arbitrary and wrongful denials. Keep in mind that these AI systems, they're using a cookie-cutter approach to health care decision-making. And people are different. Health care conditions manifest themselves differently in different people.

And so when it comes to prior authorization

denials in particular, it's these AI systems, they don't replace or obviate the need for individualized assessments. Again, that relationship with the treating provider, especially when you talk about people with disabilities, people with chronic conditions, people who have very particularized healthcare needs, this kind of one-size-fits-all approach just doesn't work.

And so to the extent that Medicaid agencies and managed care plans are implementing these systems, they really have to be designed in a way so that people can raise their hand, so they can be treated as individuals, because the machine is not going to recognize that.

The second point I do want to kind of underscore, too, is that these systems are only as reliable as the data that they're programmed with. So AI tools that are being used today are often based on historically biased data. So these automated decision-making systems can be programmed, for example, using claims data for commercial insurance. Well, I mean, commercial insurance has historically left out groups, including people with disabilities, low-income people. Claims data is only reflecting approved, paid-for claims. And so the data themselves may embed some of these

biases that are going to be, again, reflected in the outcomes or the decision-making by these systems.

So this really underscores the need for testing, testing, testing. The systems need to be pre-launch tested, monitored while they're being operated, and then the operators need to examine the outcomes to make sure that these tools are working in a way that they've been designed to do.

So often we see that MCOs and the companies that are promoting these AI systems are taking this kind of set-it-and-forget-it approach or kind of like certified bias-free, and then they walk away from it. And that's not the right approach. Again, we need ongoing monitoring and ongoing testing to make sure that these tools are performing in the way that they're supposed to.

EMMA LIEBMAN: Thanks so much, Wayne and Heather, for those insights.

I'm going to pass it over to Katherine to take us to the next questions.

KATHERINE ROGERS: Thanks, Emma.

So thus far in our work, we've cast a somewhat wide net in terms of analyzing the implications of

technological tools that may supplement or replace human decision-making in the Medicaid prior authorization process. This includes artificial intelligence but also extends to other automation tools, including non-AI algorithms we've discussed previously.

As we think about continuing this line of work, it would be helpful to hear from each of you about whether you think there's an important distinction between AI and other technological tools used in prior authorization decisions, and if so, how you suggest we think about that distinction.

And, Sanmi, we'll start with you.

DR. SANMI KOYEJO: Yeah, thanks, Katherine.

And it resonates strongly with all of the discussion so far. Maybe I'll frame some of my response historically in terms of -- and I think this is relevant for this conversation in the sense that the window of what we consider AI seems to shift over time as sort of technological tools advance. However, I think the key issues that come up often are the same and, in fact, sort of repeat over and over again. And to some extent, there's always a danger of repeating mistakes when we don't

recognize this.

So what I mean is, you know, there was a time, you know, maybe a couple of generations ago, where any kind of automated decision-making tool would have been considered the frontier of AI, and so where all of the sort of excitement was. This included things like expert rules. So this would be sort of experts sit down and sort of write down how they think about specific decisions, and then the algorithm mostly just tries to translate expert decision-making rules into sort of some automated pipeline.

I think, again, the frame now is learning from data. So this is, again, I think to Wayne's point, historical observations of sort of what exists and what kinds of decisions have been made and using this as training for an algorithmic tool to then try to hopefully make decisions of the same type as historically.

Again, the good parts of this are the potential to reduce human burden. I think the gaps that show up in here but also, again, gaps that show up any kind of automated decision-making system are, one, I think, to some extent, human automation bias. So there's, I think, quite distinct -- I think a very interesting observation that

humans sometimes can rely too much on automated decision-making as what feels like an authoritative source sufficiently that we don't use our own critical thinking skills.

There's a story from a colleague of mine that I like to tell sometimes. It's far away from health care, but I think it resonates in how people think about automated decision-making. So a colleague, Ayanna Howard, who does some work now at Ohio State University, did this experiment where they were showing people, watching people sort of in a -- the goal was to rescue people who were in a fire situation, and so you're supposed to follow these robots so that you can get out, navigate safely out of the fire situation. And the experiments they had, sometimes robots correctly lead you out, but also sometimes the robots sort of directly lead you towards the fire in a very noticeable, clear way.

And I wouldn't ask in a room, but maybe some of you may not be surprised that a large fraction of people followed the robot into the fire, even though it was very clearly unsafe, because, again, we have this -- often, I think for people, this again, some innate need -- or I

guess sometimes we'll just follow rules and follow automation and forget our critical thinking sometimes. This shows up in all kinds of automated decision-making, and I think is a gap that we should keep an eye out for -- I think Wayne alluded to some of these points -- and sort of automated decision-making at scale and the loss of human agency in that process.

For AI specifically, I think the earlier, the broader discussion. So I think some of what has changed is, again, the change of the frame from the ways that the information is being gathered, so to shift from expertise as a way to get information to automate decision-making to now data. Again, the key issues that show up and the ways that things can go wrong are the same or very, very similar, but I think the detail of how data is gathered or how information is gathered looks different. And so we want to be looking out for historical mistakes or historical biases that will replicate themselves in sort of future decision-making and the risk of scaling up these kinds of gaps, so mistakes that go from something on the order of maybe tens of mistakes per day, because it's a single individual making the errors every once in a while,

to hundreds of millions of mistakes per day when this gets scaled up across because of the role of automation.

I think these kinds of gaps have shown up all the way through the way automated tools have been built. These kinds of gaps are the kinds of things I want to look out for when we're trying to build automated decision-making tools.

So, again, to summarize, I think the key underlying issues -- and I think we'll talk a bit more about some of these over the discussion today. I think a lot of the key grounded issues look the same across automated decision-making. I think the form or the way that they get illustrated look a little bit different, the key difference here, again, being learning from data as opposed to learning from other kinds of signals to build automated tools. But, again, broadly automated decision-making can be beneficial, but has to be done carefully, and doing this with care, I think is the most important lesson to keep in mind.

KATHERINE ROGERS: Thank you.

Heather, we'll turn to you.

DR. HEATHER McCOMAS: Thanks.

You know, certainly understand that we are potentially talking about different tools and technologies here today under this umbrella but would really caution the Commission for getting too bogged down on splitting hairs on nomenclature. You know, from our perspective, any kind of machine-based AI or algorithm or automated decision-making that is making predictions or recommendations or decisions about clinical care has the potential to harm a patient and needs oversight, and that's kind of the way I think we would think about this.

From our perspective, the danger on focusing on decisions too much is that there are going to be loopholes that are going to lead certain technologies or tools outside the scope of any kind of regulation or oversight. And that's where the concern is.

If we too narrowly define AI, plans or their technology vendors can potentially skirt any state or federal regulation or legislation, and that's where the concern is.

And as I think Sanmi just so eloquently noted, how we define AI changes over time. So we don't want something to escape oversight just because it's new or it

doesn't fall under a preset definition.

All that said, I think it's something that's helpful to think about is where in the prioritization process AI might be used and what the potential risks are in that potential use case. Starting off on the provider side, AI could be very helpful in helping physicians pull together the data from the EHR to send to the health plan.

So some potential things to think about there, first of all, is obviously the data quality and data standardization. I think Wayne was alluding to this before. We need good data. The old adage, "Garbage in, garbage out," certainly applies here. So that's a huge concern.

Obviously, there are real data privacy and data security concerns here as well. As we look at more automation and prioritization processes and payers interacting with EHRs, there is the potential for more than the minimum necessary data needed and mandated under HIPAA to be shared with the payer, more than is needed to support that prioritization request. That's obviously a huge patient privacy concern. So there needs to be guardrails in terms of what data the payer is able to access for that

prioritization request.

And then, obviously, cybersecurity is a huge concern. The more players we have, the bigger the risk for a breach is. I think we need to look no further back than the massive Change Healthcare cyber breach last year to realize what the consequences could be for our whole health care ecosystem. So, again, data security is a real concern.

Also, I think something to think about from the provider side is that as we advance technology and AI and improve efficiency on the provider side, we don't want to leave smaller or rural practices behind. We just simply don't have as many resources to invest in technology. So we need to make sure that they are able to access these new technologies and benefit from them as well. We don't want it just to be confined to a large health system that have a lot of resources.

And then, obviously, on the payer side, with payers using AI to make these decisions, there is an alluded-to huge risk in terms of inappropriate denials, and that's why transparency and governance and regulation are so important, again, having a clinician involved in any

adverse determination, a clinician that is trained in that area of care.

And then also, again, being completely transparent about when we're using AI, how it's being trained, has it been trained for any biases, that sort of thing, all really important as we talk about this.

KATHERINE ROGERS: I think some of you have gotten ahead to our last question, but I'll give Wayne an opportunity to talk about the distinction between how we consider AI and how we consider other tools.

And just a note that we're closing in on our time today. So I encourage you to be as succinct as possible.

WAYNE TURNER: Sure.

I do want to kind of call out that we're talking about prior authorization, but these AI tools have other uses in Medicaid, specifically on level of care assessments to determine, for example, how many hours of private-duty nursing a person with disability in an HCBS program might receive. And so a big shout out to my NHeLP colleagues who have done a lot of work on the use of AI in the assessment tools, eligibility systems.

So I know MACPAC is specifically looking right

now at prior auth but really encourage you to think about the broader spectrum of the uses of these tools within the Medicaid program.

We use "automated decision-making systems" because that's a really broad term. It applies to the kind of machine learning, but it's also the very more simplified protocols used to kind of match up someone's eligibility, for example.

I do commend you to the National Association of Insurance Commissioners, which developed a model bulletin that's been adopted now in well over a dozen states, and the model bulletin is, again, the beginnings of a regulatory framework. But it includes definitions for things like machine learning, some of the AI systems. So that could be helpful to you all as you're kind of pursuing this work.

KATHERINE ROGERS: Thank you so much.

So a last word from each of you, considerations for oversight. So, as we wrap up just our line of questioning and we'll turn it over to the Commission for their questions, what tools do you think are needed to balance those risks and benefits? Some of you have already

mentioned some of these before. But of emerging AI tools and other tools in health care, what role do you see for policymakers to make these tools available?

And as you think about your answers, if you have evidence of effective policymaking, the model bulletin is a great reference there, Wayne, in this arena to date and what that looks like if you could share those.

So, Sanmi, we'll go back to you to start.

DR. SANMI KOYEJO: I think both Wayne and Heather have highlighted a lot of what I think are most important to maybe discuss today.

I'll also confess that, again, my clearest expertise is on the AI side and with work on health care applications. So I think both about the core on the AI side and some of these connections, I don't have nearly as much policy expertise to be able to give. So I'll leave maybe Heather and Wayne to dive in on details there.

I will say from someone who has been learning a lot about the policy space, to our earlier conversation, an observation I have is there is this frame of newness that sometimes allows for existing policy to be skirted when sort of some of these new tools come up, and I think this

is often -- I've just seen this as a very common failure mode, and so maybe, to your question, it is very easy to think of this as a new thing. Nothing we've thought about before applies to this new thing. So we have to do policy all over again.

And what I find most often is that existing policy almost always can apply. So framings around, again, sort of what it means to have good decision-making, what it means to have good outcomes, often don't need to be reinvent it. I think some of the details might have to be. In particular, I think some of the data questions sometimes can be a little bit different than they've been in the past, and some of the ways that -- new ways that there can be gaps, I think can be new.

But I think a lot of it's -- so I guess maybe as a high-level take before I think some more people with more detailed expertise chime in, I think my observation has been existing policy can take you a long way. And so we should be leaning a lot more in thinking about how some of these new tools can be governed by existing ways of thinking about sort of existing policy and governance.

KATHERINE ROGERS: Wayne, we can go back to you.

WAYNE TURNER: Sure. Thanks.

And I think one of the biggest challenges in regulating AI and prior authorization is getting to those third-party entities that are developing and operating these systems.

I know that that's been a real issue that the NAIC has been struggling with.

I think the good news is that in Medicaid, we have two really important tools for oversight and accountability. So the first is Medicaid due process, right? And so the requirement for notice and an opportunity for a fair hearing, that's not only statutory, but it's constitutionally based. And so when a request for medical assistance is denied, that beneficiary must be informed of the reason and the legal basis for the care denial, as well as the right to a hearing.

So my colleagues have litigated this issue in the context of an assessment tool that was used by a health care company that had a contract with the D.C. managed care plan, and so the company refused to disclose the criteria used by the tool, claiming trade secrets. We hear this a lot, the kind of black box, the trade secrets of what the

algorithms look like and what they're doing. But what the court -- in the Salazar case and dozens of other cases in Medicaid -- found that the Medicaid coverage decisions must be based upon ascertainable standards. So that is to guard against the arbitrary denials of care, that there's an obligation to explain the criteria for decisions rather than just simply stating the result of the decision. And so, again, I think that the requirement, the due process requirements for ascertainable standards is an important way to reach inside that black box so that we know what is the basis for these coverage determinations.

The second big feature in Medicaid that you don't have in commercial insurance is the single state agency requirement. Right? And so under federal law, it's the state Medicaid agency that's ultimately responsible for everything that goes on in the state's Medicaid program. So the state contracts with managed care organizations, which may in turn contract with these third-party entities that are using these AI tools. But it's ultimately the Medicaid agency that's responsible, and so that's an important accountability tool and one, again, that state insurance regulators don't have that same kind of hook

under federal law when they're trying to hold the third parties that are contracting with insurers accountable.

But the last thing I'm going to flag, too, is we do have a framework in place. You know, we have non-discrimination laws from Section 1557 to Section 504. In Medicaid, we have not only beneficiary protections but requirements for state quality strategies, reporting and consumer-informing requirements for enrollees in Medicaid managed care. So those are the kinds of tools that are already in place that as regulators, as advocates, we can make use of, again, to hold Medicaid agencies and the managed care companies and the companies that they're contracting with accountable for the decisions made by these AI tools.

KATHERINE ROGERS: Thank you.

And, Heather, you alluded to a few different things in your last response, like HIPAA and cybersecurity. So I'll let you expand on that.

DR. HEATHER McCOMAS: Yeah, sure thing.

And I'll maybe start by harkening back to an analogy that I saw you used in your past discussion on this topic, which was fear that we were going to throw out the

baby with the bath water out of our fear of AI, or we weren't going to even give the baby a bath because we were so scared of AI. So I'm going to pick up that analogy and say, first of all, I thoroughly understand that concern.

But I also think we need to think about the fact that our AI baby is pretty young and vulnerable. AI has not been around all that long, And so to kind of further the analogy, we don't want to put that young, vulnerable AI baby in deep water unattended. In other words, we need oversight, and I think that's what we've all been talking about here.

Everything that I've said today is grounded in AMA health and medicine policy. I will pull up this document, which I will share with the MACPAC staff so you can send it on to the Commissioners. It was developed by state medical associations and national medical specialty societies, and it's the kind of first set of provider-led health care AI policies. And we firmly encourage anyone looking at exception guardrails on AI use to look at it.

There is particularly a section on fair use of AI that I think is very relevant for your discussion that you're having here today. Again, the key themes, again,

are what I've been talking about, improving transparency in all different angles, ensuring the clinician is involved in any denial. Protecting data privacy for patients is obviously really important moving forward and obviously preventing cybersecurity events as we introduce new players into our health data exchange.

And then, you know, to kind of Wayne's point, ensuring that AI is not leading us to a cookie-cutter approach to medicine, we're still treating people as individuals with our own unique clinical circumstances. That's really, really important.

And I'll just close up by saying at AMA, we look forward to working with anybody and everyone who's formulating policy and regulation or legislation on this topic, and we think it's really important to have the physician voice at the table because physicians are really concerned about how AI is going to impact their patients and our patients' access to care and data privacy as well. So we welcome the chance to talk about our policy on this, whether it be with Congress and discussions of new legislation with state legislatures and certainly with MACPAC, with the administration, certainly CMS and ASTP,

ONC, on looking and making sure that AI is not negatively impacting patient care and that there is transparency on how it's being used.

So thanks so much for including us.

KATHERINE ROGERS: Thank you so much. Thank you, all three of you, for all of your comments so far.

With that, I will turn it back over to the Chair, who will lead us through any questions from the Commission.

CHAIR VERLON JOHNSON: Absolutely. And thank you all so much for your time today. It's been very helpful. You're all very knowledgeable and really has helped us think about this issue even more so.

With that, I see that the Commissioner Angelo has his hand up first. So I'll see if you have a question then for the panel.

COMMISSIONER ANGELO GIARDINO: That was an accident.

CHAIR VERLON JOHNSON: Oh, was it? Okay. All right.

So I have a question. I didn't want to jump in as the Chair, but I can, I guess, right?

So, you know, we're going to continue to

obviously explore this issue as MACPAC, and as we think about that -- and you've kind of touched on this a little bit what types of data or case studies would be most valuable to understand where the tools are helping or potentially harming access to care from your perspective?

WAYNE TURNER: I'm happy to start with that and appreciate the question.

So Heather alluded to it. So at the National Association of Insurance Commissioners, they have a working group, the Big Data and AI working group. So they are just finishing up a nationwide survey of just really documenting the use of AI by health insurers, and so this is such an important kind of first-of-its-kind survey, pretty detailed and extensive.

And so we heard some preliminary results at the national meeting last month, but we should soon have that full survey, and that's going to give us a lot of detailed information, again, on how insurers are using these products, how they're testing them, how they're launching them, looking primarily at prior authorization and major medical but also things like step therapy and other utilization management. Again, I think that that's going

to be a really helpful tool.

I think state insurance commissioners and Medicaid agencies have kind of kept each other at arm's length, and that has to stop, because it's the same companies, it's the same vendors who are selling their tools. So I think that as MACPAC kind of proceeds with this, really taking a good look at that NAIC survey, is going to really help get kind of like paint what the landscape looks like in terms of the use of AI.

