PUBLIC SESSION

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9:30 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

AGENDA PAGE

P R O C E E D I N G S

[9:30 a.m.]

CHAIR VERLON JOHNSON: All right. Good morning and welcome to MACPAC's September public meeting. On behalf of the Commissioners and staff I want to welcome you all for joining us. I would like to first extend a very special welcome to our new Commissioners, Dr. April Hartman and Anne Karl. This marks their first year on the Commission and we are so thrilled to have them with their expertise and voices as we go about our work.

As you know, MACPAC has always sought to provide thoughtful, evidence-driven analysts to help policymakers make the best possible decisions. So today's agenda reflects that mission, and I am so grateful to my fellow Commissioners and to the MACPAC staff for the dedication and preparation they have brought us to this point.

So the work we do here, of course, matters. It really is to help ensure Medicaid remains strong, responsive, and centered on the people we serve. And so today, to kick off our first session, we are going to turn to Chris Park, who is our Policy Director and Data Analytics Advisor. Chris will provide an overview of the

Medicaid and CHIP provisions in the 2025 Budget Reconciliation Act.

So with that I will turn it over to Chris.

SUMMARY OF P.L. 119-21, AN ACT TO PROVIDE FOR RECONCILIATION PURSUANT TO TITLE II OF H. CON. RES. 14

* CHRIS PARK: Thank you. So on July 4, 2025, Public Law 119-21 was passed. This bill goes by several names. We'll be referring to it as the 2025 Budget Reconciliation Act.

This legislation includes several provisions affecting Medicaid and the state Children's Health Insurance Program, or CHIP. Today I will provide a high-level overview of those provisions contained within the bill. For organizational purposes, I have grouped things into broad categories of eligibility and enrollment, financing, services and payments, and then there are a couple of other additional provisions that are not Medicaid- or CHIP-specific, but are of interest.

The presentation is informational so that the Commissioners can be aware of how these provisions may interact with existing and future MACPAC work. There is no

specific action required at this time, but we are happy to respond to any questions at the end.

The 2025 Budget Reconciliation Act places a 10-year moratorium -- so that's July 4, 2025, to September 30, 2034 -- on two eligibility and enrollment rules that were recently released. Those are the Medicare Savings Program rule, published in 2023, and the Medicaid and CHIP Eligibility and Enrollment rule, published in 2024.

I won't list out all of the provisions that are subject to the moratorium, but did want to flag that one of the recommendations MACPAC has made in the past regarding the Medicare Savings Programs, or MSPs, is affected by this moratorium. You know, we had recommended the use and transfer of Medicare Part D low income subsidy application data, also known as leads data, be used, and these provisions on the LIS leads data have been paused.

For eligibility determinations starting on or after January 1, 2027, states are required to make redeterminations every six months for individuals in the Medicaid expansion new adult group. Certain Indian tribes, and those eligible for the Indian health Services, are exempt from these more frequent redeterminations.

The Secretary of Health and Human Services, acting through CMS, will need to issue guidance within 180 days of the date of enactment, so that means by December 31, 2025.

And for this provision, states are defined as the 50 states and the District of Columbia. I just wanted to note that I won't always specify this, but it is noted on the slides specifically where certain provisions may exclude the territories.

Under current law, certain specified non-citizens, referred to as qualified aliens, can access public benefits. The Budget Reconciliation Act limits the types of qualified aliens that can get Medicaid and CHIP. Beginning October 1, 2026, federal funding for coverage of qualified aliens through Medicaid is only available for lawful permanent residents, certain Cuban and Haitian immigrants, and individuals lawfully residing in the U.S. under a Compact of Free Association. So those include individuals from Micronesia, the Marshall Islands, and Palau.

Other qualified aliens, such as refugees and asylees, will only be able to get limited Medicaid coverage

through the Emergency Medicaid pathway.

There is an exemption for coverage of lawfully residing children and/or pregnant women without a five-year waiting period in states that have adopted the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option.

I won't spend too much time here on the work and community engagement requirements because the next session is focused on these provisions. But beginning January 1, 2027, states are required to impose work and community engagement requirements for certain individuals in the Medicaid expansion new adult group. Individuals will have to engage in work or other qualified activities for 80 hours in a month to be eligible. Certain populations are exempted, such as those who are medically frail or have a disabling condition. And states must implement these requirements by January 1, 2027, but they can receive up to an additional two years through a good faith waiver given by the Secretary. And there is $200 million appropriated to the Secretary to award grants to these states to establish the systems needed to implement these requirements.

The Budget Reconciliation Act also reduces the number of retroactive months of Medicaid and CHIP coverage that may be provided. Beginning January 1, 2027, retroactive coverage for the Medicaid expansion new adult group can only be provided for one month prior to the application month. For all others not in the Medicaid expansion group, retroactive coverage can be provided for two months prior to the application month, and this same limit is applied to states in the CHIP program that choose to provide retroactive coverage.

Beginning January 1, 2027, states are required to obtain address information for Medicaid and CHIP enrollees, through reliable data sources such as return mail by the U.S. Postal Service with a forwarding address.

By October 1, 2029, the Secretary must establish a system that will be used to prevent an individual from being simultaneously enrolled in multiple states. States are required to report information such as Social Security number into the system at least monthly. And if an individual is identified as being enrolled in multiple states, then the state must determine if that individual is currently residing in a state and then disenroll anyone who

is not.

Beginning January 1, 2027, states are required to review the Death Master File at least quarterly to disenroll Medicaid enrollees who are deceased, and then January 1, 2028, they also will need to review the Death Mater File at least quarterly to see if Medicaid providers are deceased and then disenroll them as well.

Next up are the financing-related provisions. Currently, states are penalized the amount of federal share for certain erroneous excess payments over 3 percent of total expenditures. However, the Secretary can waive these penalties if a state has made a good faith effort to meet all requirements.

The Budget Reconciliation Act adds a new category of erroneous excess payments that includes payments for items and services to an individual who are not eligible to receive those items or service, or payments where insufficient information is available to confirm eligibility.

The legislation also limits the amount of financial penalties that the Secretary can waive under the good faith effort waiver beginning in fiscal year 2030. It

is limited to one type of the erroneous excess payments. This essentially means that the Secretary cannot waive financial penalties over the 3 percent error payment rate, for payments made for ineligible individuals or payments for ineligible items and services.

Beginning October 1, 2026, federal matching funds for emergency Medicaid individuals who would otherwise be eligible under the Medicaid expansion coverage group except for their immigration status will be determined at the state's regular FMAP, federal medical assistance percentage, rather than the expansion FMAP.

Under the American Rescue Plan Act, states that expanded Medicaid coverage to the new adult group after March 11, 2021, receive a 5 percentage point increase to their regular FMAP rate for eight quarters. The Budget Reconciliation Act eliminates this FMAP incentive for states who expand Medicaid after December 31, 2025.

For a one-year period beginning July 4, 2025, no federal funds can be used for Medicaid payments to a prohibited entity. A prohibited entity is defined as an entity that, as of October 1, 2025, is a tax-exempt, essential community provider primarily engaged in family

planning services, reproductive health, and related medical care that provides for abortion services, and also received total Medicaid payments exceeding $800,000 in fiscal year 2023.

There are exceptions for providers that only perform abortions in the case of rape, incest, or when the pregnancy endangers the life of the mother.

The Budget Reconciliation Act also changes the safe harbor threshold on provider taxes for upcoming fiscal years that were not in effect as of July 4, 2025.

The hold harmless threshold for any provider tax that was not in effect as of July 4, 2025, will be set at 0 percent. This includes new tax arrangements as well as increases in the tax rate for applicable provider classes for existing arrangements.

For existing provider taxes, the safe harbor differs between expansion and non-expansion states. So for states that have not adopted the Medicaid expansion, the hold harmless threshold would be grandfathered at the applicable percentage of net patient revenue that was in effect as of July 4, 2025.

For expansion states, the hold harmless threshold

is similarly grandfathered in at the applicable percentage of net patient revenue that was in effect as of July 4, 2025. However, these existing tax arrangements will be subject to an upper limit starting in fiscal year 2028. In fiscal year 2028, the hold harmless threshold will be the lower of the existing percentage of net patient revenue, or 5.5 percent. This upper limit phases down by half a percentage point annually until it reaches 3.5 percent in fiscal year 2032.

Note that the taxes on nursing facilities or intermediate care facility providers classes are exempt from this upper limit in expansion states.

The 2025 Budget Reconciliation Act also establishes new standards for waivers of the uniform tax requirements for provider taxes. A provider tax will not be considered generally redistributive if the arrangement taxes Medicaid units, such as hospital days, or high-volume Medicaid providers more than non-Medicaid units or low-volume Medicaid providers. These new standards for waivers of the uniform tax requirements are effective July 4, 2025, but the Secretary has discretion to apply a transition period not to exceed three fiscal years.

The legislation also puts the Section 1115 budget neutrality requirements into statute. Beginning January 1, 2027, the Chief Actuary for CMS must certify that a Section 1115 demonstration waiver is budget neutral. That means that spending under the waiver is not expected to result in an increase of federal funds compared to the amount of federal expenditures that would have accrued without the waiver.

The Secretary will need to specify a methodology for how any savings accrued during the approval period may be used during subsequent waiver periods.

The budget bill also places a 10-year moratorium on the implementation of certain staffing provisions from the Long-Term Care Facilities Staffing Standards final rule that was published in 2024. It pauses the implementation of the provisions related to the definitions of hours per resident day, as well as the minimum nursing staffing standards, that included a registered nurse on site 24/7 and a minimum of 3.4 hours per resident day.

The act also revises the home equity limit used for determining the eligibility of an individual for long-term services and supports. This limit, beginning January

1, 2028, for homes that are not located on a lot that is zoned for agricultural use, is capped at $1 million, with no further adjustments for inflation over time.

The limit for homes located on a lot that is zoned for agricultural use continues to be indexed for inflation, which means it could exceed $1 million after adjusting for inflation.

The home equity limit must be applied for purposes of determining eligibility for LTSS for individuals who are not subject to modified adjusted gross income financial eligibility rules, such as older adults and individuals with disabilities. And a home equity limit cannot be excluded when determining an individual's eligibility for LTSS.

Beginning July 1, 2028, states will have a new standalone 1915(c) waiver option to provide HCBS services to individuals who need less than an institutional level of care. States must demonstrate that adding this new waiver does not increase wait times for individuals who do need an institutional level of care under other approved 1915(c) waivers. And there is a $100 million for fiscal year 2027 to support state systems to implement and deliver HCBS

under these waivers.

Beginning October 1, 2028, states are required to impose cost sharing on specified Medicaid expansion enrollees with incomes over 100 percent of the federal poverty level. These cost sharing requirements must be an amount greater than zero dollars but cannot exceed $35 per item or service. The total aggregate amount of cost sharing for all individuals in a family is capped at 5 percent of the family's income. And certain services are excluded from this cost sharing requirement, such as primary care or mental health services.

The provision also allows states to permit providers to deny service for nonpayment of the cost sharing, but also allows providers to reduce or waive cost sharing on a case-to-case basis.

The 2025 Budget Reconciliation Act also reduces the upper limit for state directed payments for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center. This limit is currently set at the average commercial rate.

For rating periods beginning on or after July 4,

2025, the limit on total payments for state directed payment arrangement is 100 percent of the total published Medicare rate for expansion states, and 110 percent of the published Medicare rate for non-expansion states.

Current state directed payment arrangements applying to rating periods within 180 days of July 4, 2025, are grandfathered in under the existing limits. So this means arrangements with written prior approval made before May 1, 2025, arrangements for rural hospitals with written prior approval by July 4, 2025, or arrangements with a completed preprint submitted prior to July 4, 2025.

For rating periods starting on or after January 1, 2028, the total payment amount for the grandfathered SDPs must be phased down by 10 percentage points each year until the payment level reaches either 100 percent of Medicare for expansion states or 110 percent of Medicare for non-expansion states.

These next two provisions are not Medicaid specific but do relate to the program.

For taxable years beginning on or after January 1, 2026, lawfully present individuals with incomes below 100 percent of FPL, who are ineligible for Medicaid during

the five-year waiting period, are not eligible for a premium tax credit.

The Budget Reconciliation Act also appropriates $50 billion to CMS to provide allotments to states to support rural health. These funds will be distributed, $10 billion per year over a five-year period, from fiscal year 2026 to fiscal year 2030. Any expended or unobligated funds as of October 1, 2032, will be returned to the federal government.

Note that only the 50 states are eligible for an allotment, so this means that D.C. is not included.

CMS just announced that the application period is open, and states must submit an application by November 5. And CMS will announce their rewards by December 31, 2025.

The states must include a transformation plan that specifies goals such as improving access to hospitals and other health care providers for rural residents, improving health care outcomes for rural residents, and prioritizing new and emerging technologies.

There is $200 million appropriated to CMS to carry out these provisions, and half of the annual allotments go to states with an approved application

equally, and the other half of the amount will go to states distributed by the CMS at the discretion of the Administrator.

So with that I will wrap up and ask if Commissioners have any questions. As a reminder, there are no specific actions required today, but we just want to make sure everyone is on the same page as we are, beginning our report cycle.

CHAIR VERLON JOHNSON: All right. Thank you, Chris. Heidi.

COMMISSIONER HEIDI ALLEN: Thanks, Chris. I just had two questions. One, for the requirement that people reapply for Medicaid every six months, how does that interact with states that have waivers in place for continuous eligibility, or does it supersede the waivers?

CHRIS PARK: It supersedes the waivers for those particular populations in a new adult group.

COMMISSIONER HEIDI ALLEN: Okay. And then in terms of the home equity limit, I'm trying to understand. So they created a cap of $1 million, but it says that the asset will still be included in -- I couldn't quite understand if it meant that up to $1 million is disregarded

for eligibility. Is that what it's saying?

CHRIS PARK: Right. So in terms of determining eligibility, a home up to $1 million --

COMMISSIONER HEIDI ALLEN: -- doesn’t count.

CHRIS PARK: Right.

COMMISSIONER HEIDI ALLEN: But then it's the amount after that that gets applied to eligibility?

CHRIS PARK: Yeah. So currently like there's an amount set in statute that is indexed for inflation. So that amount could go over the exact amount written in statute. So they have changed that amount to $1 million, but for homes that are not on a lot zoned for agricultural use, like farms, can only go up to $1 million to be waived. But farms, because they would still be indexed for inflation, could exceed $1 million, and that person would still be eligible for LTSS services.

COMMISSIONER HEIDI ALLEN: Thanks.

CHAIR VERLON JOHNSON: Thank you. Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks. Thanks for this presentation. I think me and a lot of other people are still digesting all the information, about what the changes are going to be. It would be helpful to me, I

think, as a Commissioner, if there was a table, the kind of provision, and in columns, so the first column would be the provision, and the next the effect on efficiency, and the next would be effect on effectiveness, and the next column would be access. So we have a better sense of what the anticipated effect will be of each provision on efficiency, effectiveness, and access, so that we can contextualize and anticipate how the change will affect everything in the future, and given the timeline that we have. Is that something you think you would be able to do?

CHRIS PARK: Yeah. This presentation was merely, you know, really focused on just level setting and being the facts of what is included in the bill. As we go about our work, we will be thinking about how these provisions may affect various aspects of the program. It is a little bit too early to know the exact effects because a lot of the implementation is delayed until like 2027 or later.

But we can certainly think about kind of broadly, you know, certain things will certainly reduce eligibility and enrollment. Other things, kind of like the new home and community-based waiver option may allow for new people to access services. So there are certainly various effects

that we will be thinking about as we go about our work.

COMMISSIONER DENNIS HEAPHY: Thanks.

CHAIR VERLON JOHNSON: Thank you. Mike.

COMMISSIONER MICHAEL NARDONE: Chris, thanks for this great presentation. I had a couple of questions that I just wanted to ask you. So it sounds like, based on your comments, that some of the recommendations by MACPAC around to streamline eligibility for dual eligible into Medicare savings programs are generally not impacted by the moratorium.

I just wanted to, just a question or maybe a finer point on that. Does that mean states will have the option to use -- in other words, the regs require the use of a LIS data, right? Does this mean that states can use the LIS data, so that's an option that states have? Or they can't use LIS data at all?

CHRIS PARK: Yeah, I think we can certainly look into it a little bit more. I'm not the dual eligibility expert. But what was paused was the requirements to use LIS data. So I think to the extent that states currently use it, they would still be able to do that. But let me --

COMMISSIONER MICHAEL NARDONE: It's something to

look at. I just wanted to understand that a little bit better.

And then I was going to ask, on the state directed payments, so the cap is set at Medicare, or if it's a service for which Medicare does not have a rate it would be based on the Medicaid rate. So does that mean that -- and I would assume, and you can tell me if I'm wrong, that the place where you wouldn't see Medicare rates would be services for pregnant women, children. Is that a correct assumption in terms of where I'm going with my thinking around this, that there wouldn't necessarily be rates in those categories? Because I think that would be something we might want to keep our eye on going forward.

CHRIS PARK: Yeah. Certainly Medicare does not necessarily pay for like a delivery very often, but they do publish like DRG rates for that particular DRG category. I think a lot of services may be covered, but things such as like HCBS, particularly things that may be billed under a code that is state-specific, would not necessarily have a published Medicare rate. So those are the places where it would be limited to the state plan rate.

COMMISSIONER MICHAEL NARDONE: Would that be the

same for hospital services for children?

CHRIS PARK: Potentially, but this is where it might get tricky, is that some states use a different DRG group or all the all-payer refined DRG system. Like Medicare has their own MS-DRG classification system. So the alignment may not be perfect. But Medicare does develop like the MS-DRG for a lot of services, like newborn services or deliveries, so there would be a published rate for that particular service, even if Medicare does not bill for that.

And certain, like the CPT 4 codes, they usually develop a pretty comprehensive list. So there probably would be a lot of overlap between the billing codes that are used for children for those services with Medicare. But it might not be 100 percent overlap.

COMMISSIONER MICHAEL NARDONE: Right. And I guess just my last question, and this is more maybe my lack of knowledge on the topic, but can you help me understand who are the groups of legal immigrants primarily impacted by this legislation? You mentioned refugees and asylees. Are there other categories, because I don't know all the intricacies. And you might not know it either, off the top

of your head. But it is just something I was trying to understand a little bit better in looking at this legislation to see which were the categories of folks who are most impacted by these changes.

CHRIS PARK: Yeah. Certainly I don't know all the categories off the top of my head. You know, refugees and asylees was kind of like a big one that was called out, you know, in a lot of summaries. But we can kind of look at the very specific language within the bill to see which classes may have been --

COMMISSIONER MICHAEL NARDONE: It's just a question for the future. I didn't expect you to have an answer right now, Chris. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you. We're getting close to time, but let's go ahead and take from Doug, and then following you we'll have Bob and then close it out with John.

COMMISSIONER DOUG BROWN: Thank you. Thanks, Chris. Two quick questions. First, I just want to make sure I understand. Does Medicaid expansion new adult group, is that just the definition for Medicaid expansion.

CHRIS PARK: Yeah. I use both because it's been

referred to sometimes as Medicaid expansion population, and some people refer to it as a new adult group.

COMMISSIONER DOUG BROWN: It's not new based on the reconciliation bill.

CHRIS PARK: No, it's not new. It's just a commonly used term for the expansion population, the new adult group.

COMMISSIONER DOUG BROWN: Okay. Second question has to do with, as you know there are about a dozen states that have trigger laws referencing reductions in FMAP, which could jeopardize their current status with Medicaid expansion. One of the provisions, and perhaps more the provisions in here talk about reduction in FMAP for like this, emergency Medicaid, for example. Do you foresee where any of these provisions that are in there would affects states where the trigger law would happen, and Medicaid expansion in some of those states could be jeopardized?

CHRIS PARK: I don't know specifically like to what extent, like how each trigger law has been put into place. It could trigger it in a few places. Certainly other things such as the reduction in provider taxes could

have an effect, because certain states do use provider tax revenue to help fund expansion. So certainly the various provisions here could, even without states' trigger laws, could have an effect on states' decisions to continue with that expansion.

COMMISSIONER DOUG BROWN: Thank you.

CHAIR VERLON JOHNSON: Bob.

VICE CHAIR ROBERT DUNCAN: First of all, Chris, thank you for a nice job of laying it out so simple. Mine is a little general question. As you went through the presentation there were a lot of checks and balances that rely on the state. For instance, the Medicaid across different states in making sure that they are not enrolled.

Knowing that states have had trouble since COVID with both their technology systems and workforce, have you heard from the states how they feel like some of these things can be implemented over the next couple of years so that there is efficiency and effectiveness in what they are trying to derive from the new policies?

CHRIS PARK: We have not spoken with states specifically on any of these provisions outside of the work and community engagement requirements. Certainly that is

another systems change that will be going on in a similar time frame. You know, there is some money appropriated to states to help with this -- well, more with CMS to develop the system. You know, states will have to report the information into the system, and they will be required to use certain information such as from the post office, for address information. And managed care plans will also need to transmit address information to the state when they know of a particular change in the address.

But certainly there are a lot of things going on at the same time, and we have not spoken with states at this point, in terms of what it might be in terms of administrative effort in implementing all these changes.

VICE CHAIR ROBERT DUNCAN: Thank you, sir.

CHAIR VERLON JOHNSON: Thank you. We'll do John and then Carolyn.

COMMISSIONER JOHN MCCARTHY: Hey, Chris. Again, great presentation. This is more of a question going forward on this one. I don't think you'll be able to answer it because I haven't been able to get answers from some other people on it.

But the question comes up for states who are

currently expansion states, the requirements around provider taxes being phased out for them versus non-expansion states where they don't have a phase-out. So much of this SDP, state directed payments, also because you have got Medicare and Medicare plus 10. But for a current expansion state, the question I have is could that expansion state unexpand, drop down to where their eligibility populations were before expansion, and then not using Group 8 or using Section 8, but re-expand up to 100 percent and get regular FMAP, so not the 90/10 match, would they then qualify as a non-expansion state to be able to keep all of their provider taxes at the current levels that they are at, and stay at 10 percent?

And the reason I bring that up is in the law there are some dates in there, that say as of this date an expansion state, but it's also unclear, I think, in some other areas. So that was just a question I have for us to be looking at as we go forward.

CHRIS PARK: Yeah, we certainly can look into that. I know there are various places within the statute where they refer to not only like the expansion under the statutory provisions but also like a waiver of coverage

that is subject to minimum essential coverage standards. And so I think potentially depending on like how that is defined, it probably will require some guidance from CMS. It may or may not be allowable.

COMMISSIONER CAROLYN INGRAM: Chris, real quick, thanks again for putting this together. My question is also about the going forward piece, and I want to bounce of a little bit off of what Dennis brought up, and Bob. There are all these things here that I know people are concerned about, wanting to see what the effects are going to be. But at the same time this is happening, we have new high-cost drug therapies coming out, raising costs. GLP-1 is raising our costs. We have got states making a shift away from prior authorization. We have inflation, providers needing more to be able to do more.

And I'm wondering if we could look at what some of those effects are on the program and access to care. I understand there is a lot in here people are concerned about, but really this is coming out of convergence where there are a lot of other things going on in the health care system, I think, that are going to actually affect access to care more than what states are going to be able to pay

for than these particular provisions. So I'm wondering if we could add that into our evaluation. Thanks.

CHAIR VERLON JOHNSON: All right. Thank you.

Okay, Chris, this was very helpful, as you could see, and we will be talking more about this, I'm sure, so thank you.

We're going to spend some focused time now on work and community engagement requirements, both because of the importance, of course, of the policy as well as the pace at which states may need to implement it as well.

So we're going to take about 45 minutes for some background information to help us align in the landscape, another 45 minutes for us to hear from a panel of experts who are closer to operations and beneficiaries, and then about 30 minutes for Commissioner questions and reflections.

So I will say to the Commissioners, as we listen, let's just keep the idea about timing, benefits experience, implementation feasibility in mind, and then focus. And so with that framing, I'll turn it over to Janice and Melinda to get us started.

BACKGROUND ON WORK AND COMMUNITY ENGAGEMENT

REQUIREMENTS IN MEDICAID

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

Today Melinda and I will provide a brief background on Medicaid work and community engagement requirements. First, I'll give an overview of the requirements prior to the new federal mandate and highlight the experiences in two states. Then Melinda will walk through the new community engagement requirement and federal statute. Then I'll highlight the current landscape with respect to Section 1115 demonstration requests, and then we'll wrap up with next steps.