And then of course, I mean, my organization has done extensive work on this, and we have cases and AI principles that we're really glad to share that really focus on specific examples of kind of wrongful denials of care, wrongful denials of eligibility. So those are important pieces to look at, but always glad to be helpful to MACPAC. You play such an important role in this policy analysis and development, so thank you.

CHAIR VERLON JOHNSON: We definitely appreciate you.

DR. HEATHER McCOMAS: Can I quickly say, I completely agree with Wayne's suggestion, but I also think, again, getting back to publicly reporting prior

authorization program metrics could be really helpful, both in terms of the positive and the negative. Plans should be transparent if they're using AI, and we see that their processing time is going down. And when they're using AI, that's obviously showing a positive effect. However, if their denial rate is going up and especially if the overturns of those denials is going up with using AI, that indicates there's something funky going on with that AI technology.

So I think, again, getting some transparency around how plans are using AI to begin with but also how it's impacting their overall prior authorization program's performance.

CHAIR VERLON JOHNSON: Great. Thank you.

All right. Heidi, I think you have a question.

COMMISSIONER HEIDI ALLEN: Well, I'm just like trying to wrap my mind around all of this because -- and I really, really appreciate the panel. The discussion has been so interesting.

And I think that, you know, one of the things that I'm curious about is, like, if --I guess like where I'm stuck are that these algorithms owned by the third-

party vendors are essentially setting benefit packages, but they're setting it based on these criteria attached to the patients that -- I don't even know if the plan knows what those are specifically or -- and especially if they are maintained by a third party vendor that is constantly changing that algorithm, whether the plan would actually ever know. And yet, in many ways, it is a defined benefit, right, package. It's like you get this, yes, if you meet these criteria. You get this, no, if you don't meet these criteria. And yet I'm not sure who's going to be able to say what those criteria are.

And so one thing that I think would be very helpful in any kind of requirement is for the communications to say you don't meet this criteria, because your blood pressure isn't above, so it's very, very clear, so that the appeal can be specific to the reason of the denial. And, Wayne, you mentioned, you know, one of the comments you made was, like, related to that.

And then, you know, the other thing that really strikes me is this tension between innovation and person-centric care that could be used in, like, generative AI, where you could put in somebody's -- and I'm saying this

out loud and to you rather than just among the Commissioners to see if I'm getting something wrong. But that could be used to say, wow, with this person's blood work and their labs and their x-rays and their blah-blah-blah, all of these characteristics, this is actually the best treatment for them.

But then they'll go against a generic AI from the insurer that will say, no, we're not going to take into consideration any of those things, you need to try one, two, and three before you have access to this other thing.

And so I'm wondering if these conversations are happening together. Are the generative AI people who will be working with providers working with the same vendors' tables, conversations with the people who would be making these denials, so that there is some synergy there, where the people making the decision on the payer side would be like, oh, right, with that same information, we would come to the same conclusion? And how that could ever work with these proprietary three-party vendors who are going to have these very specific -- God only knows how and where and when they're going to be getting their stuff.

So I'm just -- how is that tension being

navigated, or do you know?

DR. SANMI KOYEJO: I don't have a great answer, but I'll maybe engage with the question. I think it's a -- both of those questions are important ones, so just maybe some thoughts.

So the first one about this ability for, again, an individual to get explanations and sort of some sense of how to engage with, in particular, denials, I think is an important one.

From the -- maybe just a bit of lingo, if folks want to look this up, there is a -- I guess the two aspects of the technical work that try to engage with this question, there's a lot of work on interpretability in AI, which is very much this question of like building tooling to better understand the provenance of a decision, and so can I look into this black box, as we've been alluding to and over again, to be able to explain better in a human understandable way how a decision came about?

And there's a more targeted technical tool set called "individual recourse." So this is framed around this question of asking what could I have changed to get a different outcome, which again engages with your question

of what are ways to sort of explain and also maybe intervene in different outcomes that you might get from an automated tool.

I wouldn't -- my sense of the literature is that -- or at least the technical work here is that these are still works in progress. I think the excitement about deployment has gone ahead of technical tooling for these kinds of questions. There is some work but I would say not nearly as developed as, again, the push in terms of deployment and -- the deployment side of things.

My group works on things related to this, and so the hope is that we'll have more scientific work then help close these gaps over time. But I wouldn't say that -- there's tooling out there that tries to do versions of this. I wouldn't say that that line of work is nearly as developed as, again, the deployment side of things. But I think it's an extremely important question, given people, agency, and a way to again intervene in outcomes of their own care.

The second question you asked is also an important one, this question of disagreements among decision-makers and how that's navigated. Your specific

question was about what is done now. This, I don't have an answer to, but I do want to maybe give a broader frame.

I guess, to my view, this also looks similar to physicians disagreeing in terms of clinical care. It also looks -- you know, with each other, but also -- and this is also for those of us who work in sort of data-driven methods for thinking about various aspects of health care.

I think when you start working in this area, one of the first things you learn is how often experts would disagree on what a good outcome is or what a good care plan is and potential outcomes, and so this make some of the -- for technical tool building, this makes some of these questions quite challenging.

I think this comes to a head in versions of what you've alluded to, Heidi, in this question of how should we think about tools that may come to different decisions based on just being developed differently. I don't know that -- well, I don't know of any great answers, as I said at the beginning, but I will say I think there's a lot to learn for how we navigate differences in clinician care plans, for instance, and tensions that happen now when there are disagreements across with experts and say experts

and say payers and payees.

Maybe I'll stop there.

CHAIR VERLON JOHNSON: Thank you.

Tricia?

COMMISSIONER TRICIA BROOKS: Good afternoon. Thank you all for being here.

I mean, clearly hearing, you know, that the growth in prior authorization is growing -- and it's going to grow even more if managed care plans find them to be successful in utilization control, because that's the area of the business that they reside in. And they call it "utilization management," but "utilization control" is a good word as well.

And we also know that a lot of people are not going to appeal a bad decision. It just doesn't happen, and so we've got to do something in between those two things to make sure that AI is working well.

So my question to you all is what are we seeing in best practices around the review of denials, and is there a role for some kind of standards that if denials exceed a certain percentage -- and that might be different on different kinds of services, but could those be the

kinds of things that trigger an external review or whatever? So I guess I'm trying to get at what do we do in the system to build a system that is going to help to take care of the wrongful denials and not rely on, oh, people can always appeal.

Thank you.

WAYNE TURNER: I really appreciate the question, Tricia.

Just a couple of thoughts immediately come to mind. First, Heather mentioned the HHS OIG report that found that only a small handful of states actually do any kind of review on prior authorization denial rates, and that's a problem, right, because states have the authority, I would say even the obligation, but they're just not doing it.

I think the point about having an independent medical review is a good one, and we do see some states adopting that as a model that should be automatic, right, for when there's a care denial, that it should go automatically to an independent medical review. And my organization and I know others are looking at states' implementation of that and lifting that up as a best

practice, because, as you said, it's hard to file a grievance and go through that exhaustion requirement first. Remember, that was a regulatory change. So Medicaid beneficiaries have to exhaust the internal appeal grievance process before they can even go to a fair hearing, but it's hard to do that, especially if you're experiencing a health crisis or your child is experiencing a health crisis and to go through all of that, so really front-loading the protections in terms of making sure that these systems are operating in a non-discriminatory way, that they're not being overused, and that there are kind of like oversight, kind of like data-tracking mechanisms.

The last thing I'll say is, I think that for a Medicaid beneficiary, always will have an outsized relationship with their managed care plan, right? That is a disproportional relationship. There's only one time in that relationship that the Medicaid beneficiary has any kind of authority or power, and that's at the time of plan selection.

So my dream of dreams is that when a Medicaid enrollee is like going through their plan options, you know, right now they're supposed to be under the

regulations provided with information on performance and satisfaction. I would love to see this kind of data also shared at that time of plan selection, so that when a person is choosing their plan, they know what the prior authorization denial rates are, have that data disaggregated by benefit type, and that would really go a long way to curb the abuses of prior authorization denials that we see.

DR. HEATHER McCOMAS: I'll just jump in real quick and say I completely agree with what Wayne said, and just make the point that a lot of states are passing prior authorization reform bills, and many of them in recent years have included requirements regarding exactly that type of public reporting that Wayne just referenced. You know, it depends on which state, whether or not Medicaid is within scope. I see Wayne kind of going, yeah, it depends, but that kind of reporting is essential, particularly so important for patients selecting plans. But I think that could also point to areas for further oversight and concern.

If you look at it and you're seeing high denial rates and, again, high overturn on appeal, that's really

concerning. We want that first decision to be correct, because I am really glad, Trish, you brought up this issue of the low appeal rates. That's why the concern that AI could potentially drive up denial rates is so crucial, because we know that patients just don't appeal that often.

CHAIR VERLON JOHNSON: Thank you.

Jami and then Dennis.

COMMISSIONER JAMI SNYDER: Yeah. Thanks so much for joining us today.

Heather, I have a quick question for you. I really share your concern about getting AI into the hands of smaller rural providers so that they're able to take advantage of some of the tools and efficiencies that are available. Are there any programs or states that have been particularly successful in making sure that smaller providers are able to access AI? It's sort of a best practices question, I guess.

DR. HEATHER McCOMAS: That is a really good question, Jami, and I'm not aware of anything so far. But I think that there have been previous models for trying to ensure that technology gets in hands of rural and smaller providers.

Certainly, working back to the regional extension centers for meaningful use, not saying anything about meaningful use, good, bad, whatever, but the idea of providing support to specific providers that are under-resourced and might need help accessing technology, I mean, I think that's a model that we can think about.

Certainly, we're thinking about it and talking about it in terms of implementing the application programming interfaces that are required by the CMS interoperability and prior authorization rule that Wayne has referenced a couple of times, but expanding that to ensure that smaller practices can access AI is something as well. But I definitely agree that some kind of support is needed. because otherwise we're just leaving these practices further and further behind, and we don't want it just to be large health systems.

Nothing against large health systems. We have many members in large health systems, but we want all physicians to benefit from this technology and all patients also to benefit as well.

CHAIR VERLON JOHNSON: Thank you.

Dennis.

COMMISSIONER DENNIS HEAPHY: Thank you.

Heather, I really appreciated when you said "garbage in, garbage out," because that's what I was thinking as you were talking.

So we're thinking about health insurance industry, maximization profits in, denial of care is what's going to come out. And so how do we -- what do policymakers -- what kind of skill sets does a new generation of policymakers need to have or implementers of Medicaid need to have to ensure that they're able to actually protect consumers?

And then second to that would be, how do we shift the conversation from one of defense to one of opportunity to advance equity and making sure that folks are actually maximizing access to benefits they have a right to receive? And so moving away just from like a defensive mode to a more proactive mode of, wow, there's a good opportunity here to maximize access to services that people have a right to receive and historically they have not received for a variety of reasons.

I guess those are two questions. Anybody?

DR. SANMI KOYEJO: I'd like to comment a little

bit on your second question, because I guess this is, again, a bit of a broader frame but I think applies here.

So the second question about what does offense look like and advancing equity with algorithmic tools more broadly, so my observation has been that the conversation around equitable outcomes seems easier to engage with when it's algorithmic decision-making versus when it's human or other decision-making, which is a bit of another weird human bias, but one that I think seems consistent enough in my view.

So what I mean by this is talking about how tool development -- sorry -- how decisions by individuals can lead to inequitable outcomes can be a very hard conversation that can rarely happen when it's known individuals making those decisions, whereas these conversations seem to be easier to start when we know that it's algorithmic tools.

I think this meeting and, again, the framing around what policy and governance could look like is an example of this.

So I actually think, in some ways, this is a human bias of preference. Again, we are more aware of when

we see gaps that come from algorithmic decision-making.

I think this is a good sign and one that we should, you know, anchor on quite a bit, the fact that, again, we want to make sure that these tools work well and we are hyper aware of when outcomes can lead to -- we can have disparate outcomes, for instance, across individuals and across groups. And so I've written about this. I've talked about this. Again, it's a bit of a weird one, but I think it's a good instinct.

There's a recent opinion piece in The Guardian where I talk about this in health care, but also, I think this is broadly an observation in AI. So it's more a -- maybe almost a repetition of your statements, but I actually think the positive pro-social comments on the second part of your question is, again, your instinct here is one that I think many people share, and I think it's an opportunity that we should be thinking about measuring outcome differences. Again, this has come up. I think many of the Commissioners have mentioned this. I think Heather and Wayne have talked about this already. Think about measuring as we go and always sort of being aware of when we see gaps. I think this is one that is more likely

to happen with automated decision-making tools.

And the governance policy framework, again, hopefully gets more developed so that there are -- beyond the measurements, there are, again -- we think about interventions and making sure we get good outcomes when we're building and deploying these tools. But excellent questions.

DR. HEATHER McCOMAS: Dennis, I'll just chime in really quickly. And I think that your question is very good and challenging. I think that it kind of gets back to something that Heidi mentioned, like the tension between, you know, maybe AI and the provider side that's being -- you know, deploying a way to be very personalized care versus a more blunt tool, user-payer side that's maybe, to use someone's phrase, like utilization control versus utilization management, and how do we bring these two sides closer together? I think that's really important to more kind of, as Sanmi just said, the pro-social goal, making sure everyone gets care.

And I think that's, you know, again, where this public reporting metrics is so important, and maybe, you know, it is putting guardrails around, you know, before any

new AI technology is used, there has to be measurement of outcomes, you know, denial rates but also, like, looking at specific outcomes, like, are hospitalizations going up? Is ER usage going up? Those kind of clinical outcomes as well, because, you know, our physician survey shows as well, you know, we know that prior authorization is touted as this way to control costs, and that's the intent. But our physicians are reporting it can actually lead to increased utilization. If that patient doesn't get their insulin and they end up in the ER -- and first of all, we've hurt somebody, which is horrifying, but second of all, that is expensive. That's not the goal of all this, so trying to bring these incentives closer together, and some of it is very much the fragmented way that health insurance works in this country that we have, like, you know, drug benefits carved out for medical benefit management. And so those costs are not commingled, and we don't see that, you know, the drug cost was saved, but on the medical side, this patient is in the hospital, and we've just driven up the overall cost.

So excellent questions, for sure.

CHAIR VERLON JOHNSON: Thank you so much. That

was very helpful.

And we have one more question. John.

COMMISSIONER JOHN McCARTHY: I know the comment, the topic on this one was AI and prior authorization, but I want to end on hopefully more upbeat note on this one. Is there areas that you all can see that AI can be helpful to manage care organizations and the Medicaid agency? I know you already -- Heather, you touched on it for physicians, but is there other things that we could use it for, like fraud and abuse or underutilization, or is a way to use AI along with HIEs to see when somebody isn't getting their insulin? Are there other areas, ways that AI could be used by Medicaid agencies in a positive way to ensure that people are getting the care they need?

DR. SANMI KOYEJO: I think you gave some great examples.

COMMISSIONER JOHN McCARTHY: Anybody. Anybody on --

DR. SANMI KOYEJO: I imagine all of us are thinking of some great examples. I think the examples you gave are salient. Again, I think, you know, the benefit, it's always this balance that one wants to hit. Again, the

possibility is much more ability to pay attention or at least notice things that you may have not noticed before. The risk is, again, we anchor so much on this that, you know, we miss the gaps, and so trying to find this balance.

I think the examples you gave are great. Maybe I'll give -- this is not super close, but maybe to your general sense. I've done work on what are sometimes called "opportunistic diagnoses," which I think are an interesting set of questions where one does sort of routine evaluation of -- within health care systems, looking at clinical records and other kinds of data to find opportunities to find conditions that may not have been the reason people came in for care.

And so we've done some work, for instance, in diabetes, showing that there's some of these mechanisms or algorithmic tools that can actually work pretty well or at least can find cases that would have been missed, because, again, there was a reason for coming into the health system and this was not the reason. But by having some of these algorithmic tools and AI tools, there's an opportunity to screen sort of more broadly and so find potential health issues early and come up with mitigation.

So I strongly resonate with, again, the opportunity. I think it's a good point, and I think it's a good point to make in this panel as well, that, again, we're always grappling with this balance again between the potential for good outcomes but, again, the potential for misuse. And so we're always trying to find the right balance to this.

So I agree with you. I think great examples that you gave. I've given a couple more. And I think that's the job of, again, thinking through positive technology use cases.

DR. HEATHER McCOMAS: Let me just jump in. So I think that the care gap issue is something that folks can noodle on, and one thing -- and this is just me spitballing here. My understanding is that care continuity can be a huge issue with the Medicaid population, people coming in and out of coverage or going -- switching between fee-for-service or MCOs, between MCOs. And so the opportunities to leverage AI to make sure that, for example, a new prior authorization requirement for the new plan does not disrupt ongoing successful treatment. We know that prior authorization can really impact continuity of care, and

it's particularly distressing if someone is stable and then they just change insurance and then that's disrupted. So somehow leveraging AI to ensure that administrative requirement is not getting in the way of someone getting the care that's kept them well for a long period of time.

And I think that particularly could be leveraged in, again, the Medicaid setting with folks coming on and off and just getting really easy to lose track of people in that sort of situation.

WAYNE TURNER: And if I could just chime in, I really appreciate the question, but wouldn't it be lovely if Medicaid beneficiaries could have an app that helps them find providers? We've heard so much about the lack of enforcement of network adequacy standards and ghost networks, providers that aren't there or are no longer accepting Medicaid patients. So something like that would be great.