After our presentation today, we'll be joined by an expert panel to discuss considerations for implementing work and community engagement requirements in Medicaid.

And just to note that when we're summarizing community engagement requirements in the 2025 Budget Reconciliation Act, we will focus on the legislative text. In the absence of CMS guidance, we can only respond to what is in legislation, and we're unable to describe how certain provisions will be further defined.

We've undertaken this work to identify key policy

and operational considerations for states and the Centers for Medicare and Medicaid Services, or CMS, as they implement community engagement requirements.

For our research, we conducted a literature review as well as stakeholder interviews. We will present our interview findings this fall and publish a chapter in the March 2026 report to Congress.

Work requirements are a longstanding feature of certain low-income benefit programs, such as the Supplemental Nutrition Assistance Program, or SNAP, and Temporary Assistance for Needy Families, or TANF.

Before the 2025 Budget Reconciliation Act was enacted this past July, Section 1115 demonstrations were the only way states could implement Medicaid work and community engagement requirements.

In 2018, CMS issued guidance allowing states to test these requirements through Section 1115 authority. That guidance pointed to evidence suggesting that improving social determinants of health, like employment, can improve health outcomes.

Between 2018 and 2020, CMS approved demonstrations in 13 states, but only a couple were fully

implemented. Arkansas and Georgia were the two states that proceeded the furthest in their implementation.

Arkansas was the only state where beneficiaries were disenrolled for not meeting work and community engagement requirements, but court rulings, state actions, and the federal withdrawal of approval ultimately brought Arkansas and most other demonstrations to a halt.

Currently, Georgia is the only state with an active demonstration. They were allowed to move forward with their demonstration because they were applying the work and community engagement requirement to a newly eligible population.

Among the states that implemented work and community engagement requirements, they experienced or projected substantial coverage losses due to beneficiaries not meeting the requirements. Studies and evaluations of these demonstrations found that beneficiaries often did not report their qualifying activities or exemption status because they weren't aware of the requirements, faced barriers to employment, and encountered technical challenges.

In Georgia, some experts point to work and

community engagement requirements as a key reason for their lower than expected enrollment in the state's demonstration.

On the next two slides, we'll provide more detail on the implementation experience in the two states that advanced the furthest with their demonstrations.

Beginning with Arkansas, Arkansas began implementing its work and community engagement demonstration, Arkansas Works, in June 2018. But in March 2019, a federal court vacated CMS's approval of the demonstration, forcing the state to halt its implementation.

The demonstration required expansion adults between 19 and 49 years old to complete at least 80 hours a month of qualifying activities, such as employment, education, or participation in a health-related class.

Certain groups were exempt from the requirements, such as beneficiaries who are medically frail, pregnant or postpartum, or caring for a disabled person.

By December 2018, more than 18,000 beneficiaries were disenrolled for failing to comply with the requirements. Assessments of Arkansas Works found that

lack of beneficiary awareness, inadequate beneficiary outreach, and administrative challenges, such as accessing the beneficiary portal, were barriers to compliance.

Arkansas recently submitted a new Section 1115 demonstration amendment called Pathway to Prosperity. This proposal differs significantly from Arkansas Works. The state noted lessons learned from their earlier demonstration, including the importance of providing clear communications through multiple means.

In this proposed demonstration, Arkansas will use data matching to identify beneficiaries needing support, and they've eliminated the requirement for self-reporting of qualifying activities.

Georgia launched its Section 1115 work and community engagement demonstration, Pathways to Coverage, or Pathways, in July 2023. To qualify for coverage, adults who are 19 to 64 years old with incomes up to 100 percent of the federal poverty level must complete at least 80 hours a month of qualifying activities, such as employment, community service, or education.

Because Georgia's demonstration expands coverage to a population that isn't traditionally eligible for

Medicaid in their state, general exemptions are not a feature of their program. However, the state allows good-cause exemptions for certain circumstances, such as a beneficiary or an immediate family member experiencing hospitalization or serious illness.

Beneficiaries must report their engagement in qualifying activities on a monthly basis. If a beneficiary did not comply with the qualifying activities, their coverage could be suspended or terminated, though Georgia has not yet taken those actions.

According to an interim evaluation of the first year of the program, enrollment was lower than expected. Only 4,300 individuals were enrolled compared to the state's projection of 25,000 individuals. As of May 2025, the state reported about 7,500 individuals enrolled in the demonstration.

The evaluation also found that older adults between 50 and 64 years old were more likely to be found ineligible for the demonstration due to not complying with work and community engagement requirements.

Georgia has recently requested an extension to Pathways and proposed new changes, including adding

caregiving of a child under six years old and compliance with SNAP work and community engagement requirements as qualifying activities. Also, they reduced beneficiary reporting from monthly to annual.

I'll now turn it over to Melinda to discuss the new federal community engagement requirement.

* MELINDA BECKER ROACH: Thank you.

So I'm going to talk now about the details of the new statutory community engagement requirement that was included in the 2025 Budget Reconciliation Act. It bears some similarities to the demonstrations that Janice just discussed, but there are also some key differences as well.

The law requires states to implement a community engagement requirement for non-pregnant, non-dually eligible individuals between the ages of 19 and 64 who are eligible for coverage under the adult expansion group or a Section 1115 demonstration that provides minimum essential coverage.

Individuals must comply with the community engagement requirement to enroll in Medicaid and to maintain their eligibility.

Those subject to the requirement must engage in

80 hours of work or community service or halftime education or a combination of those activities for a total of 80 hours a month. Individuals are also compliant if their monthly income is greater than or equal to the minimum wage times 80 hours.

For seasonal workers, states can assess whether the individual meets that threshold by looking at their average monthly income for the previous six months.

This slide shows populations that are exempt from the community engagement requirement. They include current and former foster youth, certain parents and caretakers, individuals who are medically frail, individuals who are or have recently been incarcerated, and those who meet SNAP or TANF work requirements, as well as others that are listed here.

States can choose to provide short-term hardship exceptions to individuals who have experienced certain events. Hardships include having stayed in an acute care setting, such as in a hospital or a nursing facility, or receiving care of similar acuity, including in an outpatient setting. States can also grant hardship exceptions for individuals in areas affected by a federally

declared emergency or high unemployment rate.

Individuals who had to travel for an extended period of time outside their community for medical services, either for themselves or for a dependent, may also be eligible for a hardship exception.

States must verify compliance when an individual applies for Medicaid and every six months as part of the redetermination process. They can also choose to verify compliance more frequently, such as every month.

States have some discretion to decide the look-back period for compliance. That can be one to three consecutive months before an individual applies for Medicaid, and one or more months, consecutive or not, before redetermination or other compliance check if the state decides to verify compliance more frequently.

To reduce the need for individuals to have to provide additional information and report, the law requires states to use existing data where possible to verify compliance and identify individuals who are exempt.

States must send notices to beneficiaries at least three months before the start of the period in which their compliance will be assessed, as well as periodically

thereafter. Notices must be delivered in more than one format and include certain information, such as how to comply, including criteria for exemptions, the consequences of noncompliance, and how to report changes that could affect an individual's exemption status.

If an individual's compliance can't be verified, the state must send a notice with certain information, including how to demonstrate compliance or an exemption and how to reapply for Medicaid if needed.

Following receipt of the notice, there is a 30-day opportunity to cure. If the individual does not demonstrate compliance or that they are exempt within that 30-day period, they will be denied coverage or disenrolled. These individuals will also be ineligible for federal subsidies for purchasing marketplace coverage.

To avoid conflicts of interest, the law bars states from using managed care entities to determine whether an individual is complying with community engagement requirements. States are also prohibited from using Section 1115 demonstrations to waive any aspects of the community engagement requirement.

States must implement these policies by January

2027, with some exceptions, and HHS is required to issue an interim final rule by June 1, 2026.

States can implement earlier than 2027 via a state plan amendment or Section 1115 demonstration. They can also seek to extend the implementation timeline, potentially through December of 2028, by requesting a good-faith effort exemption.

HHS must consider certain factors when reviewing state requests, such as actions that the state has taken towards compliance and any significant barriers to meeting the requirements.

States that receive an exemption must submit quarterly reports on their progress and information about how they are mitigating any new risks or barriers to compliance.

This slide provides an overview of the timeline for implementing community engagement requirements. There is a period leading up to 2027 in which states can implement early under the state plan or a waiver, if approved by CMS. And states are expected to implement by January 2027, though that timeline could be extended up to two years for states that request and receive CMS approval.

The law provides $200 million for states to establish systems to implement community engagement, as well as other provisions in the law that affect Medicaid eligibility determinations and redeterminations. There is also $200 million for CMS to support implementation.

Having trouble advancing the slide. There we go.

As noted earlier, HHS is required to publish an interim final rule no later than June 1, 2026, without advance notice and comment. CMS may also issue sub-regulatory guidance, such as state Medicaid director letters or fact sheets, in advance of the interim final rule.

CMS officials have publicly acknowledged that states will need guidance in some areas before June and have indicated that they are working on providing that.

Additionally, CMS may provide technical assistance to states in various forms. CMS officials have talked publicly about some of those efforts, including work that is being done with states to pilot a new income verification tool.

The forthcoming interim final rule is expected to address areas where the statute defers to the Secretary to

define certain standards and establish processes. For example, HHS is required to address mandatory exemptions, including the standards for determining exemptions and the definition of medical frailty or having special needs.

Other areas that require additional guidance from CMS include the standards and criteria for granting short-term hardship exceptions, standards for notifying beneficiaries, procedures for verifying compliance, and requirements for gaining and maintaining approval of a good-faith effort exemption, among others.

In the interim final rule, CMS could also potentially identify additional implementation parameters or state requirements.

And I'm going to turn it back over now to Janice.

JANICE LLANOS-VELAZQUEZ: Thanks, Melinda.

This slide shows the states with pending work and community engagement demonstration applications as of July 2025. As we noted earlier, Georgia is the only state with an active demonstration, and they currently have a pending request for an extension.

Six states have applications pending CMS approval, and five states have had some state legislative

or other activity related to moving work and community engagement requirements forward.

Though this map shows Montana as having released their proposal for public comment, they just recently submitted their application to CMS this month, and that update is not reflected in this map.

Most of these states would apply the work and community engagement requirements to their expansion population. However, South Carolina's proposed demonstration is unique in that they would apply the requirements to a new population, making them more similar to Georgia.

The features of these proposed demonstrations differ significantly from the federal community engagement requirement. As Melinda noted, the federal statute does not allow states to use Section 1115 authority to waive any aspect of the new community engagement requirement. So questions remain regarding the future of these pending applications.

If these states would like to implement before 2027, they could revise their applications to align with the statutory requirements, or they could consider

implementing community engagement requirements under their state plan.

For our next steps, we welcome Commissioner questions about the information we've presented today. And as noted earlier, following this session, we have an expert panel joining us to discuss considerations for implementing community engagement requirements. And in October, we will return to discuss considerations that surfaced from today's panel and from the stakeholder interviews we've conducted over the summer.

And with that, I'll turn it back over to Verlon.

CHAIR VERLON JOHNSON: All right. Thank you so much, Janice and Melinda. This was very helpful and very thorough.

I know I already see some hands up. So with that, I will turn it over to John.

COMMISSIONER JOHN McCARTHY: I don't know if we can answer this question, because I've asked it a couple of times. Anytime you have new legislation, it's complicated in working through, like, very nuanced details like we all work with.

So my question is this. It is clear expansion

states, the community engagement requirements apply. It's also clear in a couple of other states. Specifically, like a Wisconsin or a Georgia, these would apply, assuming Georgia stays the way it is, expanding up there.

But what about for non-expansion states? Because when you read the regulation, it says for groups that could be covered under expansions. But in non-expansion states, there are some states that did raise their parental eligibility above what was in place in 1965, right? You could just do that through disregard.

So, for example, in Ohio, pre-expansion, parental, parents were covered up to 90 percent of the federal poverty level. That was increased from what it was previously, which was like 25 percent.

So if you're a non-expansion state and you had expanded that, not using group VIII, but through disregards, do the work, do the community engagement requirements apply to those populations?

MELINDA BECKER ROACH: Our understanding is that it's limited to individuals applying for or enrolled in group VIII in the new adult group as well as those states with 1115 waivers, but that might be an area where further

clarity from CMS would be helpful.

CHAIR VERLON JOHNSON: Thank you.

Jami.