But I do want to caution that if we're going to extend benefits or tools for the use of Medicaid beneficiaries, it needs to be available to everyone. Not everyone has broadband. Not everyone has phones with unlimited data. So that's a caution that we have to meet

Medicaid enrollees where they are and what their capacities are to make sure that any kind of use of AI and apps or other kinds of uses are accessible to people with disabilities. Those are important considerations to keep in mind as well.

CHAIR VERLON JOHNSON: Thank you so much. This again was very helpful.

So, Katherine and Emma, do you have any last things for the panelists at all?

EMMA LIEBMAN: No, but thank you all for joining us. We really appreciate it.

CHAIR VERLON JOHNSON: Thank you again. We appreciate it.

DR. SANMI KOYEJO: I'm very impressed at how close we are at a time.

CHAIR VERLON JOHNSON: Well, I try.

[Laughter.]

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

All right. So now we'll just turn back to the Commissioners. So we do have a couple more minutes left just to talk amongst us. So are there any other pressing

items or thoughts that you have?

I know, Carolyn, you had one I completely forgot today.

COMMISSIONER CAROLYN INGRAM: Oh, that's okay. It was just a -- I think they kind of started to touch on it at the end that things that AI can help with and wanted to see if they had examples.

I mean, we get pitched constantly about new companies developing apps or tools that are going to help people around social isolation, especially elderly people who are duals, and remind them of things like taking your medication or helping them with activities of daily living in terms of reminding them to do certain exercises. And so I was wanting to know from them if they've seen any of those that are super effective.

I think the other areas when people get frustrated, you know, when they call the call center and they want to file a complaint or something and they have to repeat it to the person who answered, then they have to repeat it to the UM coordinator. Then they have to repeat it to the medical director. and AI can actually take what they've said, put it into a quick transcript, so that when

they call and they get transferred to the person who's really supposed to deal with it, they don't have to say it five times. And I think that's something probably, as consumers of -- that we would all appreciate.

And then the last area was just in terms of doing analysis. I think of disease management and wanted to hear from them about, have you seen tools that are effective at finding cancer faster because something's able to screen a mammography that maybe somebody on the ground missed and find those issues? So it'd be interesting to hear some of those good things. I think we focused a little bit on the negative, but I'm sure they've got some ideas of things like that.

And when we look at this chapter further, maybe including some of those things that are positive towards members might be helpful.

CHAIR VERLON JOHNSON: Yeah. Does that work, Emma and Katherine?

KATHERINE ROGERS: Absolutely. I think our goal is definitely to explore both sides of this issue. I think our work is specific to the prior authorization process, but definitely, you know, there are a lot of benefits, and

it's just a question of exploring how to ensure that the tools are able to achieve those benefits safely.

CHAIR VERLON JOHNSON: Great. Thank you.

Tricia.

COMMISSIONER TRICIA BROOKS: So this was the first year we ask on the 50-state survey about the use of AI and eligibility enrollment processes, and I was actually surprised that we only got a handful of states, you know, not even a quarter of states saying that they were using it. And we asked, you know, more specifically about how, and generally, it was chatbots, you know, online or during the application or renewal process being able to access questions there. But it seems to me that -- you know, I understand that the work is embedded right now in prior authorization, but I think it's an area of where MACPAC has to watch.

I mean, I don't know that we get into the depths of those clinical debates, right? Like, we don't get into the delivery of care in terms of but should this person get that care or not. We leave that to experts. So I think it's important for the Commission to think about, you know, where our interest is and following that, because this is

really going to become a big deal. And I'm optimistic in many ways about what AI can do.

I think there's also a lot of confusion, you know, about where's the dividing line? Is the ex parte reviews where we're using data and the system is programmed to make a decision on eligibility based on the data that it finds? Right? Is that AI, or is that just a computer system being programmed? I don't know. I'm confused, you know, about where one starts and one ends.

But I do think we need to make sure that we keep an eye on the eligibility enrollment process because I do think that there's a lot of policy there too, in addition to prior authorization.

Thank you.

CHAIR VERLON JOHNSON: Thank you.

Adrienne?

COMMISSIONER ADRIENNE McFADDEN: So I think I have three comments really.

I remain optimistic that technology -- I'm going to broaden it out beyond AI -- is an access opportunity that has yet to be fully tapped for the promise of sort of streamlining decisioning, which I think has been the focus

of many state and federal legislators trying to decrease the amount of time for decision-making for utilization management.

That said, automation and technologies have been in use for quite some time, and that has helped to streamline sort of the workflow of clinicians who are doing this work.

I won't be as colorful as Angelo, but imagine that this is sort of like a legal associate having to do discovery with many boxes of documents 40 times a day. And so there needs to be some ability to streamline their workflows in a way that can make them more effective in their decision-making processes.

That said, I also want to sort of bring up a couple of things that were mentioned in the panel that I want to sort of correct a little bit. Wayne appropriately mentioned that there's the Medicaid sort of agencies that have sort of the rulemaking and sort of the guard rails around decision-making for utilization management. It is very clear in almost every Medicaid contract that I've ever laid eyes on that any adverse determination has to be made by a medical doctor with a degree who's board-certified in

a particular specialty area. So I have yet to enter into a medical school where a computer is one of the classmates in that classroom. So I don't think that denials can be made by AI, because they are not a medical doctor with a degree, and until those contracts are changed, then that's not going to change.

The other thing I think is an opportunity that we haven't really discussed and I think a lot of people sort of roll this into sort of the denial numbers is the lack of information denials, which is one of my soapbox issues. And so I think this is an opportunity where technologies from both the provider side and the managed care side can really sort of have an opportunity to streamline that process, because wouldn't it be great if we had a -- whatever the portal is where physicians are entering in a request for prior authorization could see right away, you're not entering enough information for us to make this decision, so they can go back and enter in the right amount of information, so they don't have to go through the process of getting a lack of information denial and then go through appeals, et cetera. And so I think that's really an untapped opportunity that really could be a really good

thing for denial percentages and overturned percentages, which I think people are thinking are medical necessity denials, and they are not.

CHAIR VERLON JOHNSON: Thank you. Very helpful.

Heidi and then Dennis.

COMMISSIONER HEIDI ALLEN: So I also am very excited about technology and how it can be used to help people in health care and medicine, and I think it will lead to people discovering specific treatments that would be best for people, and then, again, that's that tension I bring up that then it'll come against a more normative response but from a different denial perspective.

But one of the things I think about that Tricia brought up about the difference between a computer program and AI is that a computer program will make the same decision all the time, and AI will say, oh, wait a minute, there's a rule that if we have more than 5 percent denials in this condition, that we trigger a review and can actually be constantly manipulating the entire platform, right, to be staying within the margins of the regulations.

And I think -- and the fact that it is a black box and nobody even knows what it's being programmed to do

is, no, they could never be -- it would be very hard to catch that, right? So that it's making sophisticated decisions that are towards profit maximization and not being -- and not triggering penalties. And so I think that whatever those margins that we decide or, you know, the trigger points will have to be thought of carefully. And I guess the only way that I could imagine us trying to track that would be for us to keep an eye on how these vendors advertise their services to MCOs. Like, what are they saying that they can do? How are they differentiating themselves from other vendors? Because if they demonstrate that they have, you know, the highest on appeal -- I mean, like, I just -- I don't actually know how they will do it, but they will have some way that they show themselves, and tracking that might be helpful.

And then, you know, to your point, Adrienne, it's like, you know, the journalistic work in this has found that a licensed, board-certified medical provider is, you know, hitting the button in less than two seconds. So, you know, that's when they look and see how that interaction is. You know, there are these people, from my understanding, in reading some of these investigated

reports, that are essentially hired to just push a button. And, you know, they do have a license, but they're not actually -- unless they're able to read faster than the speed of light, they're not actually reading the cases, and they're just denying. And so, you know, how do we put checks and balances in for providers, that that somehow is a form of malpractice to, you know -- to do some -- I mean, I think we're going to have to be very creative to come up with ways.

And fortunately, it's not just us, but we have such a vulnerable population with so much pressure to constantly be cutting costs, that I think that, you know, our population is really susceptible.

And then I would be very interested to know if they have different programs for Medicaid than they do for commercial insurance, because that would say a lot if they did, because it shouldn't be different, right? Yeah.

CHAIR VERLON JOHNSON: Thank you, Heidi.

Dennis?

COMMISSIONER DENNIS HEAPHY: I just want to go back. To me, the question is, what skill sets do folks in Medicaid need to have in order to be able to drive positive

utilization of AI in decision-making around benefits and determination and utilization management? I think that's like -- I mean, that's really important. What skill sets do they need to have so you can actually be contracting appropriately with plans and then having the tools on their side to do utilization management, to contract management, to ensure that utilization management being done in plans is appropriate, using the same tools that the plans are using?

CHAIR VERLON JOHNSON: It'd be interesting to see the states that are doing it now, right?

COMMISSIONER DENNIS HEAPHY: California.

CHAIR VERLON JOHNSON: Yeah, for sure.

John?

COMMISSIONER JOHN McCARTHY: I agree with Dennis on that. I mean, part of it is, what are we going to be saying to Medicaid, both at the state and federal level around, you know, how do you keep an eye on these things and having the right people but also using AI to find AI and if things are wrong?

And I also want to hit on -- because we are in this chapter looking at prior authorization process, I want

to hit on the other, make sure you all look at the other side too, which Adrienne hit on, which is on the other side of the prior authorization process, which is AI that's being used to help providers get things approved, because of what Adrienne said. It's saying, hey, you missed this, or, you know, you didn't have that information or things like that. So you're seeing companies also helping people get services through that and reducing burden on providers too at the same time, so making sure we got that side of the equation in the chapter too.

Thanks.

CHAIR VERLON JOHNSON: Thank you.

Any other Commissioners before we close out?

[No response.]

CHAIR VERLON JOHNSON: All right. Well, thank you, Emma. Thank you, Katherine. Again, you know, I'm always very excited about this. I really appreciate everything you've done so far to get us where we are. So thank you.

All right. With that, we can go to public comments. We will open it up. Now, remember, we are inviting the audience to raise your hand if you'd like to

offer comments. Make sure you're introducing yourself and the organization that you represent. And then we also ask that you keep your comments to three minutes.

I don't see anybody so far.

PUBLIC COMMENT

* [No response.]

CHAIR VERLON JOHNSON: Okay. We look like we don't have any comments, but that's okay. If you have comments later, remember you can submit those comments to the MACPAC website at any time.

I do at this time want to thank you all for a full -- it was a very full day but a very good day. And I thought a very thoughtful day with all of our conversations. We started out, I thought, in a very good way about the landscape of the Medicaid program and really moving some great opportunities for the Medicaid program.

I also want to thank the staff for all of your hard work on these materials and presentations. We tell you that most days. We want to tell you that for sure today. Those 560 pages that we had, I read every little one of those pages, and I have to say they were very well done. And we also have some briefs that were just released

as well that the staff did on top of all of this. So let's give them a round of applause for all that they've done.

And for everyone else, we will reconvene tomorrow at 9:30 a.m., correct? Yes. All right. Thank you so much.

* [Whereupon, at 5:00 p.m., the meeting recessed, to reconvene at 9:30 a.m. on Friday, March 11, 2025.]

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PUBLIC SESSION

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

Friday, April 11, 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: Welcome back to our second and final day of our MACPAC meeting.

Before we get started in our sessions and as we continue to navigate a complex fiscal environment, I just wanted to briefly highlight two new MACPAC policy briefs released this month that recaps our prior work that explores strategies to manage Medicaid spending growth.

One focuses on state options to address rising costs, and the other examines alternative approaches to federal financing, including block grants, capital allotments, and shared savings models.

So, given the House's alignment with the Senate's financing proposal, these briefs really bring timely insights for policymakers and stakeholders as these conversations begin and continue to gain momentum, and you can all find them on our website. And we encourage you to share them.

I also want to take a moment to recognize Commissioner Tricia Brooks, who is completing her service with the Commission after this meeting. Tricia's deep

expertise, particularly on children and families, has strengthened our work in countless, countless ways. Her thoughtful voice and steady presence will be missed, and we are deeply grateful for her service.

Thank you, Tricia, for your time and your commitment, wisdom, and passion about the Medicaid and CHIP program over the last six years. We thank you.

VOTE ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS

* CHAIR VERLON JOHNSON: So, with that, let's go ahead and start our meeting. We are looking forward to this morning's discussion, and we're going to kick it off, our first session, with a vote on the recommendations we discussed yesterday for children and youth with special health care needs, transitions of care.

As a voting meeting, MACPAC's conflict of interest rules are in effect. For your awareness, our policies are publicly posted on the MACPAC website for reference. As required by our statutory authority, MACPAC's Commissioners bring diverse backgrounds, experiences, and expertise to the table. This diversity enhances our work, but it also means we all bring

reportable interest to our discussions and decision-making processes to ensure the integrity of our deliberations, MACPAC's conflict of interest policies in place to identify and disclose potential conflicts that might arise during voting meetings.

Here's a quick overview of the key elements of the policy. Commissioners are required to report certain financial and other interests both at the time of their candidacy and annually thereafter. These reportable interests, which are publicly available on the MACPAC website, help us determine whether an interest could rise to the level of a potential conflict during a vote.

Under our policy, conflicts are assessed based on four criteria. The interest must be particularly, directly, predictably, and significantly affected by the outcome of a vote. To manage conflicts, the MACPAC Chair appoints a Conflict of Interest Committee composed of Commissioners representing a range of perspectives. Before voting meetings, the committee reviews reportable interests and any additional relevant information.

For today's meeting, the Conflict of Interest Committee met by conference call on March 14th and

determined that, based on our criteria, no Commissioner has a potential or actual conflict of interest related to the recommendations under consideration.

Our Vice Chair, Bob Duncan, chairs the committee, and the committee members are Sonja Bjork, Jennifer Gerstorff, Angelo Giardino, and Tim Hill. Thank you to the committee for your diligence and your service.

And with that, I will turn it over to Kate to facilitate the vote.

EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Verlon.

So we will be voting on this set of recommendations as a package. So can I have Linn and Ava read the recommendation language?

AVA WILLIAMS: Recommendation 1.1: Congress should require that all states develop and implement a strategy for transitions from pediatric to adult care for children and youth with special health care needs, including but not limited to children enrolled in Medicaid through supplemental security income-related eligibility pathways and the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who

qualify to receive an institutional level of care. The strategy should address the development of an individualized transition of care plan and describe, one, the entity responsible for developing and implementing the individualized transition of care plan; two, the transition of care time frames, including the age when the individualized transition of care plan is developed; and three, the process for making information about the state's strategy and beneficiary resources related to transitions of care publicly available.

Recommendation 1.2: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to issue guidance to states on existing authorities for covering transition of care services for children and youth with special health care needs, including but not limited to children enrolled in Medicaid through supplemental security income-related eligibility pathways and the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

Recommendation 1.3: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services, CMS, to require states to collect and report to CMS, data to understand, one, which beneficiaries are receiving services to transition from pediatric to adult care; two, utilization of services that support transitions of care; and three, receipt of an individualized transition of care plan. Additionally, CMS should direct states to assess and report to CMS, beneficiary and caregiver experience with transitions of care.

Recommendation 1.4: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to amend 42 CFR 431.615(d) to require that interagency agreements, IAAs, between state Medicaid and Title V agencies specify the roles and responsibilities of the agencies in supporting children and youth with special health care needs transitions from pediatric to adult care. The roles and responsibility of the state's Medicaid agency described in the IAA should reflect the agency's strategy for transitions of care.

EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Ava.

So let's turn to the vote. Heidi Allen?

COMMISSIONER HEIDI ALLEN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

COMMISSIONER DOUG BROWN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

COMMISSIONER SONJA BJORK: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Tricia Brooks?

COMMISSIONER TRICIA BROOKS: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

VICE CHAIR ROBERT DUNCAN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Jenny Gerstorff?

COMMISSIONER JENNIFER GERSTORFF: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

COMMISSIONER ANGELO GIARDINO: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

COMMISSIONER DENNIS HEAPHY: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?

COMMISSIONER TIMOTHY HILL: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?

COMMISSIONER CAROLYN INGRAM: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Patti

Killingsworth?

COMMISSIONER PATTI KILLINGSWORTH: A resounding yes.

EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

COMMISSIONER JOHN McCARTHY: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Adrienne McFadden?

COMMISSIONER ADRIENNE McFADDEN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

COMMISSIONER MICHAEL NARDONE: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

COMMISSIONER JAMI SNYDER: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson?

CHAIR VERLON JOHNSON: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Okay. Sixteen in favor.

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

All right. So we're going to continue our conversation around HCBS workforce. We're really trying to make sure we can find ways to strengthen it, and we're going to bring Emma and Katherine up for this conversation.

MEDICAID PAYMENT POLICIES TO SUPPORT THE HOME- AND COMMUNITY-BASED SERVICES WORKFORCE: REVISED POLICY OPINION

* KATHERINE ROGERS: Good morning, everyone.

This month, we're returning to the topic we last covered in our January meeting, focusing on the ways in which Medicaid payment policies for home- and community-based services, or HCBS, can support a robust and sufficient HCBS workforce and promote access to services.

This morning, I'll provide a refresher on the project history and scope and some additional background on HCBS rate setting. After that, Emma will cover our payment principles, the findings from our work and a policy option refined since our January meeting, and the Commission's feedback in that discussion.

This work has spanned two phases and two analytic cycles. It was structured to understand how Medicaid HCBS payment rates influence or inform the HCBS workforce. We've also sought to establish payment principles for HCBS rates that promote efficiency in payment and promote a sufficient workforce and, accordingly, access to HCBS.

These phases of work have culminated in a state-

by-state compendium of 1915(c) waiver payment policies, which is available on the MACPAC website. We've also conducted interviews in a technical expert panel with a variety of Medicaid HCBS rate-setting stakeholders across the stakeholder spectrum, including states.

When we last met on this subject, we heard from Commissioners some feedback on several dimensions of this work, including where the specific gaps in wage data exist, the ways in which data are or would be used by states to set rates, the scope and scale of any new administrative burden for states, and whether reporting requirements would impose prescriptive mandates on states in lieu of the flexibility currently in place in HCBS administration and operation.

In this month's presentation materials, we will dive a bit deeper into the HCBS rate-setting world in order to clarify the context for the policy option, and this context is grounded in a couple of points that our work has distilled for us.

First, the stability of the HCBS workforce is top of mind in the Medicaid ecosystem and an important factor in ensuring access to HCBS. Payment is a clear lever for

Medicaid programs to attract workforce capacity, and providers and workers have cited wages and worker reimbursement as a known influence on workforce participation.

And finally, participants in our TEP and interviews articulated that to set effective appropriate rates, states need access to wage data that are readily available, accurate, and precise.

And so, with that context, I will dive right in.

MACPAC's provider payment framework offers a way to assess how Medicaid payment policies can be used to address the goals of the program. Medicaid's statutory objectives for provider payments include economy, a measure of what is spent; efficiency; a function of how what is spent drives what is achieved among the goals of care; and access and quality are measures of what we can obtain from provider payments. In order to promote access and quality, states can improve payment rates or find ways to achieve more efficiency.

Across the board in the Medicaid program, not limited to HCBS, states establish distinct payment methodologies for covered services. Payment methodologies

must be described in Medicaid state plans or other policy authorities. These authorities must comply with federal mandates, federal standards for notice and transparency. And CMS can exert its authority to disapprove or take compliance action when state rate-setting activities create access to care concerns.

There are a number of different authorities under which state Medicaid programs design, deliver, and pay for long-term services and supports, or LTSS, in home- and community-based settings. These authorities are also used to cover a diverse, extensive array of unique service types from in-home, one-on-one services and supports to day programs and more.

CMS guidance on HCBS rate-setting highlighted a handful of payment types commonly used in HCBS programs and authorities, which are outlined here.

Fee schedules are likely very familiar. On a fee schedule, HCBS rates are set prospectively, paid by unit, and rates are fixed over a period of time.

For certain services, payers may use a negotiated rate based on the local market. A good example would be environmental accessibility modifications.

States may also pay tiered rates, where fees vary by some feature of the beneficiary or the provider. An example is an acuity-based rate.

They may also pay bundled rates, where one fee is set and paid for a group of services that are typically delivered in tandem.

States may set interim rates and reconcile payment rates upon receipt and review of provider cost reports in a cost reconciliation model, but it's important to note that states may require and receive cost reports from HCBS providers for all kinds of payment rates, not just in this last model.

So turning to how those rates are set, while payment rate models and rates themselves vary across service types, those models generally, like any other services in rate setting, rely on several key components of the service model and data for those inputs.

Many HCBS are labor-driven service delivery models, and so worker salaries or wages comprise a significant proportion of payment rates. These may be governed by local or other laws regarding minimum wages overall or within a sector.

Providers, of course, incur other employee-related expenses, such as training and benefits, and these may vary based on the provider, provider setting, or provider type.

HCBS providers also have program-wide expenditures, such as transportation, administrative supports, including medical records management or incident reporting, and more. But, in general, worker salary or wages are the largest component of any HCBS payment rate.

Throughout this analytic work, our findings have underscored the importance of robust and complete data. While there are many important data inputs and rate models, as on the previous slide, wage and salary data are the big one, both due to the primacy of wages within HCBS payment rates and the multiple inputs into wages themselves.

In our compendium of 1915(c) rate methodologies, we found the largest share of states use BLS wage data, Bureau of Labor Statistics, wage data as shown in the table on this slide. I will come back to the BLS data in just a second.

So even though a majority report using BLS, others are using other sources. These include published

cost indices, so for example, market baskets for certain types of health care services. They may use provider survey data, and states may collect their own data in various forms due to the specific needs they have or unique features of their labor market they want to account for.

State policy also may play a role. I mentioned minimum wage requirements previously, but there may also be staffing ratios that must be accommodated in payment rates.

Coming back to the BLS data, while we found more than 30 states use BLS wage data to set rates for one or more HCBS in their state, we also heard from states and other TEP participants that there are gaps in the BLS data that make it an imperfect match for this task.

It's worth noting that the BLS wage data are designed to describe wages across the entire U.S. labor market, not the Medicaid program and not just the health care sector. The data cover a very wide array of occupations and market sectors, and even the health care occupation classifications are many and diverse. There are over 100 distinct job classifications across various health care sectors, practitioners, and support occupations.

These include HCBS-relevant occupations such as

personal care aides, but these occupations might be employed by a variety of sectors, settings, and employers. As a result, the wages that are reflected in these data may be paid by a host of payers, not exclusive to Medicaid, in different labor markets.

Also, comparatively small occupational groups or sectors, such as DSPs, direct support professionals employed by providers serving individuals with intellectual or developmental disabilities, may be subsumed into a larger group. For example, there is no DSP-specific standard occupational classification, but the home health and personal care aide classification reflects individuals working in that sector.

Turning now to the 2024 Ensuring Access to Medicaid Services Final Rule, the rule requires state reporting germane to HCBS worker wages. The rule requires states to report on direct care worker compensation and hourly rates for key HCBS services. These transparency requirements will mean states must publish their average fee-for-service hourly rates for indicated services, which include home health aide, homemaker, personal care, and habilitation, beginning next year. CMS selected these

services due to the high proportion of the payment rates comprised of worker wages.

In 2028, states will also have to report to CMS on the percentage of their payments for those services that actually pay for compensation for direct care workers. These data include a few key confounders, such as the inclusion of certain other employee-related costs, such as training, or the inclusion of a variety of worker types in the definition of direct care worker in the rule, including nurses. These data are not required to be published, and they do not result in publication of average wage rates, which is the piece of the data that states most report they are missing in the rate-setting process.

The reporting required by this rule may improve HCBS data transparency and standardization, but clearly, the impact remains to be seen, and there may be further opportunities for CMS to improve data for rate-setting purposes, including by disaggregating by worker types and services.

With that, I will turn it over to Emma.

* EMMA LIEBMAN: Thanks, Katherine.

So moving into our findings, analyses of our

compendium, state interviews, and TEP identified payment policy as a key factor in HCBS workforce levels.

In January, we presented three payment principles highlighted by our work. The first is that HCBS payment rates should promote an adequate workforce and efficient use of resources. Next, states should take a holistic approach to setting HCBS payment rates to ensure that variations across populations, programs, and geographies reflect policy priorities and beneficiary needs. And finally, HCBS payment rates should be reviewed for adequacy at a regular interval using the tools available, such as rate studies, indexing, and rebasing.

Beyond these payment principles, we found that robust wage data are the foundation for HCBS payment rates that promote an adequate workforce and that limited wage data create barriers in building and maintaining adequate rates.

States often rely on historical spending and cost data to establish baseline rates to build upon, and given that wages generally make up the largest component of an HCBS rate, robust, accurate, and timely wage data are particularly important for rate setting. However, today

there is no data source that encompasses all Medicaid worker wages across states and HCBS programs.

Findings from our interviews and TEP show the importance of wage data. While wage data alone are not sufficient for developing payment rates that address workforce shortages, as these wage levels reflect existing workforce structures and budget constraints, state stakeholders we spoke with emphasized that robust, accurate, and timely wage data provide them with a critical starting point for building HCBS rates that promote an adequate workforce. Findings from our TEP also reflect the gaps in existing data and the importance of better data.

We heard from multiple state participants that the lack of HCBS-specific wage data create challenges for states, and we also heard that more granular service and job class data would help states build wage assumptions that better reflect their programs.

Recognizing that states often supplement external data sources with their own data collection activities, a robust and timely wage data repository would also preserve states' limited resources.

And states additionally acknowledge that budget

constraints can make rate adjustments difficult, but wage data are a critical tool for demonstrating the need for rate adjustments to state legislatures and CMS.

So, as Katherine walked us through earlier, most states rely on BLS wage data to develop their wage assumptions. However, BLS data brings certain challenges, including that there is no specific code for HCBS workers. As a result, BLS data do not include all Medicaid HCBS worker types and include some non-Medicaid workers. For example, as Katherine mentioned, there is no code for direct support professionals who provide assistance to individuals with intellectual and developmental disabilities.

In the absence of an appropriate BLS code for specific job classes, states often try to approximate what workers are paid by blending different BLS codes together. States may also turn to their own internal data collection activities, as I mentioned, to fill gaps in BLS data, which can create additional administrative burden.

In 2024, CMS finalized the Medicaid Access Rule, which includes several provisions to increase data reporting on HCBS payment rates and compensation

percentages. However, for a couple of reasons, the rule requirements will not fill the existing gaps in wage data.

Firstly, while the rule requires states to report payment rates and compensation percentages for certain services, it does not require states to report average wage rates, which is the information that states rely on when building rates.

Secondly, the rule does not require compensation data to be reported publicly, which is important given that states often compete with one another for direct care workers.

And thirdly, the rule requires compensation data for all direct care workers to be averaged and reported by service. Given that CMS's definition of direct care workers includes a broad range of job classes, including home health aides and licensed practical nurses, who carry a range of annual wages, averaging the data rather than disaggregating by job class may confound the data.

For example, according to BLS wage data, in 2023, the mean annual wage for home health aides and personal care aides was approximately $33,000. This compares to nearly $60,000 for licensed practical nurses or licensed

vocational nurses. So averaging these two annual wages together may distort the actual average wage for each job class.

So based on these findings, we propose a policy option that would require HHS to make HCBS wage data available that accommodates states' rate-setting needs. Specifically, we propose to recommend that HHS require states to report and make public on a biannual basis, average hourly wages paid to HCBS workers providing personal care, home health aide, homemaker, and habilitation services. For each service, we propose to recommend that data be disaggregated by licensed nurses and all other direct care workers. As relevant, the data should leverage related data collection activities, such as those included in the Ensuring Access to Medicaid Services Final Rule or the Access Rule. The report should also be made publicly available in a format that enables analysis.

As we've discussed, wages generally make up the largest component of HCBS payment rates, and our analyses indicate the importance of wage data as a basis for building payment rates that promote an adequate workforce. However, the existing data fall short, creating challenges

for states attempting to understand what current wages look like and how those wages compare within and across states.

As discussed, BLS wage data are not specific to the Medicaid program, and as a result, they include wage data for some non-Medicaid workers, and additionally, they do not report wage data for some Medicaid-specific worker classifications.

Similarly, the Access Rule will increase transparency around HCBS rates and compensation but may stop short of filling existing gaps in data, as the rule does not require reporting of HCBS wage rates, does not require wage data to be reported publicly, and combines a broad range of direct-care job classes, which could confound the data.

So under this policy option, states would gain access to robust, timely, and disaggregated wage data, as well as the ability to compare their own wage data to that of neighboring states. Note that this policy option does not dictate what assumptions states must use to develop payment rates or what their payment levels should be. Rather, these data would create a resource that states are looking for, while allowing them to maintain flexibility in

their rate-setting process. Further note that the policy option should not require significant additional state effort, as it could build upon data that states are already required to collect through the Access Rule.

So moving on to our next steps, we would appreciate your feedback on the policy option that I just outlined. We've also included some discussion questions on the slide, as well as in your reading materials, to help guide the conversation.

First, we'd like to hear from the Commissioners about any outstanding questions or additional factors to consider with regards to this policy option, and ultimately, we'd like to gauge whether the Commissioners are interested in moving this policy option to a recommendation in the March 2026 report to Congress.

So I will now direct us back to the policy option text for the purposes of our conversation, and with that, I'll pass it to the Chair to open us up for thoughts and reactions.

CHAIR VERLON JOHNSON: Thank you so much, Emma and Katherine. So I'm definitely glad we're on that slide there.

So, again, we can really use feedback from the Commissioners on the policy option that's presented, and if there are any outstanding questions that you might have that you'd like to have more discussion around, we can do that, too.

So with that, I will turn it over to Angelo for the first question.

COMMISSIONER ANGELO GIARDINO: Yeah, I wanted to thank you both for really clarifying where this was going. I really do understand, in a crystal-clear way, the problem that you're seeking to solve, and what you've laid out to me sounds like a really rational way to contribute something that will help the HCBS providers. So I'm delighted to see where this is going, and I'm very supportive of us continuing down this path.

CHAIR VERLON JOHNSON: Thank you, Angelo.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: I also appreciate that you're taking on this topic. I do think it is the single greatest challenge that states face in providing access to home- and community-based services, and so it's critically important.

I also think this approach is a much more rational one because it provides information that states can use to actually determine the adequacy of payment rates as opposed to presuming some portion of rates that should go to supporting the frontline staff.

I'm a little bit concerned about sort of how average will be calculated. There are many different ways to report average, and unless that's reported in a way that takes into account the volume of services provided, the average won't really be the average, right? And so I would like to see maybe in the explanation in the chapter that there's some sort of defined methodology for reporting average so that we can ensure that there's meaningful and comparable data that states can actually use in assessing payment adequacy.

The other thing I would just note -- and it's probably, again, maybe for mention in the chapter but beyond the scope of this specific part of the initiative -- is I completely agree that payment to the frontline staff is a foundational aspect of ensuring the adequacy of that workforce, but this is not a single-faceted issue. It is multifaceted, right? And so there's a number of other

things that really have to be addressed if we are to ensure the adequacy of that workforce going forward, and I would hate to sort of focus only on the payment piece and not on the totality of those things at some point in this work.

But thank you. I certainly also support moving forward.

CHAIR VERLON JOHNSON: Thank you, Patti.

Dennis?

COMMISSIONER DENNIS HEAPHY: Yeah, I agree with all the points that Patti made, and there are a couple of other things. I'm just not sure how we even address this, is that a home worker, a home care employee, their job is very different than someone who's providing direct hands-on work for the person. It's a very different job.

And sometimes these folks are doing nursing-level care but getting paid PCA-level, PCA wages. And so how do we distinguish between a homemaker and someone who's actually doing the really hands-on work with the individual? They are different.

I guess the other thing -- and I think this is what Patti may have been alluding to -- is health insurance is such a huge issue. When we think of when people look

for a job, look for compensation packages. And so, particularly here, it's kind of embarrassing or horrifying to think that people are going at someone's home and providing the service and it's being paid for by Medicaid, but they themselves don't have health insurance themselves. And so I think it's something, not now, but I suppose what you're doing -- but it's something we really need to look at and address as quickly as possible.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Mike?

COMMISSIONER MICHAEL NARDONE: I was just going to say that I support the direction that this is going.

I think we also have to -- as Patti said, I think we have to also look at the other aspects of what's required to retain the workforce and looking at things beyond rates, particularly as state budgets are fairly constricted. Are there other ways that we can support the workforce? But certainly, wages are a big piece of that, and understanding how they compare is an important part of developing the rates. And that's certainly something that comes through in terms of what states are looking for to

help build the rates. They were asking for this in the TEP, and so if we can accommodate that in some way, I think that would be very helpful.

I think the one thing that I would like to continue to monitor as we go forward is kind of the context of the Access Rule and not knowing -- assuming that this is going to move forward with implementation, but if it doesn't, then what is the impact on states in terms of developing this data? Because it does feel like the Access Rule kind of sets this up for states to be something that they can build off of to develop this information.

So thank you for this work.

CHAIR VERLON JOHNSON: Thank you, Mike.

Doug?

COMMISSIONER DOUG BROWN: Just a quick point to add on to what Patti said about the average rate. I think you also need to determine rural versus urban and then regional variances among states, especially states that are bordering states where FMAPs, we know, are drastically different, and see how that also plays in here.

I'm still -- I'd like to see the project move forward. I'm not sure about a policy recommendation at

this point, but I think it's worth advancing and going to the next step before we get to there. And I'll reserve judgment as to policy options after that.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Doug.

Heidi?

COMMISSIONER HEIDI ALLEN: Thank you for this work. I agree this is incredibly important.

I wanted to just build off of what Patti and Doug said, that I think that rather than saying average hourly wages, we -- you know, I hesitate to use the word "descriptive statistics" because people think you're doing really fancy things, but really, you know, just the mean, the median, the range of hourly rate, you know, just nothing fancy. I mean, it's the things that can be done easily in Excel, but that give a little bit more information. I mean, if you're collecting that, you might as well make it as useful as possible, and that would just be, you know, very, very easy.

And then -- so, you know, if I were changing this policy option, I would say on a biannual basis, descriptive statistics on wages paid to HCBS workers, and then, you

know, agreeing with Doug that, you know, after talking about the following services, you know, asking for it to be disaggregated by regional variation, urbanicity, and, you know, would be a really positive addition.

CHAIR VERLON JOHNSON: Thank you, Heidi.

Jami?

COMMISSIONER JAMI SNYDER: Yeah, thank you so much for this work. I think it's so critically important, and I'm very supportive of the policy option as you've articulated it here.

I agree with Dennis, Mike, and Patti on the need to look at other aspects that contribute to workforce adequacy, and I don't want to lose sight of some of the work that states did and articulated in their Rescue Plan Act, HCBS spending plans, because I think that was an opportunity for states to get really creative around how they can ensure workforce adequacy using a whole variety of mechanisms. So just would like us to use that as a resource as we're looking at the other factors that can play into workforce adequacy.

CHAIR VERLON JOHNSON: Thank you, Jami.

John?