COMMISSIONER JAMI SNYDER: Thanks so much.

I have a couple of questions. Janice, do you know the percentage of beneficiaries in Arkansas that fell off the rolls due to procedural reasons?

JANICE LLANOS-VELAZQUEZ: No, we don't have that information with us, but it's something we can look into.

COMMISSIONER JAMI SNYDER: Okay. I'm just curious.

And in terms of your stakeholder interviews -- and we can certainly pose these questions to our panelists today, too -- as you noted, CMS is really encouraging states to start working on some of those more difficult questions, even without guidance in place, while they're working on publishing guidance. I would be curious to know more about what states are thinking in terms of defining and capturing those exemptions where it's not clear from the data that someone falls into an exempt category, like that medically frail category, so just hearing from states on what they're thinking in terms of that definition and

being able to get their hands around individuals that fall into that category.

I'd also really be interested in learning more about how they're bringing lessons from unwinding into this process as they establish their community engagement programs. I think the unwinding experience created a really great platform for learning, and certainly, I think some of those lessons could be applied here. So thanks.

CHAIR VERLON JOHNSON: All right. Thank you.

Carolyn.

COMMISSIONER CAROLYN INGRAM: Thank you, and thanks for bringing this. I think I've got probably more questions as well that I'm not sure we can answer today, but just in case or maybe we can look into.

In the states you looked at, Arkansas, Georgia, or the other states, do you see how they're handling job-based training programs that may not be exactly credit hours but may result in a person getting some type of job training that would qualify them for looking at a job? Has that been something that's been identified?

JANICE LLANOS-VELAZQUEZ: Yeah. So across different states, the demonstrations differed, but there

were some states that did include that as a qualifying activity and others that didn't.

COMMISSIONER CAROLYN INGRAM: Okay. I'd be curious if we can include some of that in the write-up you all are doing and how they went about making those decisions and how many hours and that type of thing qualified.

And then the next question I had is just how states looked at addressing input of what I'll call third-party data, so information from schools or departments of labor. Did they open up their access or -- I think it's called "open API access" -- and their apps and things for those third-party entities to be able to get that data in to show? So if somebody like the Department of Labor or Workforce Solutions has information or a school has transcripts and information that the person wants to submit with their application, did they open that process, their open API process, so that -- just like our apps when we order food and meals, that that stuff could be imported in and reported?

JANICE LLANOS-VELAZQUEZ: I don't know if we have that level of, like, detail. I know that there was some --

states did share information across different agencies, but what that looks like, we're not sure. But that's something we can also look into.

COMMISSIONER CAROLYN INGRAM: And I'll ask our panelists this afternoon if they know if that's in consideration or if that's something that could be done.

And the reason I ask is that, you know, back when we were running Medicaid, a lot of us -- you know, all the technology and everything has changed. And there's a lot faster ways to get that information imported into applications for members to be -- to show that they're eligible or to show that they've met those requirements. And so I hope that's something in our recommendations. Maybe we can consider making that recommendation, you know, obviously with security and those types of things in place, but allowing that information to be brought forward so that somebody is in an educational program and a school can submit it or somebody is, you know, collecting a paycheck or something, that that information can be brought in and submitted.

Thanks.

CHAIR VERLON JOHNSON: All right. So more around

data sharing and how we do that. Okay. That's helpful.

Michael.

COMMISSIONER MICHAEL NARDONE: Hi. Thank you for this great presentation. It's a complex set of requirements, and thanks for trying to simplify it for us.

I was wondering with -- I just want to be clear on this. When the state is implementing, what is the mechanism that they would use to get CMS approval? Is it a state plan amendment -- that's what I'm assuming -- or is that something that would be spelled out in the guidance?

MELINDA BECKER ROACH: Our understanding is that that would be via a state plan amendment. And again, unless they choose to submit an 1115 before 2027, that aligns with the community engagement requirement.

COMMISSIONER MICHAEL NARDONE: And am I right in saying that -- I mean, I think, you know, one of the things that I think we all want to be able to assess is really how successful these proposals are. And I'm just wondering. So if you use the state plan amendment, there's no evaluation requirement. Is there anything in the statute that maybe envisions some sort of assessment of how these programs are implemented and what the learnings are, what

the best practices are, that sort of thing?

MELINDA BECKER ROACH: The statute, the community engagement provision does not speak to any required monitoring or evaluation activities, very much unlike the 1115 demonstration where that's an expectation. So I guess the short answer is no.

COMMISSIONER MICHAEL NARDONE: So I think that's something that, you know, I would like us to be monitoring in terms of what the impact is, but it would be nice to have some sort of evaluation framework in order to assess this.

And then final question. So $200 million allotted to states, roughly $4 million a state. How does that -- I mean, I think I know the answer, but how does that compare to what the investments have been in these programs in other states? Is that, you know, in terms of the number?

Then the follow-up question might be, so that's just a grant funding, right? I assume that states would then still have access to administrative -- they could fund it through their administrative budget, and it would also be eligible for the IT funding, 75 and 90 percent?

MELINDA BECKER ROACH: Yes. That is our understanding as well, and it was something that was, I think, reiterated, I know, in a letter to governors over the summer, that that enhanced funding -- that enhanced match for certain, you know, systems changes needed to implement would be available to states.

And to answer the first part of your question, I don't have the exact numbers on hand, but I know there's been a lot of reporting about the cost of implementing work and community engagement requirements under the demonstrations, and often those costs exceeded what states will be receiving under the law to implement.

COMMISSIONER MICHAEL NARDONE: I mean, one of my -- you know, one of my concerns, if you are using the APD process, it can be time-consuming to actually get the dollars out and get approval, and these states have to be working on these IT systems now, because there's lead time that's required. It's a statement rather than a question.

MELINDA BECKER ROACH: Got it. Thank you.

COMMISSIONER MICHAEL NARDONE: Sorry.

CHAIR VERLON JOHNSON: Thank you.

All right. John.

COMMISSIONER JOHN McCARTHY: I had more questions before. I just couldn't get them out as fast as I could.

So I have three questions, so I'm going to go through them this time. One of them, Janice, on one of your slides at the end of it on Georgia, I believe you said experts think or experts something, that there is a reason for this, but I want to point out on it, some experts link requirements to low enrollment, but my understanding is there's no data on that. Like, yes, there is low enrollment, but there hasn't been interviews of people or things like that. Is there data that we have that actually links those two, or is that just what people are making a thesis on?

JANICE LLANOS-VELAZQUEZ: So there's an interim evaluation of Georgia's first year of the demonstration, and in that evaluation, they linked the lower enrollment to work requirements. So that line is coming from the evaluation.

COMMISSIONER JOHN McCARTHY: Okay. We'll ask the next panelists about that one and see what they say.

This one goes back to the question I had earlier of Chris, which is -- and then, Melinda, the question I

asked you, which these are non-waivable sections. I totally agree that that's in there, but again, on the nuance of these things in legislation, it seems like a state, going back to it, could un-expand and then re-expand just using income disregards so that group is no longer covered under group VIII. They would lose the enhanced FMAP, the 90/10, so they wouldn't get that anymore, but then the work requirements would not apply because they're a non-expansion state. I don't know if you can answer that question or not. That's just something for us to be, like, is that doable?

MELINDA BECKER ROACH: Yeah. And I won't attempt to answer it, but I'll just point out if they're providing coverage through an 1115 for that up to 100 percent FPL.

COMMISSIONER JOHN McCARTHY: Well, would they have to do 1115? You could just do it through income disregard. So if you don't use an --

MELINDA BECKER ROACH: Yeah. I guess the details would be important.

COMMISSIONER JOHN McCARTHY: Right, exactly.

MELINDA BECKER ROACH: Yeah.

COMMISSIONER JOHN McCARTHY: So if you just use

state plan amendment income disregards, could you get around it?

Lastly, in the legislation where they were talking about exceptions to this -- and there's an interesting part in here where they talk about medically frail, and they specifically say individuals with a substance abuse disorder, but then later on, there's also a section that says who's participating in a drug addiction or alcoholic treatment and rehabilitation program as defined in Section 3(h) of the Food and Nutrition Act of 2008. Well, if you go to that section of the Food and Nutrition Act of 2008, that specifically says a person who's in a treatment program for a treatment provider that is either a government entity or a non-profit. So it would seem to exclude for-profit substance abuse providers.

So, I think that is also something as we look forward on guidance of, like, do they really mean that it's only not-for-profit or government, or is it that was just kind of a drafting issue and the other section covers everyone with substance abuse? So just something to keep in mind on that one.

CHAIR VERLON JOHNSON: All right. Thank you,

John.

Anne.

COMMISSIONER ANNE KARL: Thank you so much for this helpful presentation.

I would love some more thinking -- and again, I don't think this is necessarily something you're going to be able to answer today, but just about the existing data sources that we have today. If we sort of have an eye on how do we track the impact of work requirements, what are the data sources that we have today? Could you be able to leverage those? Do they instead need to be split out by eligibility category, that sort of thing? But sort of just trying to understand from the baseline of data that states are reporting today, how would we be able to discern the impact of work requirements, and what, if any, modifications would be needed to be able to discern the impact of work requirements?

CHAIR VERLON JOHNSON: All right. Thank you.

Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks.

The idealist in me says while it's great, increase volunteers and maybe community college engagement

with communities, but then I come down to reality is that Medicaid offices don't know the addresses of people. And so implementation is going to be extremely difficult. So do we have any data from Arkansas or Georgia on how much of the issues in terms of people engagement was actually due to lack of having appropriate information on people's -- where they live? Because the population is very unstable in terms of where they live and their -- yeah, so just like basic brass nuts things. Yeah. So did you look into that? Is there a way that we can in the future track that?

JANICE LLANOS-VELAZQUEZ: The evaluations that we looked at just cited, like, issues with beneficiary outreach in general. They weren't specific about addresses, but that's something that we can look further into to see if there's more information on that.

COMMISSIONER DENNIS HEAPHY: Could be helpful to better understand what the cause is, and a lot of the cause is due to lack of accurate information.

CHAIR VERLON JOHNSON: Adrienne.

COMMISSIONER ADRIENNE McFADDEN: So Dennis helped me narrow down my questions to just two. So thanks, Dennis.

So quick question for the exemptions, the postpartum piece of that. Do we have an idea of what the time frame is that they have in mind? Is that 12 months? Is it six weeks? Is it --

MELINDA BECKER ROACH: I want to confirm this, but I think it's, like, during the period in which they're eligible for postpartum coverage, and so -- and I believe in many states now that is 12 months.

COMMISSIONER ADRIENNE McFADDEN: So, so long as the state has extended that postpartum coverage, it would reflect what the state has.

MELINDA BECKER ROACH: And I think this might be an area -- yeah, I think -- I think that's correct, and CMS guidance might provide some more clarity as well.

COMMISSIONER ADRIENNE McFADDEN: Great.

And then my second question is, I remain perplexed by some of the exemption categories because they seem a little bit incongruent with data. And so maybe not an answer for today, but would just be curious if the 1115 waivers are still an available pathway for states to maybe go slightly beyond those categories with a more data-informed approach. I have sort of the justice-involved

individuals in mind. Ninety days, finding employment seems a little bit aggressive when we know the data shows that less than 30 percent are employed after six months.

The other is the temporary hardship category for particular geographies, but we know historically and still ongoing, there are actually populations as well that have unemployment rates that go beyond just a geographic difficulty. So I know that there are states that are thoughtful about data and want to have a data-informed approach. So just wondering if the 1115 is a pathway for that.

CHAIR VERLON JOHNSON: Thank you.

Jenny.

COMMISSIONER JENNIFER GERSTORFF: So, so far for me, what's missing from the conversation is the impact for states with managed care and all of the various assumptions that are going to be affected in setting capitation rates.

CHAIR VERLON JOHNSON: Thanks, Jenny.

And Doug?

COMMISSIONER DOUG BROWN: Just a quick question. We talked about addresses and not being able to find people. For those people who are homeless, how do states

track those people today and communicate with those people today? Is there a policy? And maybe it goes to other former Medicaid directors to answer the question too, but thank you.

COMMISSIONER JAMI SNYDER: Doug, I think that's a great question.

I can just speak to the Arizona example. During the pandemic, we were able to coordinate with the homeless management information system and supply that data to our -- in Arizona to managed care organizations so they could outreach to individuals experiencing homelessness. So that was one mechanism that we employed during the pandemic anyway.