COMMISSIONER JOHN McCARTHY: I know I'm going to get blasted for this one, but I don't support this policy option as it is written right now. I think the work that you're doing is great, and it is very necessary, and I think at some level, somebody should do it.

But there's a couple of things that I have issues with, and one is -- and we're talking about this a little bit -- is who's going to pay for this? Because to have the providers report this, it takes a lot of effort for them, the time and effort to report those things. And so are we going to pay them more?

States -- and somebody brought this up. It takes states time and effort to put this together, and who are they going to have to do that? So that costs them more. So who's going to be paying for that? is one issue that I have. With all the other things going on right now, that's one issue I have.

The other thing is -- and I want to get back to what Dennis said on reporting -- you know, wages is one piece, but one of the things we don't get access into seeing is, how many of the employees are full-time. Like, to me, it's starting there, like, for providers, how many

of their employees are full-time? How many are not? How many get insurance, and how many don't? Like, what are those benefits that they receive?

And so trying to think, though, of like, how to do something -- not do nothing, because I think there does need to be something done -- like, one place to start, you kind of hit on this, but it's -- and I agree with Mike. It's hard, because the Access Rule coming out, like, what's going to be in there? What's not? Is the Access Rule going to be around? It's a question, I know.

But just to start with being more transparent on a state's methodology -- and I know it's in the state plan, but it's one of those pieces where, could you have states just post it on their website, along with their rates, here's the methodology that we use to get to this rate, and show that formula of those components that gets there, so people can see that. so you can look across states to determine those things?

So, again, I think it's great work you're doing. It is very complicated. I used to set these rates. I totally get it. I just think that right now, for what we're asking states to do, it's, at this point in time, a

little too much.

CHAIR VERLON JOHNSON: Thanks, John, I think.

All right. Any other questions? Okay. Carolyn.

COMMISSIONER CAROLYN INGRAM: Thanks. Sorry. My hand doesn't work on my computer. We'll figure that out later.

I don't want to pile on too many other things, but the only other thing I'll put into consideration is that in states with MLTSS, a lot of these rates are set in a managed care environment, and I know, speaking from experience, we offer different bumps and things like that if we do not have enough workers in a certain part of the state, especially coming from a state with a lot of rural communities.

So getting back to the whole question about how you determine an average, it's -- I think there needs to be some consideration back for those services that are probably looked at in managed care and how those rates are going to vary if we're actually going to look at some of this, and that then brings me back to John's point that it becomes complicated and burdensome with everything going on right now, may be a hard time to put this kind of policy

option forward.

CHAIR VERLON JOHNSON: Thank you, Carolyn.

Dennis?

COMMISSIONER DENNIS HEAPHY: I just have a question. Does any of this data have to be reported back to the state anyway if an agency or other folks are -- the rate payments, do they have to report them back to the state anyway? So would it be that much of a burden? John, I don't know.

COMMISSIONER JOHN McCARTHY: It depends on the state. So, for instance, if a state does have a cost report for HCBS services, then at some level -- not at this wage level, but it could be. But the states that I worked in, D.C. and Ohio, when I was medical director, they don't have those reports, but if they have them by now, still don't have them now. Most states don't collect that data, and I think that's what you guys found, right, was that most states don't even use cost reports. Is that correct?

KATHERINE ROGERS: Some states use cost reports. The majority, we found cited the BLS data as the source for wage data because they didn't get it somewhere else.

COMMISSIONER DENNIS HEAPHY: Just in follow-up to

that, are there best practices that can be recommended in rate reporting, you know, what you guys are doing?

KATHERINE ROGERS: So, I think the compendium highlights what's currently in practice across, and that -- maybe I'm making a plug for our online audience as well, but that's a really wonderful resource that's available on the MACPAC website, that it does look at 1915(c) programs across the entire country and what they do have in place.

CHAIR VERLON JOHNSON: All right. Thank you.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Just a quick note regarding kind of the administrative burden and then also the potential for kind of looking at managed care differently.

I will say that just because a provider receives some sort of an incentive doesn't mean the worker receives anything. So I think the goal is to collect it more from the worker's perspective. So maybe -- you know, maybe incentive payments and bonuses get accounted for separately from the -- I don't know exactly, or -- but again, it all kind of comes down to there has to be a standard methodology so that we really understand what is going to

the worker and what does that look like.

My concern -- well, you know, as a former state employee for like 25 years, I understand administrative burden, right? There's a lot going on. But every year that we wait is another year that we don't really have good data to base these decisions on and to really know in what is, again, the greatest challenge facing states with respect to the access to these really important services. We don't have really good information.

And in the absence of really good information, we make really bad public policy, like assuming that, you know, a certain percentage of whatever is paid should go to the frontline workforce, maybe less, maybe more. We don't know, because we don't have any data to inform the decision.

So, as an organization that is very data-driven, that believes that good policy is set based on data analysis, I think we have to start with data collection that will really enable us to make good policy or to recommend good policy. We don't get to make it. We just get to recommend it, anyway.

CHAIR VERLON JOHNSON: Thank you, Patti.

And Heidi, please.

COMMISSIONER HEIDI ALLEN: I was just going to say what Patti just said, better than I would have said it. So I will stay with that.

But I will say sometimes you have to invest a little bit of money in order to have efficiencies, and I think that this seems like a potential path for real efficiencies to be able to target the resources where they're going to make the biggest difference in access.

CHAIR VERLON JOHNSON: Thank you.

Tricia?

COMMISSIONER TRICIA BROOKS: So I'm going to say something really bold since it's my last meeting. You know, we keep playing around the fringes of how do we fix this little thing, how do we fix that little thing, and honestly, you know, home- and community-based services should be a state plan option. And then a lot of the administrative burden associated with the waivers goes away. We're not -- it's going to solve the workforce problem, but we certainly have learned enough about home- and community-based services to know that they're cost effective, and they should be a state plan option.

And so, ultimately, I would encourage MACPAC to consider a recommendation that is really that point on.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Tricia.

Angelo?

COMMISSIONER ANGELO GIARDINO: Yeah, I hear the concern about, you know, piling on and doing one more thing, but what I was told when you prioritize things is that you look at size and scale.

So, when it comes to Medicaid, I think the slides yesterday morning showed there is an enormous number -- there are enormous numbers of children and pregnant women in the program. So I'm always supportive of programs that are trying to improve care for the largest number of enrollees. But I also noticed on there that they're probably the best bargain, right? They're the ones that we spend the least money on.

The group of people we're talking about here in HCBS, if I understand these graphs correctly, is an enormous -- it's a small number of people, but we spend an enormous amount of money on them. And the stakeholders are telling us that we don't have the data to do that as well

as we think we should.

So, if I had to prioritize, I would say let's make sure MACPAC does things related to women and children when it can, and then when we're thinking about efficiency and program operations and access, let's make sure that people with disabilities or who need care in the community are high on the list. So, if I had to pick something to work on, it would be this because the stakeholders have told us it's a problem, and they don't have the data that they need to do this well.

So, in my prioritization scheme, high numbers of enrollees is one thing, high amount of dollars spent is another, and then areas where we don't have what we need to do a good job would be another. And then I think we could stop doing some other things.

So we spent a lot of time yesterday talking about PACE, which covers 82,000 people, and, you know, I still don't understand, you know, why that program doesn't get all the support that it needs. But if I had to pick, if I looked at that graph correctly, the people in HCBS are an enormous number of people, and we spend an enormous amount of money to them. So I think this really needs to be on

the priority list.

CHAIR VERLON JOHNSON: Thank you, Angelo.

John?

COMMISSIONER JOHN McCARTHY: I guess why I get stuck on this issue is, you know, each state is setting rates now, and if they want to, a state can create a cost report and from that cost report determine generally how much money is going to employees, direct care workers in the biggest picture, rather than at the -- you know, the specific person and getting the average.

And kind of going where Angelo was going, we've got access problems in other areas too. There's access issues with primary care. There's access issues with SUD, substance abuse, mental health. So, if we're going to be looking at average wages for the direct care workers, why wouldn't we also be looking, doing the same thing for all of the other types of providers? Why wouldn't we be looking at how much people -- physicians are being paid, and what's their average wage? Because not many physicians are employees. They're not -- it's not the shingle out there.

So, again, in the big picture, is the data

useful? It's a data point. It can be, but I don't know if that necessarily gets to -- so now that we know, once we have the data, we know what is the average wage people are getting paid, then what happens? And this is back to what some of the people were saying. And so, again, I'm stuck on this one. I see the usefulness of data and getting it, but it does lead us down this other path of do we start collecting wage data on all different types of providers.

And just so you know, we do this for -- most states do this for nursing homes, back to the institutional bias, and I will bring that up again, and this is why often you have these fights in states between HCBS and nursing homes, because nursing home rates are often set -- not all the time, but often set using cost reports. And so it's like a self-fulfilling prophecy because you raise your costs and you get new rate increases, where in HCBS, if you're not using cost reports, you're not getting those increases every year. And, again, states can address those issues in different ways.

So, again, good idea, great data, just how do we make this a policy going forward is my issue.

CHAIR VERLON JOHNSON: All right. Thanks, John.

Carolyn?

COMMISSIONER CAROLYN INGRAM: Just a clarifying question. Do we know from your research or from other information you've seen which states actually do set these rates? Because I'm not sure that every state sets rates for personal care, home health aides, homemakers, and habilitation.

KATHERINE ROGERS: I think the compendium data includes -- it uses the CMS typology for HCBS to set, to cluster services into bigger buckets, because one thing we also know about HCBS is that Medicaid program has set a different array of services and may call similar things different things. And so we have some of that information. It's not necessarily in that document crosswalk to, like, delivery systems so that we see, like, oh, there are this many people in fee-for-service and, therefore, the state's setting a robust, widely used fee-for-service rate. But that's an interesting question. I think the data exists, but they're not necessarily all in one place at the moment.

COMMISSIONER CAROLYN INGRAM: I guess I'll reserve further comments for when we see what happens with the access reg, and if these things are reported, then

states would come back and say, you know, what that is. But it'll be interesting to see.

I think there might be quite a few states that don't actually set each one of these categories is my gut, but haven't studied it, I only know the ones I work with specifically.

CHAIR VERLON JOHNSON: Thanks, Carolyn.

Anyone else?

[No response.]

CHAIR VERLON JOHNSON: All right. So, Katherine and Emma, you know, one of your questions was around should you go back and do additional work? And I would say yes for this one for sure. I think you got a lot of different questions to help strengthen a potential policy option. You got some questions around perhaps getting some additional information from states that could help us think through this a little bit more, but is there anything else that would be helpful before you close out?

EMMA LIEBMAN: No. This was extremely helpful. Thank you, all.

CHAIR VERLON JOHNSON: Okay. All right. Thank you again for your work on this. Really appreciate you.

Vice Chair?

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman.

Now we're going to continue our conversation on health care access for children in foster care, looking for questions and feedback as we try to wrap up the chapter on this work.

Last meeting, we had a lot of conversations looking forward to the input from the states, and so Allison is going to share with us some of that feedback.

Welcome, Allison, and look forward to hearing what you've learned.

HEALTH CARE ACCESS FOR CHILDREN IN FOSTER CARE: STUDY FINDINGS

* ALLISON M. REYNOLDS: Good morning, Commissioners.

This morning, we're continuing our discussion of health care access for children in foster care from February's meeting.

In February I presented background information on children in foster care, an overview of the federal requirements for the state Medicaid and child welfare

agencies that serve them, and the results of an extensive literature review.

During this session, I'll present findings on state approaches to meet the health care needs of children in foster care and the challenges that they face. Our findings are based on stakeholder interviews and in-depth profiles of seven states utilizing diverse Medicaid delivery systems.

This morning, I'll briefly review the unique circumstances of children in foster care that impact their health care needs, as well as the federal requirements for state Medicaid and child welfare agencies. I'll then provide you with an overview of our study methodology. The majority of our time will be spent on a discussion of the study's findings across four areas: collaboration between Medicaid and child welfare agencies, the delivery of EPSDT benefits, behavioral health challenges, and specialty managed care plans. I'll conclude with a preview of our next steps and a request for feedback from the Commission on this body of work.

Let's briefly revisit some of the background information from February's meeting. The physical,

behavioral, and oral health needs of children in foster care are greater than children in the general Medicaid population, and state efforts to meet their health care needs must account for their unique circumstances. The literature indicates that children in foster care have chronic and acute health and developmental conditions, which are exacerbated by trauma, placement disruptions, and difficulty sharing information across child-serving systems.

Children in this population experience trauma before, during, and after placement in foster care, and studies show these traumatic experiences negatively impact their physical and behavioral health into adulthood.

Adverse childhood experiences, commonly referred to as ACEs, increase the risk for long-term medical issues including heart disease, stroke, cancer, respiratory disease, diabetes, and depression. Once in foster care, placement instability can also intensify existing mental health challenges.

All children in foster care tend to have a higher rate of suicidality than children without a history of child welfare involvement. Studies show the risk of

suicidal ideation and suicidality increases when there are more referrals to child welfare, more transitions for that child, more placement instability, and as children spend longer time in foster care.

Children in foster care also receive fragmented health care when removed from their home and from placement changes while in out-of-home care. Research, including from the American Academy of Pediatrics, shows that this interruption in care from existing providers negatively impacts children's health and also raises the risk that any developmental delays will go undiagnosed due to the lack of continuity of care.

Additionally, state Medicaid and child welfare agencies maintain disparate health care data collection systems for children in foster care, putting them at risk of overlooked health needs, delayed routine care, interrupted treatments, and misuse of psychotropics. Studies indicate the decentralization of data concerning children in foster care limits the effectiveness of interventions and the ability to measure health outcomes.

Researchers generally agree the unique health care needs of children in foster care require an

integrated, comprehensive, and continuous service array, with an emphasis on cross-agency collaboration. However, federal rules make this preferred collaborative model difficult for state agencies to achieve.

As the legal custodians of children in foster care, state child welfare agencies are responsible for ensuring these children receive health care, but federal funding for foster care programs does not include the cost of their medical care or health insurance. Thus, child welfare agencies must rely on their state Medicaid programs. However, federal rules do not require state Medicaid agencies coordinate with child welfare agencies.

Coordination between agencies is further complicated by the lack of federal statutory or regulatory authority mandating sharing of children in foster care's health data. To meet the unique and complex needs of children in foster care and to address the challenges states face with coordination and data sharing, states are increasingly enrolling children in foster care in Medicaid managed care, including into single specialty plans.

A recent study documented that as of 2021, 42 states and the District of Columbia were enrolling children

in foster care into managed care for some, if not all, of their Medicaid benefits, with 26 states exclusively using managed care. The same study revealed almost one-third of the 42 states, 14 states and D.C., procure specialized plans designed for children in foster care.

Let's take a brief look at the study we conducted. We contracted with Mathematica and their subcontractor, the Innovations Institute at the UConn School of Social Work, to conduct a systematic investigation of federal policy requirements and state delivery methods of Medicaid benefits to children in foster care.

We conducted an in-depth review of seven states with varying geography, population size, and approaches to delivering Medicaid benefits to children in foster care. One state utilized fee-for-service. One state placed children in both fee-for-service and general managed care. Two states enrolled children in foster care as one of the eligible populations in general MCOs, and three states enrolled children in foster care in one statewide specialty managed care plan.

In addition to reviewing publicly available child

welfare, Medicaid, and managed care documentation, we interviewed 80 state and federal officials, national experts, and beneficiary advocates.

Four prominent themes emerged from our review of approaches states take to meet the health care needs of children in foster care: one, collaboration and coordination between Medicaid and child welfare agencies, including data sharing; two, the delivery of EPSDT benefits; three, behavioral health challenges; and four, specialty managed care plans. Let's take a more detailed look at each one of these findings.

Federal, state, and private Medicaid and child welfare stakeholders we interviewed identified collaboration on policy, data sharing, and health care delivery methods as the ideal approach to serving children in foster care but difficult to achieve. At the federal level, national experts told us coordination between agencies ensures that guidance and policy direction to states is aligned. However, stakeholders we spoke to reported this type of interagency coordination occurring on a sporadic basis, mainly due to the demands on each individual agency to meet their own federal requirements.

States did share with us some examples of effective collaboration. These included the establishment of therapeutic foster care programs, which involved braided funding, and the transition of children in foster care from fee-for-service or general managed care into specialty managed care plans.

Conversely, stakeholders reported ongoing challenges with effective data sharing. Both federal and state officials we spoke to cited the lack of federal statutory and regulatory authority mandating data sharing by Medicaid agencies with child welfare agencies. Consequently, we heard about inconsistent state practices hampered by confusing legal interpretations as well as technical limitations of aging state IT systems and the financial limitations of updating those systems.

A second finding from our study was the effectiveness of states delivering EPSDT benefits to children in foster care. State Medicaid officials consistently told us their Medicaid programs are adequately providing timely access to physical health screenings and services for children in foster care but are challenged ensuring timely access to behavioral health and dental

health care.

Several states reported children in foster care perform higher on physical health and preventative service measures compared to the overall child Medicaid population in their state and attributed this success to care coordination efforts.

In regards to behavioral health, we consistently heard that children in foster care do not have timely access to behavioral health screenings and follow-up care due to workforce shortages nationwide. This finding was consistent across all Medicaid delivery models.

Similarly, national experts and state officials reported a lack of Medicaid dental providers nationwide as the cause of delayed access to oral health screenings and dental visits for all children, including children in foster care.

Behavioral health challenges were the third finding from our study. States reported challenges meeting the unique and complex behavioral health needs of children in foster care due to workforce shortages and placement instability. All stakeholders we interviewed cited addressing this population's behavioral health needs

through Medicaid as their most significant challenge.