CHAIR VERLON JOHNSON: Thank you.

Sonja.

COMMISSIONER SONJA BJORK: Thank you. We learned so much during the redeterminations during -- at the end of the pandemic. And so I would really love to pull out more lessons learned from that in terms of many states did a great job on the ex parte methods, and for some, that didn't turn out to be a great pathway at all.

And then I really want to follow up on Carolyn's

comments about the use of technology and ability to connect with other sources and just use what we have in order to make things as smooth and easy, both for the states and their employees administering this and for the beneficiaries.

We have a lot of information out there, and in so many applications that we all complete every day, you can pull from many different sources, and you don't have to scan a piece of paper or bring it down to the office. And so I'm really curious about, for different states, percentages of successful ex parte applications and best practices.

CHAIR VERLON JOHNSON: Thank you for putting a fine point on that one for sure, and hopefully, we'll get some dialogue around it from the panel for sure.

Mike.

COMMISSIONER MICHAEL NARDONE: I just had a quick question. So I wasn't sure, To what extent -- if the Secretary will be making a decision as to whether or not you can get a delay in actual implementation, are the criteria laid out clearly in the legislation in terms of what might be the criteria they would use? I mean, I've

heard anecdotally, it'll be maybe difficult to get one of these exemptions, but I wasn't sure what the specifics were in the legislation.

MELINDA BECKER ROACH: I will double-check the text. I don't think the criteria are specified. I think there's information -- there are certain things that the Secretary is supposed to consider as far as sort of like the state's rationale for pursuing that delay in implementation. But I don't think there are a lot of specifics there, and that's something that CMS will likely have to articulate.

COMMISSIONER MICHAEL NARDONE: Thank you.

CHAIR VERLON JOHNSON: All right. Thank you.

And we'll do one more question, Heidi, so we can move on to the panel.

COMMISSIONER HEIDI ALLEN: I just wanted to second the comment that it seems like a good place for MACPAC to weigh in would be in relation to an evaluation or monitoring recommendations for implementing work requirements.

But then I just have a question, because I'm kind of naive to this part of the process. But how nimble are

claims in informing states of utilization, particularly when people are enrolled in managed care? Thinking about, you know, every six months, redetermination and how long it takes for a managed care claim to get to the state and that intersection of the two, it honestly seems like you'd have to be so nimble that if the person were still in the hospital at redetermination, that somehow the state would know. And that seems like that means that there's like zero lag between when utilization is happening and when the state is aware of that.

And I don't know how seismic a shift or not that is from where we currently are with states understanding utilization, particularly for people in managed care. So maybe one of the managed care folks could say.

COMMISSIONER SONJA BJORK: Claims will be the slowest way if you're waiting for that information, because providers have often up to a year to submit a claim. But there are many ways that hospitals communicate with managed care plans about who's inpatient. And so perhaps we could reroute that data to the state eligibility or county eligibility so that they also could know if one of the beneficiaries is in the hospital. They're not going to be

able to complete their paperwork while they're inpatient, just having had a surgery. So somebody is going to have to make sure that the eligibility folks know that they have just landed in one of those exemption categories.

And so we're going to have to look for new ways to connect really current data, and claims will be about the slowest.

COMMISSIONER HEIDI ALLEN: So just to reiterate, to make sure that I'm really understanding you. So currently, that system does not exist. So what I read in the materials is that claims data would be an important tool for understanding that kind of acuity, high-acuity participation in, you know, substance use. And what I hear you saying is that currently, the protocol is providers have up to a year to submit it to managed care, and then managed care submits to the state.

COMMISSIONER SONJA BJORK: We use it for rate development with the state. So the claim doesn't necessarily go to the state.

COMMISSIONER HEIDI ALLEN: So this is a system that --

COMMISSIONER SONJA BJORK: We submit encounter

data --

COMMISSIONER HEIDI ALLEN: Okay.

COMMISSIONER SONJA BJORK: -- for the state.

COMMISSIONER HEIDI ALLEN: So currently, the system doesn't exist. Is that my understanding?

COMMISSIONER CAROLYN INGRAM: Well, I think the data is captured at the managed care organization. So we know through our case management systems daily who is where.

I think the issue is what I was getting to in my set of questions is what is the state doing or what is the federal government going to do to open up that process to -- I think it's called, like, an open API process.

So that just like when you order things with your phone in an app, like at a restaurant, there's a way to interact. What are they going to do to allow that interaction to happen? So whether it's from a third party like a school or a hospital or a managed care company or workforce solutions to import that information in -- because right now, those eligibility systems are very closed.

And even if you go online to -- I'm sure you've

done this, and maybe I'm dragging things out a bit. But if you go online like to help somebody enroll, how difficult that is to input some of the information.

So our eligibility systems are not set up to do this. So I think it's something we definitely need to make a recommendation towards in terms of how can the federal government -- and I'm sure they're looking at this, but how can they open up those systems to allow for the import of that type of information? So maybe it's from corrections. Maybe it's from --

CHAIR VERLON JOHNSON: Right.

COMMISSIONER CAROLYN INGRAM: -- all these sources.

CHAIR VERLON JOHNSON: So we need to move on to the panel, but this has definitely been a really good conversation. And remember, we will have some time after the panel to talk some more.

So let me turn it back over to Janice and Melinda to kick us off for our next segment or our 45-minute conversation. Thank you.

[Pause.]

PANEL ON WORK AND COMMUNITY ENGAGEMENT

REQUIREMENTS IN MEDICAID

* MELINDA BECKER ROACH: Okay. So as we discussed, the law requires states to implement a community engagement requirement for certain populations. We are delighted to be joined by four experts today to discuss considerations for implementing those requirements.

We have Melisa Byrd, Senior Deputy Director and Medicaid Director for the District of Columbia Department of Health Care Finance, and also President of the Board of Directors for the National Association of State Medicaid Directors. We have Jessica Kahn. She is a Partner at McKinsey & Company and former CMS official. We are also joined by Jen Strohecker, Integrated Healthcare Division and Medicaid Director for the Utah Department of Health and Human Services. And Deanna Williams, an Enrollment Assister for Georgians for a Healthy Future.

I am going to be posing questions to our panelists for the first portion of the conversation, and then I will turn the floor back over to the Chair to facilitate Q&A among the Commissioners and the panelists.

I am going to start with Jess. To implement community engagement requirements, states will need to make

changes to their Medicaid IT systems and processes. We understand that some may have been updated more recently than others, and in some states Medicaid eligibility systems are integrated with other programs, such as SNAP.

As a subject matter expert and former CMS official, can you describe the current Medicaid IT landscape and how it could affect the way states approach systems changes needed to support community engagement implementation?

* JESSICA KAHN: Sure. Hi, everyone. So a couple of things I want to build on that question before I answer it. One is that there is both integration with SNAP and TANF for the majority of the states that are implicated in community engagement, but also integrated with state exchanges. And in some of those cases the federal exchange is making Medicaid MAGI determinations. So I just want everyone to understand the complexity is both with SNAP and TANF, and with either the state or federal exchanges.

So for example, New York, California, Washington, Connecticut, those states, it is actually the exchange that does MAGI Medicaid, and it would be the exchange system, and system vendor, in most cases, that would be there for

adding this functionality that you all have been talking about for the past hour, with those data sources.

That said, there is still not a lot of vendor diversity in this space in terms of who is maintaining the current eligibility systems. One of the things that is different, and I think Carolyn mentioned this, the technology has evolved since Arkansas did their work, and even, frankly, since Georgia started on theirs. There are now 10, 11, at a minimum, solutions out there that are what we call Software-as-a-Service, meaning it's a standalone module outside of these eligibility systems, that can grab that data and pull it into the system.

The reason I want you guys to understand that is that that means that the 40 states and D.C., like they don't have to pay their existing vendor to build this capacity 41 times. There is the possibility that states could use one of these external solutions, and then they are just building the APIs, they're building the interfaces to pull that data in as necessary to trigger their notices or all the other parts that, of course, will still reside in an eligibility system.

So the vendor landscape is quite different, and

I'll talk more about that later on, to give you guys some sense of how the states are trying to think about those SAAS vendors, one of which, by the way, is CMS. CMS has income verification as a service, that Louisiana is piloting for Medicaid. And it is consent based, where the consumer, particularly those who are gig workers -- they drive for Amazon or Door Dash, Uber -- they consent and it interfaces with the payroll providers as well as whoever that individual provides as their employer, and it creates an automatic data feed for employment data.

That is a game changer, honestly, from even three, four, five years ago. And the other thing to think about that is it's also a game changer for income verification. It's not just about employment and community service, volunteer, and education, but also just income verification. So if I were a state, I would be thinking about not just how this might help for my expansion population, that is subject to community engagement, but for everybody who is applying for Medicaid, so that I don't have to ask them to upload a pay stub or go find other information. If this is a way to get better income verification information then there is a double benefit to

these kinds of services that are out there.

And for those that already started on income verification before the law passed, they are all quickly trying to add education and volunteering data sources. There is a clearinghouse for education. There are a variety of approaches on how to capture the volunteering information. But they know they have to have all three, and there is a wide range of what they would offer. Some of them are just going to move the data around. They're not going to hold it. They're just routing it, kind of like the Federal Data Services hub does for healthcare.gov. And there are some that are actually going to apply a logic to it, and say, "John McCarthy has worked 80 hours this week," or this month, or, "He's got $580 a month." That's the federal minimum wage. Therefore, that computes to 80 hours. So they can actually apply the logic to it. Some of them are actually willing to do outreach and say, "Hey, Verlon, you're tracking at 70 hours this month. You might want to go pick up an extra shift," or "here's a link to three community service opportunities in your area." So they're kind of doing it like a case management sort of way to think about it.

I'll stop there, because I know there are more questions. But I just want you to understand how vastly different these offerings are, and the pricing, and all of that is going to vary. That's more to go into later.

MELINDA BECKER ROACH: Thank you, Jess. I want to turn now to Melisa and Jen. What stage are your states in, is the District of Columbia in, as far as planning for community engagement implementation, and what are the major considerations that are arising? Jen or Melisa? Do either of you want to chime in?

DR. JENNIFER STROHECKER: I can kick it off. Sure, sorry.

MELISA BYRD: I can --

* DR. JENNIFER STROHECKER: I will go ahead and begin. Okay. So thank you. Representing the state of Utah, we certainly, I'll say, I think the comments prior to this were fantastic with regard to states' experience with unwinding, and how much those lessons learned have really contributed to where we are in our planning phases.

I'll say, first, central to that planning work, and I really love just the touchpoints of the beneficiary, the member, the access, and really orienting our planning

work around the person who qualifies for Medicaid, and certainly has a number of potential barriers that they have to navigate in accessing the program. Thinking simply, we talked about homelessness or someone who may live in a shelter as a challenge, thinking about English as maybe not a primary language, and those health literacy barriers, and how we actually connect with these individuals who are living with chronic conditions and already may qualify for Medicaid and be receiving Medicaid.

So we bring sort of this whole set of knowledge and experience from our existing work but also from unwinding into where we are today in Utah. And I'll just say, as far as a project plan, we have a dedicated internal team that is fully dedicated to our activities around the budget bill and specifically community engagement. And then looking really at that first phase of project planning. And it's in just the initial assessment and project planning step at this point.

And there is a fair amount of work that needs to be done in this phase, as you can appreciate. Policy guides, our technology and programming, and we've got a compressed period of time to do all of this. But we want

to be thorough. And I think in the context of recognizing, for Utah, we've got a few things at play. We've got the policy, doing the evaluation. But we're an integrated state. And so if you look at that individual who qualifies for both Medicaid and SNAP and other programs that have work requirements in multiple programs, eligibility reviews at a different level, as we do our policy evaluation, our gap analysis, these are our primary areas of focus to really understand that lay of the land so that we can then lay out our next steps around technology, and then workflows and implement and also engagement with our stakeholders.

We have begun an early communication and engagement with some stakeholders and external collaboration. I think we'll probably talk about this later, but nationally, of course, engaging with our federal partners, many other states, in just that learning that's so critical. And that's a very important piece of bringing our evaluation together, in the ways that we are alike with our policy and how we evaluate the policy. It's really important we are just able to be in the room with folks and have those discussions and be able to get that feedback.