In regards to workforce shortages, state Medicaid and child welfare agency officials reported a lack of personnel within their own agencies, as well as deficiencies with provider networks, as barriers to children in foster care receiving the continuum of behavioral health services they need.

Based on research findings that placement in foster care and subsequent disruptions in placement negatively impact children's behavioral health, child welfare officials reported their focus is on preserving families and preventing children from entering foster care. For those children who do enter out-of-home care, stakeholders cited mobile crisis services and therapeutic foster care programs as promising strategies to preserve foster care placements.

Our fourth finding was that states are increasingly using a single, specialized, managed care plan to deliver Medicaid benefits to children in foster care. Medicaid and child welfare officials we interviewed in three states utilizing the single MCO model told us this approach reduced the administrative burden on state agency

staff. These officials also cited effective communication with MCO staff and the ability to resolve agency concerns regarding enrollees as benefits of the single specialty plan model.

The findings I reviewed with you today will be incorporated into a descriptive chapter for the Commission's March 2026 report to Congress. I'll return in September to present that draft chapter to you. Today it would be helpful to receive Commissioner feedback regarding issues you'd like to see emphasized or elaborated on in that chapter. Additionally, I welcome your feedback on potential future projects focused on children in foster care; for example, your interest in an analysis of states' use of managed care, including specialty managed care organizations, and federal policies impacting collaboration and data sharing between state Medicaid and child welfare agencies.

Thank you. I'll turn it back to the Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Allison. I appreciate the feedback.

All right. I'll open it up for Commissioners on questions or feedback for this chapter. Heidi.

COMMISSIONER HEIDI ALLEN: So thank you for this, and I think it's going to be a really useful chapter to set the stage for our future work in this area. The finding that there's overall inadequacies in behavioral health for kids, and that is impacting kids in foster care's ability to access the continuum of, like, particularly behavioral health care, I think, is just an insufficient answer to, you know -- it's just insufficient. Like, it's not enough to just say, well, this is a problem the whole system has. And I'd like us to think of a paradigm where kids in foster care have some kind of priority access.

The state is standing in as the parent or the guardian, and the parents -- you know, anybody who has a kid who has a behavioral health condition, which I do, knows that as a parent, you just spend all your time advocating and navigating these systems on behalf of your kid. And the fact that, you know, one, that these kids have a higher burden of behavioral health conditions to begin with, that they could have higher acuity, and that they don't have the parent and the guardian advocating and navigating on their behalf, tells me that this is a role that the state really needs to take very seriously.

So, in that, I'm interested in this idea of the specialty mental health behavioral -- or MCOs and what would be the advantages of that, and what would -- you know, what would prioritization look like? Does that look like reserving networks? Does that look like enhanced payment? But how do we address this?

It's so tied into other bodies of work that we've been looking at, including access to residential care, and I think when we were looking at, you know, the intersection between residential care and, you know, access, one of the things that we were talking about was that, you know, kids can't get in for a long time. And then once they get in, it's really hard to get them out, and this was particularly true for kids in foster care, that they would just languish for years in these residential programs.

And, you know, the solution to that was so complicated, because, you know, how -- where did they go when they leave and the disconnection to where they'd been, but, you know, the answer was always like, you have to, at all costs, try to avoid them having to go to residential care.

And so this to me seems like a very clear body of

work that we could do to try to prevent this, like, terrible cycle of kids needing to end up in residential care for years and years and years, because they don't have a family to go home to.

So I'm really excited about this work.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi.

Mike, then Tricia.

COMMISSIONER MICHAEL NARDONE: Thanks, Allison, for this work.

I just wanted to echo Heidi's request that we continue to look at these specialty managed care programs, particularly to see how they address some of the challenges that you've identified here in the presentation around coordination of care, because I do think it -- kind of understanding the effectiveness of those programs, how do they address some of the issues like behavioral health and dental and also the coordination issue. So I think that's a really good body of work to dig into, and I'd be very interested in seeing us pursue that.

I did have a question I just wanted to understand. When we talk about the 14 states that do a specialty managed care program for foster care, is it

limited to foster care kids, or is the population a broader category of children with special needs that includes foster care? I just wanted to understand that.

ALLISON M. REYNOLDS: Sure. So those statistics were from the Thompson study, but I have already started, in anticipation of your feedback, taken a look at sort of the existing and future plans, especially including North Carolina's, which some of you may be familiar with. Actually, in year two of its contract, it intends to bring in not only the kids in foster care, but their siblings and families as well, which at least from the knowledge that I have is unique.

So the populations that are generally put into these specialty managed care plans are kids that are in foster care receiving foster care payments or the guardianship kinship payments as well as subsidized adoption and also sometimes, depending on the waiver authority that they've selected, kids with SED, serious emotional disturbance, or populations that are multi-system youth, like individuals in juvenile justice. Now, each of those populations is distinct and has unique attributes and challenges, but they are generally -- including the three

states that we looked at in this body of work-- had the kids in foster care as well as the kids in subsidized adoption.

And one area potentially for the next phase would be what policy levers can be pulled, or do states think it's necessary to even further stratify those populations? Because even in a specialty plan, how you would respond and meet the needs of kids in foster care versus kids who are in a subsidized adoption placement with legal parents could be different.

So does that help answer that question?

COMMISSIONER MICHAEL NARDONE: Yes. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike.

Tricia, then Angelo.

COMMISSIONER TRICIA BROOKS: Thank you, Allison, for this work.

And I was going to mention the North Carolina effort, because I think we all recognize that if you have to maneuver different managed care plans for different members of the family, it just makes it harder, and it's already hard enough for a family who's got a child involved in foster care.

I do think taking a harder look at the single managed care or the specialty managed care plans is important, because, you know, on the surface, it sounds great. They can really focus on the population, understand them, get the systems and processes in place that serve them well. On the other hand, isn't the reason we do managed care is that we have competition so that everyone's trying to do better? So I think it's something to take a harder look at.

The other thing that I want to mention that I'm still real sensitive to is former foster youth. Between 20- and 23,000 kids age out of the system every year. I mean, these are kids that are not going back to their family. I understand that the goal of foster care is to reunite kids in their family, but these kids aren't going back to their families. And arguably, they weren't adopted along the way. So I think we would find that our former foster youth have even more unique circumstances and requirements.

On page 7 in the material we got, in the box where it talks about the different things, it talks about former foster youth and states having to cover them up to

age 26 in their state. And their state is accurate in that -- I want to remind the Commission that states are not required to cover former foster youth from another state. If the child was in care in the other state, except that the SUPPORT Act finally started to recognize that, but it phases in over years. And it's not until 2030 that all of our former foster youth, that we can guarantee them that they're going to have Medicaid until their 26th birthday, just as we guarantee kids who live with their families or in college to stay on their family's plan until age 26. So I'd like to see at least the chapter allude to the fact that this is another element of foster care that requires its own research and analysis.

So I will stop there.

ALLISON M. REYNOLDS: And just to respond to that, if you recall the 2015 chapter that MACPAC did that introduced this work did sort of look at the continuum from at risk, to out-of-home care, and then through the former. And we realized through researching and conducting this study for this body of work that that was kind of overwhelming, including for the interview subjects that we spoke to in the beginning, because they are three really

distinct -- not population, but points of time in the continuum of a child's life as they are at risk of being placed in care, are actually removed, and then what happens if they age out of care? So I did want to just illustrate that we really thought about that carefully, including again -- and it feels like there's just a distinct regulatory scheme.

There are individual challenges with each of those points in time. So I think the interest is there for looking at all three of those points in time, and the focus on the out-of-home population for this particular body of work wasn't a reflection of that. It was just that each is probably a project or multiple projects in and of itself.

COMMISSIONER TRICIA BROOKS: I totally appreciate that.

I just think anything we put down on paper about foster care, that we should at least have a little paragraph, you know, that just says something about former foster youth and the fact that, you know, they aren't covered. We should just reiterate that.

But honestly, it's a ripe recommendation area for the Commission to recommend that Congress go ahead and

expedite that phase in of age 26. It's not a big ticket item for the states, and particularly when youth live in border areas, in Minneapolis or in the D.C. area, they are apt to move across state lines, and they need access to ongoing care to make sure they make that transition to adulthood to become productive contributors in our society.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Tricia.

Angelo, then Sonja.

COMMISSIONER ANGELO GIARDINO: So, Allison, thank you. You know, I just eat this work up. This is wonderful. I'm really glad you're pursuing it.

A couple things. With regard to the specialty MCOs, I had the experience of living in Texas and working there for 13 years, and Texas used a specialty MCO. And I'm a capitalist, and I believe in competition. But for small populations that require significant expertise, I think specialization sometimes is necessary.

So I'd really like to hear from the specialty MCO community, perhaps in a panel and, you know we all love panels. But what are the best practices that make the specialty MCO the right way to do this?

I'll give you an example. In Texas, our concern, there was a report written called "Forgotten Children," where it was discovered that the vast majority of children in foster care were on between three and five psychotropic meds to control their behavior, which was stunning. This specialty pharmacy did a really good job at setting up a very robust behavioral health system across the state of Texas, and we were able to really get that, you know, three to five psychotropics down to one, if that. So there were alternative, less restrictive ways of managing people's behavioral health problems and didn't require chemical restraint.

So I would like to hear from the MCOs that are actually doing this work, and why is it that a specialty MCO might be the right balanced priority for us to pick? Because competition for a small number of patients that need high-end, sophisticated, nuanced knowledge of their clinical problem is probably not the best thing.

The other thing I would just say is one of the things that really comes up with foster children is that they get moved around a lot. So there's this idea of a passport, a health passport, where whatever entity, whether

it's fee-for-service or the MCO, that they create this passport available electronically. And I would just really encourage that to be something that we really encourage, because we know the kids are going to move.

And then I would also ask if the specialty MCOs could talk about some of the nontraditional services that these kids need. They're traumatized constantly because they keep getting moved around, and many foster children, when they have to move, have to use a trash bag to move their belongings. And whenever I have to go somewhere, I have a suitcase. I'm not traumatized when I have to go somewhere. A foster kid is because they have to put their stuff in a trash bag, and they're smart enough to know that if they're carrying their stuff in a trash bag, they're probably trash themselves. So I would really like to think in terms of allowing Medicaid to do some nontraditional, perhaps multi-sector work here, where other organizations that would attend to some of those life, human dignity things would also get factored in, since, as Commissioner Allen said, we are acting *in loco parentis*. We are their parents as the government. So we have to pay attention to how our system might be traumatizing them more and more.

The next thing I wanted to just mention is, are there best practices around how to share information? Are there some states or local systems that have really discovered ways of the Medicaid program, which is handling physical and behavioral health, working with child protective services? And then could we kind of really have this idea of really encouraging the best practices? And perhaps there's a panel there.

And then, finally, just to pick up Commissioner Brooks' view, the former foster youth is something that I do believe we have to keep reminding ourselves of because that's another area where nontraditional services and multi-sector work is essential to the health and well-being of the kids.

So, when you're between 20 and 26, you have to think of a job. You have to think of housing. You have to think of, you know, appropriate decision making around how you use your recreational time. So I think it's important for us to be aware for the small number of kids who have a significant need, their health relies on some of the other sectors to stay healthy. So I think when we think of the former foster youth, we do have to think about some of that

multi-sector work, and I believe that there are regulatory and statutory approaches to allowing us as a collective body, the government, the people of the United States, to take care of this very vulnerable population.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo.

Sonja, then Patti.

COMMISSIONER SONJA BJORK: Thank you, Allison, for your good work.

I'm from one of the states that is indeed voluntarily looking into how to have these big agencies work better together, child welfare and Medicaid, and so I'm glad that we're looking into the specialty MCOs. But I would also like a good deep look into having current managed care plans or current systems adjust and do better for foster youth.

So, in California, they decided not to go the way of a specialty MCO but instead put a lot of very important requirements in the contracts of all the managed care organizations, and that was because in some areas, it's hard for the providers to know. If there's just a few people in a small, different health plan, then the

providers for setting up their admin in terms of who to bill, where to get authorizations, who to contact, that can add a barrier that was not intended. And so instead of setting up a separate system, the current systems have to do better, and these can involve things like requiring MOUs between the health plans and the local child welfare agencies.

You can have anything you want in there about data sharing and about meeting requirements and who's going to talk to who and in what situation, and then it can also require things like now the health plans have a job title called "foster care liaison." So that if something's going on, the social worker or the foster family agency knows who to get a hold of for some extra help for a child that perhaps is moving out of state or has a complicated health care need.

So I think I'd like just as much attention on those other mechanisms for treating this population, especially, and I won't go into all the reasons, but it's not that many kids. And I think we can do so much better for them. It's just not that hard. You have to put in the resources. You have to find the right people, and you have

to pay attention.

Yes, it will be different, and it'll be a little more expensive, but how worth it to make sure that these kids get what they need.

And one of the number one things that's needed is flexibility. Some kids will move to a different county. Some kids might move out of state with relatives. They need some help during that transition. Who's covering them when they moved to the next state over before their eligibility is all settled in the new area? They'll have different behavioral health needs and services available in different areas. It's going to be quite a mixed bag. Some might be in a group home, some might be with a relative, some might be in pre- or post-adoption status. These can all be really complicated moves that a kid should not have to worry one bit about, and we need to make it as easy on their families as possible too.

So thanks for this great work. I look forward to it.

ALLISON M. REYNOLDS: And one thing I just wanted to make sure I reinforced was that national stakeholders we spoke to indicated that regardless of the delivery method,

what they really thought was successful was the identification of these populations, and we heard from states that have fee-for-service or general managed care that it can just be difficult to identify the children through enrollment codes and things like that. And so there was something about the specialty managed care plans just being smaller and focused that just made that first upstream effort easier.

And then, secondly, the data reporting piece, just the difficulty of a plan or a fee-for-service model. We were talking about hundreds of thousands and trying to focus efforts on a small -- maybe 2 percent of your enrollment. So there's something about the process of putting a waiver together, et cetera, that just seemed to lend itself to coordination.

But I think the goal would be to identify issues where policies could be looked at so that they would work across all Medicaid delivery systems. It may just be that the specialty plans, having been a focused effort, could illustrate some of those policies for us.

VICE CHAIR ROBERT DUNCAN: Thank you, Sonja. Thank you, Allison.

Patti? John?

COMMISSIONER PATTI KILLINGSWORTH: Really nice transition into my comments.

So, like my colleagues, I would love to see us dig a little bit deeper into the specialty managed care organizations. I come from a state with a long history of using one such entity for children in foster care. I would love to be able to look at outcomes data, which sort of compares the success of specialty plans versus traditional plans versus fee-for-service. That data probably doesn't exist, but any data that does exist, I think would be hugely beneficial.

I think when we think about the specialty care plans, I'd really like to understand sort of like what's different. What are the commonalities? Are they typically risk-based or not? What does the care coordination model or approach really look like? Do they have special networks or rates? Kind of really understanding a little bit more of the nitty-gritty, getting to those sort of best practices, if you will, that kind of point to this really works better for this population, especially if, like Sonja says, everyone needs to sort of elevate and do better so

that it doesn't have to be specialty care plans.

I always said about managed care plans, if you can support the LTSS population, you can support anyone. I think it makes you better at care coordination, and so these kids could improve sort of the totality of the system. But we don't want to place them at risk in order to do that, and so identifying and being able to build those are important.

I also would be interested thinking about best practices around specialty providers or specialty models of delivering actual services to these kids. So I think there is some work now of pediatric practices that are virtually available that are more targeted to these special populations. They may be in limited states but happy to provide some information there, where they can be available all the time, which I think is sometimes what it takes for these kids to really feel stable and safe in the placements that they're in.

And then the last thing I would just note is we just sort of finished this morning a vote around transitions for children and youth with special health care needs. Oh my gosh, right? Do we ever need to really think

about transitions for kids out of foster care? Now, some of those kids will probably be implicated by the recommendations we made this morning but not all of them, and so -- because they're eligible in different ways. And so we really do need to think about that transition piece maybe in a different aspect of this work.

And my last note is just to Angelo, which is "My Bag, My Story." There are organizations where you can donate funds to cover bags for kids who are in foster care, and it's those kinds of organizations are doing good things for those kids. Yep.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

John, then Dennis, then Carolyn.

COMMISSIONER JOHN McCARTHY: To me, this is where MACPAC could really could do some amazing work and harp on some things that Dennis always says is, you know, what's the best way to do this? What is -- you know, what are we looking at? So I want to just reiterate what Patti said.

What I really would love for us to be digging into is looking at, you know, whatever type of outcomes we can get with HEDIS measures, looking at a state that uses specialty plans versus -- a specialty plan versus using

their regular managed care plans versus fee-for-service and not leaving, you know -- so what is best in class that we see in there? And then also looking at not just aggregating all and looking at it, just those three chunks, but within there, you know, are certain states just doing better at this because of they've been doing it longer or whatever?

You know, I had a specialty plan in D.C., and it's tough because they did a great job. But then you also have the issue of -- and Trish talked about this -- competition. So if you only have one plan, your competition only comes every five years or seven years when you do a re-procurement, and then if you only have one plan and that plan doesn't win the procurement, that's huge change. I mean, everyone has to change management. So then you run into this issue. I think that there's a little bit of a -- you know, can you actually change a plan? And so do you really have competition when it comes to those things?

On the other hand, if the plan is doing amazing things, it makes sense, you know, to have them in there. They've invested time and money in those different pieces.

So, you know, I just really want to stress again, it feels like in this one, we really should be looking at not just specialty plans, but how do they compare versus other types of plans?

VICE CHAIR ROBERT DUNCAN: Thank you, John.

Dennis, then Carolyn.

COMMISSIONER DENNIS HEAPHY: I think it would be helpful to highlight that, you know, kids with disabilities in foster care are at greater risk of -- they're far more vulnerable. They're less likely to be adopted. They're more likely to die at an early age. So just to elevate that, that their needs are distinct. And that was Patti's point too, with them turning 22. So how do we make sure that these kids are actually getting the service they require? Because they're being shipped around, and that's not good for the kind of care for this population, which are already vulnerable. And just as a way to add some of that, I'll try to find some articles.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Carolyn.

COMMISSIONER CAROLYN INGRAM: Thanks.

To your second point on looking at collaboration between -- and data sharing between state Medicaid agencies and child welfare agencies, it would be really great to see some models, if you can find them, if they work well beyond just those two agencies. I know we have a process where we meet regularly with all of the agencies that will touch kids in foster care, not just the child welfare agency, but the department of health and legal system and having discussion around cases and what we're doing to help. And we're not even the specialty plan. So I think there's different things in different states. So maybe we could look a little bit broader than just the Medicaid and the child welfare agency in that area.

And then I just have to echo that I'm interested, again, in seeing the same thing besides just the specialty plans. What are organizations doing in general?

I know in our state, we don't mandate where Native Americans have to go, and so, actually, those folks will float in between lots of different managed care companies, besides just specialty plans for the same types of services. So there's a lot of activity going on. So just something to consider.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn.

So, Allison, I think you got a lot of feedback and input. I appreciated John's comments about the opportunity for MACPAC to really dig into this space and create something different for this population, both current kids in foster care as well as those that transition out.

I will push back on Sonja a little bit. She said it may be more expensive. I think it's one of these things where you pay me now or pay me later and it's much more. I really see this as an investment in these kids and giving them the maximum chance to thrive and have healthier outcomes long term. So I do think this is an important part of work for us.

Do you feel like you've got everything you need to continue this great work?

ALLISON M. REYNOLDS: I do. And thank you for all the detailed feedback. I really appreciate it.

VICE CHAIR ROBERT DUNCAN: Thank you.

All right. We'll be transitioning. This was mentioned by Heidi. But we're going to transition into

appropriate access to residential care because there is some correlation between these, and so Joanne will come up and share the latest and seeking input as she works on this chapter.

So, Joanne, welcome.

APPROPRIATE ACCESS TO RESIDENTIAL TREATMENT FOR BEHAVIORAL HEALTH NEEDS FOR CHILDREN IN MEDICAID

* JOANNE JEE: Thank you. Hello.

Okay. So this morning, we're going to review the draft chapter for the June 2025 report to Congress on appropriate access to residential treatment for behavioral health needs for children in Medicaid.

So, Commissioners, you will recall that MACPAC has begun a multi-analytic examination of behavioral health services for children in Medicaid. We started with -- you know, in this cycle, we started with looking at residential treatment, which is an area where challenges have been frequently documented, but I just wanted to remind you all that in addition to this work, we plan to be looking at access to intensive community-based behavioral services for children who need those as well. And as the Commission has said over numerous meetings, we really -- there's such

importance in having those services available to ensure that children can be served in the least restrictive setting. So we do plan to look at that. In addition to that, we will be looking at quality and safety of residential treatment. So those will be upcoming cycles.

Okay. So this is just the overview of the key sort of parts of the chapter. I won't really go over this slide, but this is what we'll run through today.

All right. So the draft chapter starts by putting residential treatment for behavioral health services in the context of the behavioral health continuum of care which, as I mentioned, includes both intensive community-based services as well as residential care. The chapter provides some background to illustrate that some children in Medicaid do require residential treatment, particularly when behavioral health in the community is not available or is insufficient to meet their needs.

In addition, the chapter notes worsening indicators for behavioral health for children, including persistent feelings of sadness or hopelessness or suicidality, increasing emergency department visits for mental health-related conditions or issues, and then

increased incidence of emergency department boarding. The ED boarding occurs when patients who have behavioral health needs remain in the ED because they are unable to find a placement or services for them.

All right. So the draft chapter reviews some key federal requirements for Medicaid coverage for residential services. It provides an overview of early and periodic screening, diagnostic, and treatment, which is the EPSDT benefit, and of course, the EPSDT benefit requires that states ensure that covered children have access to medically necessary services, which would include residential care.

It then turns to the Institution for Mental Disease, or IMD, exclusion. We've mentioned this several times and I know you all are familiar, but just as a reminder, the IMD exclusion is a statutory prohibition on federal payments for services provided to Medicaid beneficiaries residing in IMDs, and IMDs, as you will recall, are facilities with 16 or more beds that primarily diagnose, treat, and care for individuals with behavioral health needs.

There are two important exceptions to the IMD

exclusion, which the chapter reviews. The first is that states may choose to cover the optional Psych under 21 benefit, which allows state Medicaid programs to cover services in psychiatric residential treatment facilities, which I'll go over in a little bit more detail in just a second. Those are referred to as PRTFs because there's a lot of acronyms in the space. So that benefit is available for beneficiaries under age 21.

The second exception to the IMD exclusion is that states may use, if they choose, to provide services under a Section 1115, severe emotional illness -- I'm sorry -- severe mental illness, severe emotional disturbance waiver demonstration authority to pay for short-term stays in IMDs at the -- there's a contingency that the statewide average length of stay for those services in IMDs is 30 days or less.

Okay. So the draft chapter does describe some of the residential treatment facilities that may serve children in Medicaid, the conditions of participation, as well as some of the payment rules, and these facilities are the psychiatric residential treatment facilities, or PRTFs, and the PRTFs are the ones that provide the Psych under 21

benefit.

The second type of facility is qualified residential treatment programs, and those are QRTPs, and QRTPs provide services for children in the foster care system.

You'll recall that we talked about the number of ways that children can be referred to residential treatment. Many of these are listed on the slide, and I won't go over all of them, but hopefully, they're familiar to you.

I just want to flag the two bullets at the bottom. The chapter describes those in a little bit of detail. So, in some circumstances, families may find that they are unable to serve the behavioral health needs of children in the community, or they might find difficulty in doing so. And they may determine that their best option is to relinquish custody of their child to the child welfare or juvenile justice systems, and they do that to try and improve access or gain access to some services that might otherwise not be available to their child.

Similarly, some states allow parents to enter into an agreement with the state agency rather than

relinquish custody, and when they do this, the state assumes custody of the child for a specified period of time and provides the needed services to the child.

The chapter then discusses what is known about utilization of residential treatment services and some of the factors that affect it. We draw first from the literature to provide some national-level estimates on the use of residential care by children in Medicaid, but the key takeaway really here is that there is no single federal data source to help policymakers and researchers understand the use of residential treatment by Medicaid-enrolled kids.

States are required to collect and report some data on the use of PRTFs but not for other types of residential settings.

Some states are collecting data themselves, which are helpful for understanding within state trends and utilization, but those analyses are not necessarily comparable across states, and that's due to differences in data and data collection methods.

The chapter also draws attention to the incompleteness of certain kinds of information. The first is beneficiary demographics. So the lack of this data

makes it difficult to understand which children are being served in these facilities and whether there are any disparities that warrant some attention.

The second is there's a lack of information available regarding facilities and their bed capacity -- or I'm sorry -- their available beds and what their areas of specialty are.

You'll recall that in prior presentations, we talked about how certain facilities may be specialized in providing a certain type of behavioral health care, whereas others in maybe another part of the country or another part of the state provide care in a different kind of specialty area. This lack of information makes it hard for families and providers to find the placement that they need for their child.

Okay. So the chapter next focuses on out-of-state placements. We talked quite a bit about this as well. These placements are sometimes needed when in-state facilities are unable to provide care needed by children or if the facilities deny admission of these kids. Here again, there are no publicly available national data on out-of-state placements. I will just note for you, though,

that the Medicaid State Operations Manual includes a requirement that states submit a PRTF, annual attestation Statement, and that statement does call for some data related to out-of-state placements, but it's probably not as complete as some might like to see.

We talk about facility payment rates, and as you know, that's usually set by the states. And we learned that payments to out-of-state facilities generally are higher than they are for in-state facilities, and so that can create an incentive for facilities to admit children from out-of-state. And then you can see how that in turn creates some access barriers for children within the state.

And, again, just the chapter notes that there are no federal rules regarding provider decisions to accept or deny admissions to these facilities.

Okay. The chapter spends some time talking about the continuum of care, specifically to highlight the need for intensive home- and community-based behavioral health services as a part of any effort to improve or address access to residential care.

In this section, we call out MACPAC's prior work from the June 2021 report to Congress, in which MACPAC

identified a need for joint sub-regulatory guidance, as well as technical assistance regarding the design and implementation of benefits for children in Medicaid and CHIP who have significant behavioral health needs.

That chapter also provided some examples of state approaches to improve access to intensive community-based care, such as the use of the targeted case management benefit to improve care coordination, concurrent residential and community-based service delivery to ease transitions from facility-based care, and increasing payments to boost provider participation in Medicaid.

The last section of the chapter summarizes some of the key barriers to appropriate access to residential treatment. The first relates to what I just mentioned about the continuum, and it's that the lack of community-based behavioral health services affects the ability to access residential treatment as well. So, as many of you Commissioners have said over the last several meetings, if you don't have the community-based services sort of up front, then that leads to potentially avoidable residential care, and then for a child who's in residential care, if you don't have the community-based services to discharge a

child into, then that child may end up in residential care for much longer than they need to be.

The next barrier that the chapter touches on here relates to the IMD exclusion which, as you know, renders certain facilities inaccessible to Medicaid beneficiaries.

Next, the lack of real-time information on facility and bed availability and facility specialty makes it difficult to find timely and access placements for children who need them. The chapter notes that there are different requirements for assessing the need for residential treatment based on facility type, and those differences could lead to sort of different decisions around placement based on which population that you're talking to -- or talking about. Excuse me. And not only is it inconsistent, but it could lead to inappropriate placement in residential care, just by virtue of the population.

The lack of national data, of a single national data source on the beneficiaries, makes it hard to understand the population that's being served, and whether there are specific opportunities to address any areas in need of improvement and, again, whether there are

disparities.

And finally, the chapter talks about workforce issues, including difficulties in recruiting, training, and retaining staff at facilities, which makes it difficult for the facilities to operate at their fully licensed bed capacity, which then you can see leads potentially to some access issues.

Okay. So, in terms of next steps, we look forward to your comments today. We'll go back and incorporate your comments and feedback into the chapter for the June 2025 report.

In addition to that, staff are thinking about the ongoing work that we'll be doing in this space and scoping out some project work related to home- and community-based or intensive community-based behavioral health services. So that would be one project, and then the second area related to safety and quality of residential treatment services.

So that is the chapter in a nutshell. I look forward to your questions and comments.

VICE CHAIR ROBERT DUNCAN: Thank you, Joanne. And I do, again, want to recognize you for stepping in,

taking this on, and doing an amazing job pulling the chapter together based on the feedback and information we've gathered to date. So thank you for that.

With that, we'll go to feedback. Commissioner Allen, you're up.

COMMISSIONER HEIDI ALLEN: Thank you.

Really appreciate your work on this.

I just wanted to go to Slide 9 really quickly. We've identified in the chapter, difficulty knowing where the beds are, and we've identified workforce issues for making sure that facilities are operating at full capacity. But I didn't see anything about bed shortages. Like, if there actually is a real -- is it just that we can't find them, and then when we find them, they don't have enough staff? Or is there an insufficient supply of residential treatment? I guess that was just my question.

JOANNE JEE: Yeah, the work did look at -- well, we did hear from some stakeholders that there aren't certain kinds of facilities in certain states. So that is, I guess, sort of related to what you're saying but maybe not exactly the same thing, because there might be other types of residential placements that are available, or in

those states, they send them to facilities out of state.

The work did not really collect any data on bed shortage or anything like that. Yeah. So that's not really -- I can double-check for you, but I'm pretty sure that that's not part of the information that was collected.

COMMISSIONER HEIDI ALLEN: Yeah, I think it's a yes, and to what you're saying, both like, is there the appropriate types of care and then just, in general, did we find that there were wait lists? And how long were people waiting? And if so, a wait list to me and a wait time would indicate a bed shortage.

JOANNE JEE: Mm-hmm.

COMMISSIONER HEIDI ALLEN: And the bed shortage could be workforce capacity. It could be capacity-capacity, or it could be specialized capacity.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi, and I think it would be all three of the above.

With that, we'll go to Mike, then Angelo.

COMMISSIONER MICHAEL NARDONE: Thank you, Joanne, for this work and for stepping into the breach.

I wanted to just reflect on the panel that

presented at the recent MACPAC meeting. One of the areas that I think they focused on was that there was no place for people who were -- for kids who were in PRTFs to be discharged too, and I think there was a discussion about -- I don't know if this is the right term, but intermediate -- step down, intermediate, before people actually -- kids actually return back to their home -- and -- hopefully. And one of the things, I assume that maybe that's incorporated into the rubric of home- and community-based services, but I don't think that really came out in the chapter about that potentially causing like a -- you know, part of the problem is people aren't being discharged. They're not coming back to their state of residence, and part of the problem is not having those resources to necessarily come home to.

And one of the barriers we talked about, which I didn't really see discussed in the chapter -- and I'm not necessarily suggesting that it be Medicaid funding, but I think housing is a real big barrier in that kind of -- in that continuum. And I think one of the questions -- I think it should at least be acknowledged in the chapter that that's an issue, and also it does then -- you know,

PRTFs, it's clear to states, I think, how you fund those, right? It's clear that's a service, right? The authorities to fund some of those services in that transitional -- whatever we -- you know, that transitional residence is maybe a little different in terms of the authority states would use. So kind of understanding that I think would be helpful.

But I think my main point is I do want to -- I think there should be acknowledgment that there is -- in conjunction with the lack of available home- and community-based services, it's like that residential component is a barrier.

And I think the other piece that you did cover in the section of the chapter around workforce, but I think it also has to do with different models for particular populations, like folks with IDD. That was something we heard about as well at the last meeting, and it was discussed in the workforce section. I don't know if it was discussed in terms of -- I don't think it was discussed elsewhere in the report, in that chapter around models of care, and again, what would be the authorities on which they would be funded?

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike.

Angelo, then Dennis.

COMMISSIONER ANGELO GIARDINO: Joanne, thank you again for the chapter draft, and again, this is kind of an alphabet soup of sorts, and you've really helped us, I think, understand some of those acronyms.

I think I'm more interested in the future work around quality and safety and living in a state where there's a lot of residential treatment facilities that receive a lot of out-of-state folks and not many in-state folks, because the in-state folks are in a system of care where we try to use home- and community-based services. But this is my bias. A number of investor-owned companies have taken advantage of the regulatory environment and have established residential treatment facilities for out-of-state.

The thing I would ask you is, as we get to that other work for quality and safety, to think about what these primarily investor-owned residential treatment facilities do in terms of assuring that there's a system of care for the children that they bring into the state from

their state of residence, because the kids are from a different state. They have Medicaid coverage from that original state. Then they come to the residential treatment facility. They do have mental health problems, and then they decompensate. And then there's no level up. Many of these institutions don't have other parts of the continuum. So they use the emergency department. And then, again, the kid has a different state's Medicaid, and then that burdens the emergency departments and the psychiatric facilities that then this child has to go to. And there's no existing arrangement for them.

And the investor-owned organization gets all the benefit of bringing the out-of-state people. When they decompensate, they use the emergency room and the psych facilities in the now new state, and it's now everybody else's problem. And then they go and they take another person from a different state, and they keep their census high. Meanwhile, those of us in the new state now have to deal with not only our own kids but all these other kids from other states, and those state Medicaid programs tend not to want to compensate us correctly.

So I really kind of feel like it's a dirty little

secret in residential facilities that you take the sickest of the sick. If they work out in your residential treatment facility, great, and if they don't, you just use the emergency department, and then the people that are running the hospital systems can deal with the other states. So I would like that to be part of what we look at.

And I'd like to see that in a quantitative way. So how often do people taken from out of state end up needing a level up, and then where do they go? And has the organization that's running the residential treatment facility -- have they made arrangements to have a level of care above what they can provide? And in health care, it's really irresponsible to not have the level up.

So, when we open a hospital and we want to take people with pneumonia, we make sure that we have an intensive care unit if that pneumonia decompensates. So we can't responsibly run a hospital without having a level up, but it seems residential facilities are allowed to operate, and then they just use somebody else to take care of one level up.

So I hope I didn't confuse the waters, but that's

what I'm really interested in.

JOANNE JEE: Yeah. No, that's helpful. Thank you.

I mean, we heard that from some of the stakeholders over the course of this work as well. So I get what you're saying, and we'll do our best to see what we can do with some data.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo. I was a little disappointed you didn't give a nice analogy with that.

COMMISSIONER ANGELO GIARDINO: I left it all on the table yesterday.

VICE CHAIR ROBERT DUNCAN: All right. With that, we go to Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks. I appreciate you mentioning Olmstead in the context of folks with behavioral health need and serious mental illness. What I'm wondering is, I doubt there is anybody tracking ADA access in terms of beds for folks with other disabilities.

JOANNE JEE: So that did not come up in our work. So I'm not sure if there is anybody tracking that.

COMMISSIONER DENNIS HEAPHY: I'm not surprised.

JOANNE JEE: Yeah. Okay.

COMMISSIONER DENNIS HEAPHY: So basically, I think it might be worth a note that that is an issue or that it's an issue to explore. I know that that's happened years ago in Massachusetts where there were all these folks with disabilities that couldn't get beds in detoxes or in rehab systems, folks who were deaf being sent to -- being hospitalized, and nobody knowing where they were and then not knowing where they were, because there were no interpreters available for them. So I just think bringing into the context the whole idea that there are folks here that need reasonable accommodations and are they being met. Is that actually an access barrier?