Also, I think, another place that I would say as far as a major consideration. I mentioned sort of that person experience, and I think where we are considering some of our greater challenges. There's new to Medicaid, and I have to have compliance to these standards so that I can get access to Medicaid. And then there's the renewal piece. And I think a lot of our mindset is thinking about both pathways for the individual to consider how you are maybe new, and you even understand what these work requirements are and how to fulfill them so that you can get access to health care you qualify for. And you may have an exemption or other, but how do we get those medical claims? How do we help people understand it? And then from an integrated perspective, I think that's another challenge for even ongoing evaluation.

I also think we should think about the worker, because there is a person moving through the process, but then for us we have a sister agency that manages this integrated application or the integrated renewal. And there is a lot happening, right. There is a lot changing between even just Medicaid and SNAP, and there are different renewal time frames, there are different policies

driving these. And how do they work together most seamlessly so that the worker is able to have the fewest touches? How do we bring in our data sources? How do we think about the impact to the workers themselves; to really lift that burden off of them so there's fewer errors, but also fewer steps of that sort of outreach and verification.

This is, again, where we're kind of bringing in our lessons learned from unwinding. We can certainly get into more of that.

Primarily, you know, I think we're interested in making sure people don't fall into the gaps. And this is like where we see this as a challenge. It's our commitment that if people are eligible for Medicaid, we want to find that path to get them to Medicaid. But the gaps are sort of where once we've figured out what we believe are, okay, we have a firm understanding of these policies. There are areas where we may not yet understand. But what are those gaps? How do we identify those gaps, and how do we build processes in our systems to minimize those interruptions?

Last and not least, I'll just say, lessons learned from unwinding -- communication early and frequently is important. And while we're still in that

first phase of project planning and we don't want to get too far ahead of ourselves at this point, I do think interfacing with partners now has been critical for us to think about how to bring this whole body of work together.

It was discussed, education. In Utah we have a system that's called Utah State Higher Education. It's a centralized database where there is the majority, all but maybe three of our universities, but our trade schools, our community colleges, put data into this system. And we're connecting with that database today and beginning that work. We're thinking about Utah is considered one of the highest volunteer states in the country, year after year, and figuring out where there is community service, what's compliant, how do we grab that data.

So I think working with our Department of Insurance, thinking about marketplace changes, Chambers of Commerce, community-based organizations. I'm kind of saying a lot here, but these are all the things that we're thinking about in our planning phases today, and making sure -- I'll just loop back and close my comments with -- making sure we're central to our purpose. That is really considering the complexity that most Medicaid members face

in just enrolling in Medicaid. And that's a lesson learned. And how we reach that member, how we keep that address current, how we engage with our managed care entities properly, and use those right touchpoints, but also stay in touch with them.

But also the complexity of their continuity of health care coverage and how we can build a system that helps support those individuals to get credit for their exemptions, but also to fulfill work requirements, where applicable, as well.

MELINDA BECKER ROACH: Thank you, Jen. Melisa, do you want to add from your end, in D.C., as far as planning and considerations that are arising in that work?

* MELISA BYRD: Of course, and my apologies for going off camera. I'm having some connectivity issues this morning, but thank you guys for your patience, and more importantly, thanks for letting me be part of the conversation today.

You know, I'll speak kind of broadly and then specifically about the District of Columbia. As you will hear, compared to what Jen just talked about, states are in very different stages. I think, first and foremost, and we

heard some of this in the discussion earlier, that it's really important to note that not all states are subject to the requirements. So for some states this discussion isn't particularly relevant, and they aren't planning for something they don't have to do.

For us, or for the states that are subject to the requirements, so, as you just heard from Jen in Utah, are kind of well down the path and probably looking at where do we have those gaps, where we do need to make changes from the plans underway to make sure that they're compliant with the reconciliation bill. And the for other states the discussion has been ongoing, so they may already have some thought or legislative direction on how to move forward.

And finally there are other states, and D.C. is one of them, that are at the very beginning in considering and planning and thinking about work requirements. And for us in D.C., work requirements has not been an area of focus outside of the reconciliation bill, so we really are just embarking on the planning and development, and thinking through these things.

So for us right now, in D.C., the major considerations are just starting with the basic and the

internal governance and structure. We are in the midst of two other significant initiatives with go-live dates of 10/1, so a couple of weeks from now, and then January 1st. So it's how are we organizing and fitting this into the work that's underway.

Budget formulation is another major consideration. We're walking into our fiscal year 2027 formulation also. We're really in it now, but officially in a few weeks. And we have to consider how is this new requirement is going to impact enrollment, which, as you all know, is really the driver of budgeting, as well as thinking about the potential administrative costs that may come along with implementation.

From a systems perspective, D.C. has an integrated eligibility system that also serves SNAP and TANF. The eligibility system is housed here within the Medicaid agency. So we are thinking through how do we align with SNAP? What are the other program priorities? What has to be shifted, and so forth.

And like Jen mentioned, too, and I would second most everything she said, outreach and member engagements. I think it was Jami earlier who did talk about the Medicaid

unwinding, and I do think we are much better positioned to be successful in outreach because of the unwinding process that we went through, and for really the first time for the agency. Actually, it was really the first time we had significant outreach from the agency level, and we're just building on that. So I think that's a real benefit to us as we walk into work requirements.

The other area is really thinking about what other state agencies or district agencies that we need to partner with and establish relationships, like our Employment Services Department, to see where and how we can leverage the existing data.

So those are kind of the things right now that are first and foremost as we start planning towards the end of next year.

MELINDA BECKER ROACH: Thank you. I'm going to bring Deanna into the conversation now. Georgia is the only state that currently has a work requirement, and though it differs in many ways from the federal community engagement requirement, Georgia's experience is nonetheless instructive for other states.

As an enrollment assister in Georgia, how do

beneficiaries and individuals applying for Medicaid experience the compliance verification process? What are some of the common challenges that you see?

* DEANNA WILLIAMS: Okay. So in Georgia we use the same system. We have our state portal, which is Gateway, and that is used to process our Medicaid and medical assistance applications, along with other state benefits, such as SNAP, TANF, WIC, and CAHPS, as well.

During the process, before it was updated in May, a lot of clients had issues with reports with the system crashing and data loss while they were trying to submit their applications. Before the website was updated it was definitely not accessible from smartphones or other devices, so it made it very difficult for clients who lived in rural areas to use their phones to complete applications or upload documents. And uploading documents was a particular issue that was very difficult for them. A lot of clients may not be as tech savvy as others.

On our Gateway portal you are only allowed to upload documents in certain formats. So if they don't have it in the correct format, that was giving them an error message for uploading documents. So it wasn't that the

client does not work or does not have proof of their income. They were just having issues uploading the documents to verify their income, which if not provided within a timely manner could lead to your application being denied.

I would also say that the work requirement, some of those were not a big problem because in our Gateway system we do have an e-verification system that verifies their employers and gives them the options to look and see which payment system they use. So if they work for an employer that uses ADP, they can log into that account directly, and then Gateway will pull their pay stubs from that system. But if their employer is not listed, then the client had to submit proof of income, and that was in the form of a pay stub, a written statement from their employer, or a timesheet. And again, those are the documents that need to be uploaded.

One of the other hindrances could be for those who report self-employment. The documents that they have to use to upload can be more difficult or hard to get. In Georgia, they requested that you have a signed, standardized work or participation calendar that indicates

the hours that you are engaged. So it could be a worksheet template that indicates the total hours they worked per client or activity, and they had to submit a snapshot of the actual calendar from which they worked for that month, or a photo of appointments or screenshots, and upload that into the Gateway system.

MELINDA BECKER ROACH: Thank you so much, Deanna. I'm going to turn back to Jess now. What types of IT systems changes will states need to identify individuals who are exempt from or compliant with community engagement requirements? I know you started talking about this a little bit earlier, but if you can maybe build on your earlier comments.

JESSICA KAHN: Sure. I would encourage everybody to think of the changes in two buckets. One of the buckets are the things that they have to make to their existing eligibility systems regardless. So you're going to have to add new questions to the application, right, to the online portal and the health text, and your paper application and how you adjust that. There is going to be new noticing language, so you're going to have new consumer notices. There are going to be new business rules, and your rules,

if unfortunately, your rules are hard-coded into them that way.

So there are some things that just -- your data model, right? These are new data elements. So there are some things that are going to have to happen, and very likely it is going to be states' existing eligibility systems vendors who will do those things, because you are not going to go get a new vendor just to add three new questions to your portal, right? So think of that bucket as this is the stuff that has to happen, no matter what choice we make about the new functionality.

The second bucket is that new functionality. These are new data sources, new interfaces, new cadence of how that information is going to be queried. And those kinds of changes are the ones that I was saying a lot of states, especially given CMS's guidance requiring an assessment of alternatives, meaning you have to decide whether you are going to buy something, like a software service product, or build it, or reuse it, that is now required in the APDs that Mike mentioned in order to get the 90 percent match.

So for those new things, states could be

assessing what's out there, and if any of those products would meet their needs. As you heard from Jennifer and from Melissa, each state is going to make different decisions about what functionality they need, what their systems can and can't do, what they already have and don't have, and also, frankly, what the minimum viable product is going to look like for December of 2026. So there could be something that is -- you know, I've heard some states say, "We're going to go with that legal MVP," like this is what compliance looks like. I've heard other states say, "We have a floor that's slightly higher than the legal of how we're going to define what's acceptable for our state," and what you're doing then is matching that.

So for example, if you are a state that is considering accepting self-attestation for exception -- you guys mentioned exemptions earlier, medically frail, substance use treatment -- if you're going to accept self-attestations for those, that is a lower burden of data that you're going to need, because now you're looking only to verify that you are complying with community engagement.

If you aren't going to accept self-attestation for exemptions, as was discussed earlier, you are going to

need clinical data or historic claims data, like from an all-payer claims database, or some other new source, or you're going to have to accept a lot of documentation for people to prove, for new applications, or renewals, that they need those exceptions.

So the burden of data, electronic data sources, or even paper data -- God help us -- goes up way higher based on that one decision around how you're going to handle exemptions or not.

So these are the planning that you heard our state colleagues talk about. This is what that early planning is, is making decisions about those policy and design decisions. Because from there flow all these other IT and data systems. You can't decide what it is you're going to use from a technology and data perspective until you've decided what's your look-back period going to be? Are you pinging it for every month, or are you pinging it for once every six months? That has a cost implication? That has a data implication. Accepting a lot of paper data for something once every six months is very different than if you're doing it every month.

So really asking yourself each one of these

questions and thinking about what's the IT cost implication, the data cost implication, the workforce cost implication against every one of those policy decisions, and then you can back into what are the IT solutions that are out there that would work for me. But just to remember to put the horse before the cart.

MELINDA BECKER ROACH: Thank you. This is a question for Jess, Melisa, and Jen. What guidance or assistance do states need from CMS in order to move forward in a timely way with their systems changes, and what opportunities may exist for CMS to work with states and vendors to make the process more efficient and less costly, considering the number of states that will be making similar changes in a short time frame?

So whoever would like to jump in and take that first.

MELISA BYRD: I'm happy to jump in. One thing I do want to say, just jumping off from Jess' comments too, there's all these system requirements, and then once you have the policy that can drive the system requirements then there is all of the training of the caseworkers, which is no small feat if we actually want this to be successful in

the end, as well.

Having an integrated eligibility system is really fantastic for a number of reasons. At the same time, it makes it extraordinarily so much more complicated, because once you tweak one thing you might be impacting how a caseworker looks at something else. So how you can line up all those changes to make it, to simplify it so that you're making changes for caseworker processing, once instead of two times or four times or six times. It's extraordinarily important if we're going to be successful on that kind of go-live operational side, too. And that training really just can't be underestimated, but it’s something we've certainly learned in our time in running the integrated eligibility system here.

In terms of what other guidance or assistance from CMS, I think one thing that's really important is that we're all on the same timeline and working from the same information, which is the legislation. So I say that more like we're all, I think we're collectively trying to figure this out as we go.

So keeping that in mind, another major consideration, from a state perspective, or at least I

think most states are thinking about how are the decisions we make today, at the state level, how are they going to align with the decision at the federal level? So then in future years our state policies and systems are compliant and that we meet expectations when we know we'll be audited in the future.

I think what is important right now to states' success is the collaboration across states. I learned the most, usually interacting with my state colleagues, and also that collaboration with CMS. And fortunately, the open dialogue across states and from states to CMS is already established.