And also, particularly folks going from one state to another, if one state has more generous benefits when it comes to LTSS services versus another state that is not, which level of the state -- which level of services is the state required to provide? A little complicated.

VICE CHAIR ROBERT DUNCAN: Dennis.

Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: Again, Joanne, thank you. We look forward to the chapter in June. Great work so far. I think more to work through as we tackle this project. So thank you.

With that, Madam Chair, it's back to you.

CHAIR VERLON JOHNSON: Thank you.

All right. So this is our -- we're going into our last session, Medicare and Medicaid Plan transition, or MMP, which provides Commission with updates on the status of transitioning MMP enrollees to integrated dual eligible special plans, or D-SNPs.

If you recall, MACPAC, we have been committed to monitoring these activities to ensure a smooth transition for beneficiaries.

Now, we know that there has been recent leadership transactions or transitions within the CMS office that oversees the Medicare and Medicaid integration, and while it is not clear to us how these changes may shape priorities moving forward, today's discussion will offer us an important opportunity to ground ourselves on what states are experiencing on the ground as MMP's transition progresses.

And so, with that, I'll turn it over to Drew to give us an update. Thank you.

MEDICARE-MEDICAID PLAN (MMP) TRANSITION: PROCUREMENT, INFORMATION TECHNOLOGY (IT), AND ENROLLMENT

* DREW GERBER: Thanks. I'm happy to close us out today with an update on the Medicare-Medicaid Plan transitions, this time focusing on what we heard from our stakeholder interviews regarding procurement, information technology, and enrollment.

I'll start with some background on the transition and what we've monitored so far and presented to the Commission previously as we near the end, about three years later, and then I'll walk through some of the high-level details we heard from our state colleagues on procurement, IT, and enrollment.

The Centers for Medicare and Medicaid Services launched the Financial Alignment Initiative, the FAI demonstration, in 2012. Several models were available for states to test under the demonstration, but most states elected the capitated Medicare-Medicaid plans, or the MMPs.

The MMPs were fully capitated -- or rather are

fully capitated health plans that cover essentially all Medicaid and Medicare benefits through a single entity holding a three-way contract with CMS and the state. The three-way contract allowed for integrated federal and state oversight, integrated medical loss ratios, and several other unique elements.

In 2022 rulemaking, CMS decided to sunset the demonstration, noting that a number of the demonstration features had been carried over into the Medicare Advantage dual eligible special needs plan model, or D-SNP.

Additionally, evaluations of MMPs struggled to show clear effects on improving quality or reducing spending. CMS allowed the eight remaining participating MMP states until the end of 2025, this year, to transition those enrollees to integrated D-SNPs. States submitted their tentative transition plans back in October 2022.

As part of the Commission's interest in integrated care models for dually eligible individuals, we've been monitoring the transition using a framework which was included in our June 2023 report to Congress. In that chapter, we focused on four main components to monitor: stakeholder engagement, which we presented on in

December of 2023; Medicaid managed care procurement; IT system changes; and enrollment.

To start with procurement, in planning for their transitions, most states told us they would need to procure Medicaid managed care organizations with affiliated D-SNPs. In interviews, state officials, now finished mostly with that process, described it as typical if challenging on the short timeline for the transition.

We identified in our June 2023 report, the end of that year, 2023, as a suggested milestone to issue requests for proposals for procurement in order to allow time for other transition activities and to account for delays. While only two states operated in line with what may have been an ambitious timeline, states issuing RFPs between November 2023 and September of 2024, all states with a competitive procurement process had awarded contracts by March of this year. Two states that participated in the demonstration accept all willing and qualified applicants, a process which has a shorter runway than a competitive procurement. All in all, this largely fits with our expected milestones for states to award by the end of 2024.

We found through our interviews that several

states did face protests of their awards which caused delays, along with some internal staff or leadership turnover that contributed to other delays of the procurement.

Across the board, state officials emphasized a significant chunk of the procurement timeline was dedicated to the RFP design itself to ensure that the integrated D-SNPs could replicate as much of the MMP model as possible, such as care coordination requirements, while also relaxing some requirements that staff felt from their experience conducting the MMP demonstration, as well as from what they heard in stakeholder feedback, that could be improved upon.

Turning now to IT, states had shared, when we spoke with them back in 2022, that the transition would require some IT system updates. During the demonstration, an enrollment broker handled enrolling dually eligible beneficiaries into the MMPs, and while some states may continue to have an enrollment broker for their Medicaid managed care populations, in general, states told us that they will have a larger role in facilitating enrollment transactions with integrated D-SNPs.

These IT updates require significant pre-planning

and occurred often in parallel with procurement activities. Post-award, we heard that these systems will continue to be tested by state teams and in coordination with the selected Medicaid managed care organizations.

A few states did mention other IT systems they've changed or are changing as part of the transition. One state official said they were adding functionality that would allow a more automated enrollment process for those who were assessed for their state's home- and community based services waiver but who were not found to be currently eligible for Medicaid.

Another state said it is switching from its current Medicaid Management Information System, or MMIS, which it described as outdated, to a tailored encounter reporting system, similar to that used by North Carolina and Virginia.

Finally, on enrollment, states have said that they've been testing enrollment systems to ensure a smooth transition at the start of 2026. This includes practicing enrollment scenarios with CMS and post-award with their Medicaid managed care organizations.

Other state officials added that they have

already mapped out readiness review activities for these plans with their external quality review organizations, and in one state, officials did say they intend to adjust their state enrollment timelines to better align with those of Medicare Advantage open season, as has been done in other states.

And finally, we plan to continue to monitor, obviously, and engage our state colleagues as needed through the end of the transition this year. From the state perspective, an upcoming milestone is the July 7th deadline for D-SNPs to upload their state Medicaid agency contracts, or SMACs, to CMS. D-SNPs that wish to operate in a state must sign this contract, or SMAC, with the state. More information can be found in our report chapter last year in the June 2024 report to Congress. State officials largely said they plan to copy from their three-way MMP contracts into these new SMACs.

I'm happy to turn it back to the Chair.

CHAIR VERLON JOHNSON: Thank you, Drew. Appreciate that.

So, with that, I will turn it over to the Commissioners to see if there are any questions or thoughts

from what we just heard in terms of the update.

Patti.

COMMISSIONER PATTI KILLINGSWORTH: Drew, thank you. I appreciate that we're watching and trying our best to sort of monitor what's happening with these.

I would like to better understand how the timelines may be impacted by some of the procurement protests. I know -- I think there are some states that are worried that they won't meet the 2026 timelines as a result of those protests, and so just kind of understanding what's happening in those states, I think would be helpful.

I would also like to understand specifically what D-SNP model each of the states is transitioning to, so coordination only, HIDE or FIDE. I think we stand to lose a lot of alignment and integration in these transitions, and that's ultimately, I think, one of the biggest measures of success is, you know, can we sort of transition from the current MMP model to the D-SNP model without a significant reduction in the number of people who are in aligned or integrated arrangements, not just coordination only arrangements. And so I'd love for us to be able to be a little bit more granular there as well as, you know, sort

of the continuity of care pieces that typically go along with any transition.

And then I would just sort of reiterate my concern over both oversight and also technical support in light of the changes at MMCO and just understanding from a state's perspective, in particular, right, whether they have access to the support that they need to really finalize these transitions.

DREW GERBER: I do have two quick answers to some of your questions there.

At the time of our interviews, several states had indicated that they were still under procurement blackout, so they were not able to share information with us. Since then, I would say that there is only one state that appears to remain under protest. All other states have successfully awarded their plans.

As to the second part, all of the states have indicated that they're transitioning to FIDE SNPs or HIDE SNPs. I think, more often than not, the FIDE SNPs. We'll obviously see, once the transition occurs, how many enrollees successfully transition over.

I will note that CMS shared in our panel in

December 2023 that their experience with California's transition at the end of 2022, all but 2 percent of the demonstration enrollees had transitioned to integrated D-SNPs.

COMMISSIONER PATTI KILLINGSWORTH: That would be a huge success. I would like to just monitor that. Thank you.

CHAIR VERLON JOHNSON: Thank you. I agree with that for sure.

Dennis?

COMMISSIONER DENNIS HEAPHY: Thank you.

This transition is really large, and as others have raised concern about the closing of the MMCO office, the guidance on SMACs, the creation of SMACs, is a big concern, and whether or not in some states where the plans may actually drive within the SMAC is a huge concern. There's also opportunity in other states to be more creative and work with plans to provide more services.

A colleague of mine and I have had a couple of things published about how to strengthen SMACs and how to look at SMACs as a way of integrating behavioral health services into the HCBS services. It isn't just how to

strengthen the SMACs themselves. It's like the SMACs are the only now vehicle plan states have to build robust contract requirements with plans. I think we should track and see what the SMACs look like. Are there best practices that states are putting in place? Are there other states where the SMACs are not as robust? What are the barriers to actually implementing robust SMACs?

In interviews with different states, it seems the level of expertise, understanding of the Medicare and Medicaid requirements is very varied. So that means that, depending on what state a person lives in, the quality of their D-SNPs is going to change. So how are we going to be sure that there's actually appropriate access to all the services people need, regardless of the state? The SMACs, we need make sure they're at a baseline level of requirements and SMACs need to adhere to in order to support states.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Carolyn?

COMMISSIONER CAROLYN INGRAM: Thank you.

Thanks for the update.

Do we know if states were getting help for all

the audit and readiness reviews in addition to the SMAC agreements from the office?

DREW GERBER: I don't have much I can share on that right now. I just know that state officials did share that they were in regular contact with both the Duals Office and the Integrated Care Resource Center sort of throughout the transition planning and up till recent months. I know they've gotten assistance on all parts of the transition.

I'm a little less clear on providing you an answer about sort of oversight of the operation of the MMPs as it's winding down.

COMMISSIONER CAROLYN INGRAM: Yeah, I think that's one thing that I'd be most concerned about. Having gone through transitions where you close out a D-SNP or bring up a new D-SNP, there's a lot of work with members to make sure that their plans of care are appropriately going in the right direction and that no balls are dropped in terms of that.

And I know our state officials work a lot across all of our states back with that office on just, you know, getting tools, getting information about how to do

readiness site visits. I think doing some of the site visits together, looking at notices that have to go to members, whether they're grievance and appeal notices or notices about what's changing in terms of their rights and benefits. So I think we would like to hear some about what the states are experiencing or monitoring that to make sure it's going smoothly for the members.

My concern would be, do we make some type of recommendation that things slow down in terms of the transitions if we find out that actually states are struggling with this now that they don't have the support that they need? Because I think our biggest concern would be if something were to happen to members in this regard.

So there's a lot of work that has to be done, having done both starting up one and closing one down, and a lot of coordination back with the state, back with the Feds on these types of transitions. So I think it's something we should pay attention to.

Thank you.

DREW GERBER: Yeah, that's great information we can take back.

One thing I did want to flag that I don't think

was in the slides is that for many of the states, several of the organizations that received awards to operate integrated D-SNPs are run by the same parent organizations who operate the MMP plan. So there is at least some overlap there, but we can take back some of those oversight issues.

CHAIR VERLON JOHNSON: Dennis?

COMMISSIONER DENNIS HEAPHY: I don't think we can overstate the transition from having the two-way contract between CMS, the state, and the plan, and then moving through having separate contracts between one with the state, one with plan and CMS, and the other with the state and the plan. And so transparency is a concern between this continuity of services.

And as you're looking at this, there's a way to see how both states are doing and ensuring there's actually transparency in the contracting requirements, and they have access to all the information contained within the CMS contract to ensure that people are actually getting the service they require.

CHAIR VERLON JOHNSON: Thank you.

Mike.

COMMISSIONER MICHAEL NARDONE: Yeah, I just wanted to pick up something you said at the end of your comment, Drew, to Carolyn. I was wondering, how much transition has there been in the plans that states were contracting with? Is it generally the same plans? And I'm just wondering if it's the same plan that the parent organization, do they still have to go through the enrollment process, a new enrollment process?

DREW GERBER: Well, so I would say in many of the states we've seen, current MMP organizations were organizations that also received award. There were additional organizations in some states that will newly be operating integrated D-SNPs as well.

I'd have to come back to you with some more information there on enrollment there. I know we've heard in the past that there were some materials being prepared that would help to crosswalk these populations in terms of enrollment, but I'd have to come back to you with more information.

CHAIR VERLON JOHNSON: Thank you, Mike.

Any other Commissioners? Oh, Sonja.

COMMISSIONER SONJA BJORK: Mike, are you

referring to things like passive enrollment or an automatic enrollment? I just wanted to clarify what we're looking for here. Yeah, thanks.

COMMISSIONER MICHAEL NARDONE: If you were in a plan and the same plan won the bidding for both contracts and there was a D-SNP, would the person just automatically go in, or would it have to be a new process? I just don't know the answer to that.

COMMISSIONER SONJA BJORK: Well, I think it'll be interesting to see what states have decided in that regard, which approach they're going to take.

CHAIR VERLON JOHNSON: Other thoughts?

[No response.]

CHAIR VERLON JOHNSON: All right. Again, with all the -- you know, definitely want to keep track of things that are challenging, but also things that are working, too, I think would be really good to always call out as well, particularly around enrollment communication and beneficiary support, for sure.

All right. Anything else from the Commissioners while we have Drew up here?

[No response.]

CHAIR VERLON JOHNSON: Okay. Thank you so much, Drew, for keeping us in concept with the progress, how the progress is going. We appreciate you.

All right. With that, it's time for us to go to public comment, and I'm going to, again, reiterate that we do invite you to provide any comments that you have. If you do, please make sure that you are raising your hand, introducing yourself to us as well as the organization that you represent.

Okay. With that, looks like -- so we have one comment. Ellen, your mic is open, and feel free to provide your comments now. Thank you. And keep them to three minutes too.

PUBLIC COMMENT

* ELLEN BRESLIN: Okay. Can you hear me okay?

CHAIR VERLON JOHNSON: We can hear you, Ellen, yes.

ELLEN BRESLIN: Okay. Well, thank you very much to the MACPAC Commission and to Drew for this wonderful report on the MMP transition.

I wanted to share a little bit about my background and history. I worked with Bob Master during

the 1990s to create these programs. They were very, very special, incredibly special in terms of the care model. They were grounded in independent living and recovery.

A lot has changed in our ecosystem and healthcare system. When they were initially started in the '90s, we put the plans at basically no risk, and it was to incentivize the care model working. And that may sound strange to somebody who believes very strongly in incentives and alignment, but it was so that plans were not incentivized to use prior authorizations, to deny claims, et cetera, but really to try to look out beyond the code book and beyond what we had seen before in the form of potentially preventable hospitalizations and so forth and to expand the concept of what is HCBS, to expand the concept of what independent living and dignity of risk really meant.

So we've come a long way from those small programs in Massachusetts and Minnesota to these very large programs, and I'm very hopeful that integrated care programs, when they're grounded in the right values of health equity, independent living and recovery goals, that they have a very good chance of success. They need strong

care coordination programs, but they definitely need state oversight.

And as a former state Medicaid official, that's firmly what I believe in, which is state Medicaid oversight, and in a time where the federal and the state relationship is changing, I really would like to ask MACPAC to maybe stand in and pay more attention than they normally would. And you've been doing an excellent job on the topic of state Medicaid agency contracts.

They're critical to ensuring a good partnership. They're critical to ensuring that we still have a North Star, especially in these times when states are going to be haggardly looking at their Medicaid budgets and wondering what they can do. Hopefully, you can provide a very thoughtful piece of guidance here and be a source of that North Star and source of truth.

So, in a recent Health Affairs article, which I wrote with my colleague, Dennis Heaphy, I'd like to share some recommendations to move the needle on recovery goals. This is a very personal request that I make since I have a son who has overdosed twice of fentanyl. So I know recovery is possible, and I know that who lives and who

dies is incredibly, incredibly random. And these folks, the adults who are dually eligible, absolutely need, 100 percent, an opportunity for recovery, and you can do that in working with partnership with the plans by state Medicaid agencies providing the right guidance.

That is a Health Affairs article. Dennis and I, since we're both from Massachusetts, have met in many circles, Disability Policy Consortium. We've also written a couple of other pieces for Community Catalyst. These all might feel like, you know, far-flung, you know, liberals from Massachusetts, but they're really not. This is the essence of these care models.

And I know people like Carolyn Ingram, you know, worked with Melina for many years. You believe in this. And I know Patty Killingsworth believes in this. And you all have been in this march for justice, for civil rights, for independent living and recovery for a very long time.

So I'd like to ask you -- and it's very long-winded, and you're very -- you've given me an enormous grace in these comments, but what role do you think you should play now and in the future in shaping SMAC policy to continue to improve these programs and evolve them from

where they've landed? The MMP was a great start, but we're not finished with our work.

And so thank you very much for your indulgence.

CHAIR VERLON JOHNSON: Thank you, Ellen, for your remarks.

Do we have any other comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. Well, seeing none, I'd like to remind you that if you do have additional comments later, you can feel free to post them on our MACPAC website. We're always open and very interested in what the public has to remark on.

So, with that, we are at the end of our time here. Thank you to the staff, the Commissioners, and all of our listeners and stakeholders for a very thoughtful and productive day, actually two days of discussion. This, as I mentioned at the very beginning, was our final meeting of this analytic cycle. We will be returning in September with our next public meeting, and until then, I hope that you all have a restorative spring and summer. And we look forward to talking with you in the fall. Thank you so much.

* [Whereupon, at 11:54 a.m., the meeting was adjourned.]