One of my takeaways from Medicaid unwinding process, and we've referenced that in a few different ways so far this morning, is that -- I don't know if folks know but we had Friday afternoon calls that was CMS and states, hundreds of folks on there. And it was a really collectively focused time on unwinding. And when we have that collective focus, the efficiency just increases tenfold. And overall, obviously, therefore we're more effective. And seeing that, I think we're headed in that direction with work requirements is a good place for us to

be.

I think also from CMS what would be helpful, they have started signaling some things, and more of that, I think states would welcome that, particularly where, you know, CMS is feeling like the legislation says what it is, and it's not up to interpretation, versus where there may be areas where CMS sees that there is room for interpretation, and they're going to be providing that detail or sub-guidance. So having signaling to that piece is really important.

And then also I think it was Mike earlier that noted that there is funding appropriated to support states in implementation. As always, the sooner we know when the funding is available and how to access it would be, you know, just extraordinarily helpful. This gets really kind of bureaucratic and process oriented, but we all, at the state level, have processes to work through. For example, we need budget authority if we're going to spend any money. And most states' fiscal year 2026 budgets were already finalized before the appropriation, which means we don't currently have that authority, which means, you know, if we could get the money today, you know, we can't spend it

today. We have to go through that process. Sometimes it's shorter. Sometimes it's longer. And just given the timeline of go-live for next year, every little delay in time like that is impactful.

So, as always, just more information sooner than later, but those are some of a couple of things.

JESSICA KAHN: I'm going to say something very emphatically. No state needs to be waiting for CMS guidance to start doing their IT systems planning. The things that need guidance are things that affect business rules mostly and business rules logic, which is really important, but that's not the hugest lift here, right? The hugest lift here are identifying what these data sources are, how are you going to have them. It's going to take you longer to do the MOU, honestly, than to do the tech.

So going after the data sources, being really clear in that hierarchy, how many of your members those data sources are going to touch, making sure you have a procurement path, like Melisa mentioned, to be able to make it, to get to whatever those changes are, whether it's your current vendor or a new vendor, all of that work can be happening right now.

If they come back out in three months, six months and say this is how we define seasonal worker or this is what we want you to do in terms of determining eligibility for people who are renewed in January, that's business rules logic. You can change that. There is time to change that. That is not the long pole in the tent from a systems perspective.

So everybody needs to move on those design decisions that are going to dictate what you need to do to your eligibility system and then concurrently be able to look for guidance.

Now, that doesn't solve the problem of APDs and the time it takes to get APD approval and the time it takes to get contract and RFP approval. That's just the world we live in, and perhaps CMS might offer some relief there in terms of some expedited path. I don't know.

But in terms of like the planning process, when I go through all of the provisions -- and you can look at a variety of resources that have been put out there by a lot of other entities right now that go through what all the milestones are -- there is a tremendous amount that you could be planning that have large IT and data implications

that don't require any additional guidance. And in fact, again, to reiterate Melisa's point, time is a wasting already.

DR. JENNIFER STROHECKER: I so echo the comments already made by Melisa and Jess. And I'll add just a couple bullets around moving ahead.

I mean, Medicaid is a complicated living, you know -- there's so much happening, and this is not the only thing we're doing.

Melisa mentioned the other priorities that states have, and even in Utah, we're going live with reentry work. That impacts adult expansion this year. Before the end of the year, is our goal to launch our first jail. And you think about, like, all the different pieces that have to fit in, we're mapping out as we're moving from, you know, our phase one to phase two in that development phase. You know, we're laying out all of our programming and time slotting all the way up until go live, what change requests are needed for our system and where those interfaces are going to come from.

So I appreciate Jess saying that because states should not wait, and we're feeling very pressed with time

and waiting for answers on how to define medically frail. We sit with that question, right? Chronic illness like diabetes, while a person can have diabetes and be compliant with their insulin and be very functional and working or they can have diabetes and have severe neuropathy and have vision impairment and other things that may really interfere with their functioning -- and for us to wait to understand what medically frail might mean and if we have flexibility in defining that or not will not serve us well or serve our members well when it comes down to really going live with this.

So I would also say one other thing. We've really appreciated the engagement that we've had so far with other states through our national association and the collective work we've done also with CMS. They have introduced some technology solutions that at least for Utah, we've been able to see those and be able to assess what we have and what's being offered and what's being developed and really consider what's out there. And so I think that's really important, because some of this stuff is just being built. And you've got to use what you have and think about how you're going to grow what you have

today.

But time is of the essence, and I think getting on that in the context of all the work we're doing to still support the children and pregnant individuals and individuals who have disabilities who really rely on Medicaid every day is essential so that our workers are able to do all of that work collectively successfully and were able to connect with the members as well.

So yeah. Thank you.

MELINDA BECKER ROACH: Thanks to all three of you.

This is my last question, and then we'll turn to Commissioner Q&A. And this question is for Deanna. So communicating with beneficiaries who are subject to community engagement requirements is another topic that will be top of mind as states get closer to implementing community engagement requirements and Medicaid. From your experience in Georgia, what do you see as some of the most effective beneficiary outreach strategies?

DEANNA WILLIAMS: Okay. From my experience, some of the most helpful experience, just to start with, was partnering with trusted community organizations.

With my one-on-one work with beneficiaries, many of them don't trust -- they trust local organizations more than government agencies. So partnering with community health centers, faith-based groups, food banks, libraries, schools, and other nonprofits are very beneficial. It's just that they feel they have a sense of trust working with someone who's looking for their better health. So working with FQHCs who have helped them with their maintenance drugs and now they need coverage or can refer them to someone to help with coverage, that's a more trusted source than just trying to visit the local Department of Family and Children Services for assistance, which in Georgia, I have heard stories that haven't worked in their favor by visiting state offices.

Also, pushing that the state assures that they have trained health navigators or community health workers to properly assist with the application process, here in Georgia, we do have a gateway community partners with a list of nonprofit and other organizations who are willing to provide their services to their clients who may need assistance applying for, again, Medicaid and other state benefits.

Another source would be direct multiple communications. Beneficiaries receive information in different ways, so repetition across multiple platforms ensures that the message sticks. So using a mix of mailers, text messages, emails, phone calls, as well as in-person outreach, which is highly pushed, is very helpful with letting them know what's available to them and that you're actually there to help. And with that outreach information, make sure you prioritize simple, clear language, and also use multiple languages relevant to different populations.

One of the things I also noticed is that sometimes the reading of one-page flyers is not always helpful. So make sure you include visual aids and infographics to make sure they improve the comprehension of the information you're trying to provide.

Also, I want to say always leveraging our managed care organizations. Our care management organizations in Georgia are Amerigroup, CareSource, and Peach State, and they already have relationships with enrollees, so they can provide more personal support.

So normally, we may have a mother who is not

eligible for Medicaid but could be eligible for Pathways, but her children are already receiving Peach State for kids. So it'll be easier for one of the CMOs to provide additional guidance and educate their members about those requirements upon trying to apply as well as regular check-ins and care coordination, as you all spoke about earlier -- and using them also, in addition with the state, with their call centers and care managers to remind and guide their enrollees.

And one other thing I definitely want to speak on is accessible support channels. We need to make sure that they're offered hotlines or walk-in services or walk-in centers where beneficiaries can get help with their application, as well as if they have questions, and with their documentation and reporting. That is very crucial. If this is required for me to do from a state agency, the state should have somewhere for me to receive this service.

And as I said, in Georgia, that hasn't been as successful here. So they do rely on other organizations like Georgians for a Healthy Future to provide those services.

And one other note from the client's perspective

is try to avoid using punitive tones. A lot of beneficiaries are more likely to engage with the messages when they're more encouraged and not threatened. So when we constantly frame requirements, requirements to receive Medicaid, maybe pushing it as an opportunity for support and job training or connections, rather than a rule and penalty.

MELINDA BECKER ROACH: Thank you so much, Deanna, and to all of our panelists. And I'm going to turn it over to our Chair now to facilitate Q&A with the Commissioners.

CHAIR VERLON JOHNSON: Yeah. Thank you. Thank you, Janice and Melinda, for putting this together. This is a great panel. And thank you to Deanna, Jennifer, Jess, and Melisa for your knowledge about this topic. I think I speak on behalf of all my colleagues here, it was very helpful.

We do want to turn to questions, but before I actually turn it over, I do have a question for Melisa and Jen. I know that you noted opportunities for CMS to support the IT and systems changes that states are going to need to implement for these requirements. But beyond systems, where would your states most benefit from some

near-term CMS guidance or technical assistance? You know, for example, you know, we just heard some great ideas around beneficiary outreach and notices, for sure, exemption, identification, documentation, cross-program data, when we think about SNAP and TANF. So where would you say would be the most helpful?

MELISA BYRD: Well, sure, Verlon. Thanks for the question.

I mean, I think it is some of what we've mentioned already, like you referenced. You know, really, any signaling of where CMS, you know, may feel like there's no additional guidance forthcoming is great to know.

I also think you pointed out, like, the alignment with SNAP and other benefits. So where CMS can really make those connections with their partner agencies on the federal level with, like, Food and Nutrition Service where there can be discussions so that there's -- there may not be the time or the ability to align requirements, but even just having the awareness of what, like, your Medicaid colleagues are focused on when you are looking from the SNAP perspective, even, you know, through whether it's nationally or your local partners, that's really important,

too, because when you have an integrated eligibility system, we have the priorities for the Medicaid program. But there are priorities for the SNAP program, and they're all happening at the same time.

And so, you know, from the regulator perspective, if they have that awareness across the board as well of, like, what the states are taking on, I think that that would benefit us all quite a bit.

CHAIR VERLON JOHNSON: Thank you.

DR. JENNIFER STROHECKER: Yeah. And I'll just add a couple things. Early on, we kind of sent a list of top 10 questions we had around policy areas to CMS, because I think there's just additional clarification we need.

I think -- and where will CMS provide that clarification and where will states have flexibility in being able to create, you know, our own definitions and then use those, I think, is important.

I mentioned earlier, medically frail, and this question that's presented, people say, well, there's a definition for medically frail, but you can see sort of the continuum that someone may present with in a state of chronic illness, for example, and really helping us

understand. And this goes back to one of my original comments, that a person may be healthy today if they're getting the medications they need, but they could quickly decompensate if they lose access to Medicaid and therefore lose access to medications. Something as simple as, you know, insulin -- it's not simple, it's critical, but something like insulin to treat diabetes, for example, the person's very healthy and functional with insulin, but if they fail to complete the work requirements, they may change.

So I think that's one aspect of what will be -- what are areas where we -- states have flexibility and what are areas where there will be more discrete parameters that are yet to be defined but will be defined.

Secondarily, our state is still asking the question around self-attestation versus -- and verification, and there's a lot that, you know, can go out in the sense of -- and this is where if you're new to Medicaid, again, I think we've been challenged to think about how a person who may meet an exemption criteria but may not have medical documentation or verification, where do states have flexibility in using tools like self-

attestation or verification?

And so I think those to us -- Melisa commented, we are an integrated state as well. It's complicated, and it's going to be really complicated for our systems, for our workers, but also for people to really understand what's required of them on six-month eligibility reviews and changing work requirements.

Way back when, you know, Utah did draft an 1115 waiver that looked at aligning SNAP work requirements and Medicaid, thinking that that would be a most ideal pathway, at least from a member impacts perspective, but that's not our reality today. And so I think sifting through that soon so that we can really operationalize it effectively would be ideal.

CHAIR VERLON JOHNSON: Thank you. That was very helpful.

Let me turn it over to John.

COMMISSIONER JOHN McCARTHY: The question, I think, is for Jess first and then over to Melisa and Jennifer.

So one of the issues when we were working on this way back in Ohio and we had submitted an 1115 waiver, a

community engagement waiver, one of the issues that I ran into was the issue of privacy, data privacy.

So one of the things I wanted to do was just link into -- because I know, Jess, you talked about third-party vendors who use payroll sources, but I just want to go right to the Department of Taxation of Ohio because most of these -- well, I shouldn't say most. Individuals will be paying payroll taxes. But we ran into this barrier where the Department of Taxation couldn't share their data, and we at Medicaid per Ohio law couldn't share our data because of the Joe the Plumber issue.

And so it was like, how do you get around this issue? And I didn't know just with technology, because this was back in the day, Jess, was literally like, you will give us your whole database and we will check against it, or we will give you the whole data.

And so I don't know what technology things have changed. You know, can we get around some of those issues just instead of being -- having to download a whole file the whole time, but just checking, you know, live?

And then second for Melisa and Jennifer is, have your states been able to get around -- do you have these

same issues on privacy, or can you just go to payroll tax data from the Department of Taxation to be able to get that so as to remove one of the potential barriers for an individual?

JESSICA KAHN: Yeah. That's why I was sort of alluding that the longer journey here might be the legal MOU one than the tech build one, because that's certainly what I hear. So this seems to vary by state, John. Like, there are some states that have either stricter rules on data sharing or stricter interpretations of those rules on data sharing than others. And that sometimes is even just SNAP and Medicaid. Sometimes it's not even going to labor or to revenue data for sure.

Certainly, the technology has evolved. There are ways to query almost like a health information exchange. You're querying to see what medication someone's on. You're querying to see whether that person shows up for that month or for that period that you've defined as your look-back period as having any taxable income.

The consumer can consent and should consent for those kinds of solutions either at the point of application or renewal or when they're using one of those third-party

solutions. But whether or not your state partners and their sister agency agree that that is adequate is one thing.

And then also whether or not their systems have an open API or something that is query-able, you know, it's one thing for you to throw the ball. Somebody over there has to have a decent catcher's mitt also. And they have other things on their list to do as well in the next 14 months. So it's like there's a lot of variables.

But that's what I meant by saying to yourself -- and I think it was Anne who mentioned, like, what are the data sources we have and what are the data sources we need? For each one of those, I would be ranking them by how many people we think that's going to provide us with meaningful data for, and what's the feasibility of getting to that data source? Because there's no point running after something that's really complex, to your point, there's consent or technology or privacy rules, if it's only going to answer the question for a really small number of people that you're matching to.

But the question of privacy does seem to vary by state and whose lawyers are answering the question.

CHAIR VERLON JOHNSON: Thank you.

Carolyn and then Dennis.

COMMISSIONER CAROLYN INGRAM: Yeah. This may be belaboring the point, but I guess to everybody on the panel. So on John's topic and where you were going, Jess, about that open API, do you think states are looking at that and starting to say, oh, we need to do something about our eligibility systems, or is the federal government looking at making that recommendation around that?

And then I have one other follow-up question for our panelists on a different topic.

JESSICA KAHN: So states already have APIs to the federal data services hub to a number of other data sources directly their own state departments of labor. Sometimes it's batch; sometimes it's real time. That seems to vary by state, by system.

I think the lure of having real-time data sources here is really high for all the reasons you've noted about admin costs.

To the extent that -- I mean, I left CMS eight years ago. We had guidance about having real-time APIs and encouraging electronic data sources. So this isn't a new

topic.

I think the question you're asking, Carolyn, is can they go beyond just recommending and pointing to good industry best practices and actually -- so they could, for example, add some of these data sources to the Federal Data Services Hubs, which states already have a connection to in real time. And so that would be an easier way to get it.

But there's upsides and downsides to that, including cost and contracting and testing and all of those things. So, again, it's an option.

But I'm less worried about the employment data. I am more worried about the data that would have to be accessed through exemptions, because that's more of a clinical nature, or if it's for people -- you know, if it's someone who was being renewed, we might have data on that member already. If it's a new applicant, I have to go query, you know, the all-payer claims database, or I have to go query from my health information exchange. That gets way more complicated, and that's a lot more systems that you would be hanging and expecting to be able to respond in real time, or even --

MELISA BYRD: I just -- and this is Melisa, and I

just want to follow up on that, because that's where I was going to go, Jess. It's really worth thinking -- we also are the regulator for our health information exchange within the agency here, and it is how -- because, you know, there was the earlier conversation about claims data and the lag, right? We already have those challenges in identifying women who are pregnant, and so that we can get them timely enrolled into case management or into the right eligibility code with the extended 12 months. And so it is kind of like how can we leverage the HIE components, where we have real-time data, clinical to that point, and then maybe it takes the lift off of a person, but then trying to explore the privacy issues as well.

But I think that's one source, at least from the District, that we'll be thinking a lot about, of how we can leverage, just so that we have as more real-time information than the claims database, since that's just not as reliable for these purposes.

COMMISSIONER CAROLYN INGRAM: Thanks.

And then just one other follow-up question on somewhat a different topic, but for the states who've been implementing or looking at these issues, how you're looking

at accounting for people who are in programs such as job training. They may not be getting actual college credit, but would that be something that's qualifying? They might be in a job training program that's not accredited, but it is actual workforce training. Are you all looking at ways that that can be counted? Or maybe in Georgia, did they address that?

DEANNA WILLIAMS: So I can speak to in Georgia. So they do have on-the-job training. So if they are on the job and they say they're going to get some form of certification while they're there, they just have to provide -- like, if they're working and they're doing, like, shadowing, job rotation, hands-on practicing with tools, normally that's paid. You're already with your employer, you're doing additional training. So the employer can write them a statement for that.

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

JESSICA KAHN: I think the job training question is a good one, Carolyn.

The other thing I want to flag for people about volunteering, because that's another one that seems really

hard for people to get their minds around, is -- and who knows? Maybe I'll be wrong about this, but there is one area of precedent here, and that's court-mandated community service.

So in states, they could go to their sister agencies, departments of justice, probation and parole, or it depends on the state or the location what it's called, but they do have a process where they are monitoring and in an auditable way validating that there is community service. And that means that there are entities on the other side of that, nonprofits or other, who know that process and are used to it and have some -- so like there is a place to start there that maybe isn't step one.

And again, if you're thinking about an MVP, that might be a place to start from an MVP perspective.

DR. JENNIFER STROHECKER: I'll just say from our perspective, this is a place where some additional CMS guidance would be helpful with regard to job training and how to get the individual credit for that. So --

COMMISSIONER CAROLYN INGRAM: Thank you. That's helpful.

CHAIR VERLON JOHNSON: All right. Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks.

This question is actually for Deanna, and that is, what do you find is the most -- like the three most common causes of people they work with not being able to move to Pathways? What are the most common frustrations or barriers they face to getting into Pathways?

DEANNA WILLIAMS: One of the most common issues can be like meeting the hourly work requirements, because a lot of people who I work with, they may not work like a regular job where you're guaranteed 40 hours a week. So they may work side gigs such as Uber, Lyft, certain jobs that are not steady. So verifying that form of income and reporting it can be a hindrance to them, because they're not guaranteed to have the same amount of hours each week.

And those also go for my clients who work in restaurants or retail. You need to know when it's off season and they're not as busy. The first thing someone may say in a restaurant is, hey, who wants to go home early? Or the person who's been there the least amount of time may have to leave early. That cuts their hours, which can hinder them from being eligible for Pathways going forward.

One of the other issues also include the system itself. We have -- before we had updates to our system, a lot of times the gateway system would say they were not eligible for Pathways, but because I'm an assister and I know what the requirements are and I've looked at their pay stubs, they meet the hours, they've submitted everything correctly, but sometimes there may be a system issue or error that has to be taken up to a next level by notifying the supervisor or customer service. That's one of the major issues that I've experienced with my clients.

COMMISSIONER DENNIS HEAPHY: Just a follow-up question. Is there any success story for you that exemplifies how this can work well?

DEANNA WILLIAMS: Yes. I would say in Georgia, one of the success stories or the group that's been the most successful has been the students, because students don't have to go through the process of reporting on a monthly basis. And Georgia Gateway has a third party where they can verify them being in school through the university sites. They don't have to worry about doing the monthly reports. So they'll verify that they have a schedule, that they're enrolled, and so that verification is fairly easy.

And it's something that they don't have to worry about on a month-to-month issue. So the students are definitely well successful. It's just some of the other qualifying activities that are a little harder to verify.

COMMISSIONER DENNIS HEAPHY: But do you have any stories from folks who are homeless or other folks that may have greater challenges in finding employment or volunteering?

DEANNA WILLIAMS: Yes. So I do work with some of the FQHCs. So they may have a client who comes in for maintenance, routine health concerns, but then they'll find out that they have stage IV cancer. And they need additional services beyond what that clinic can provide. So they'll call me to see if they're eligible for Pathways, and typically, some of those clients are not working or they can no longer work due to their medical condition. So that's where I have to go in to provide education, because in Georgia, they have to already be participating in these events, not planning to.

So I have to let them know, hey, are you doing any community service? Are there any job readiness programs? Especially if they can no longer work? So I try

to inform them on what's available to meet the requirements for qualifying activities. But sometimes in those clients, in those instances, then I have to push them to go another route.

COMMISSIONER DENNIS HEAPHY: Thank you.

CHAIR VERLON JOHNSON: Thank you. It'd be great if some of those other community partners could mimic what's happening with the colleges for the students, for sure.

Let's see. Next up, we have Michael. Mike. Sorry.

COMMISSIONER MICHAEL NARDONE: Hi. Thanks for this great presentation today.

I wanted to ask Melisa and Jennifer, as I put on my former Medicaid director hat, this seems like a fairly big undertaking over the next year. And I think both Jen and Melisa mentioned some of the other big priorities that you're also implementing in the year ahead.

And I guess I was wondering, at the same time, Medicaid directors have great capacity to manage a lot of things at the same time. And I just was wondering, as you were thinking about the next year, what are the types of --

are you thinking about -- what are the types of -- what's the capacity building that you need to do over the course of the next year? Is it mostly focused on IT? Is it focused on the eligibility workforce? Are there other areas that you're thinking, well, we're really going to need to be able to supplement our staffing here? Or I'm imagining you can't do this within current state staffing -- or it's a challenge to do it within current state staffing.

DR. JENNIFER STROHECKER: Yeah. I'll chime in quickly.

I've been amazed at the capacity of Medicaid staff over the years, as you know. These folks are really loyal. They are public servants at heart. And it's really incredible. In Utah, we have just about 340 full-time staff, and we don't rely a lot on external consultants. We have some but do not rely as heavily as some states do.

Our sister agency runs eligibility, and I'll say one of the things that we have done to think about what this next year will look like is just be honest about what we need to say no to.

And there are really lots of things we might want

to do, but there are many things we have to do. And if we're going to do them well, we have to really align our existing staff and resources behind those.

And I think also being realistic with our lawmakers as well in understanding what their priorities are and recognizing what federal requirements we have coming down the pipe and how those align with existing services that we have to maintain.

So I'll say the one thing we've done, first of all, is thinking about our current staffing is really helping them focus on the work that they should focus on and saying no to other things, because other things are always coming in and asking, right, and putting those to the side.

I think our workforce on the eligibility side will need to be and is -- we are planning on hiring additional staff there as well as really thinking about how to enhance technology so that it's not so much on the worker, if that makes sense.

So I think we've begun good work through unwinding where we were able to take advantage of more data inputs, increase our ex parte rates, use flexibilities that

came about and carry forward with those, but continue to do that work.

And then I would also say think wisely about our managed care contracts. They are really the ones interacting most regularly with our members, and so thinking about how to equip our managed care contracts with the right requirements to help them be that support to bring in -- some of the thing that just sits in my mind all the time is how do we connect with members? And that's the hardest thing. Phone numbers are disconnected, the address has changed, emails, and thinking about how to get the best address.

So I'll say leverage our existing resources and then considering what we want to deprioritize, but also improving our staffing in key areas too,

MELISA BYRD: I mean, everything Jen said is spot on.

I'll add -- and I'm sure Jen's staff is the same way. I hear from my folks that they love solving problems, and they like being creative. And so we've got a lot of opportunity for that over the next several months.

We're very similarly situated to Utah in terms of

our size of staff. We don't do a lot of outsourcing, if you will. And I don't anticipate doing a lot going forward for several reasons. One is the timing issue. By the time we procure something, we'd be probably at timeline to implement so that we don't really have that luxury.

Two, you know, the District is already -- as we are going into [fiscal year] 26, our city revenues are down, and we're already up against some real budget challenges. So adding funding for things is not the first place for us to go.

The one area I do think that we will look to outsource -- and we have a dedicated source of funding for this -- is really on the outreach side. I think, you know, what Deanna said earlier, you know, that is not the best place for us to be or the best place or best use of our resources. We really need to be working with folks who are in the community and then can better connect with the residents that we serve. It's just more effective. So we sort of need to know our lane on that one.

And I think what Jen said, too, it is really being disciplined in what we can or cannot take on, and some of the things that would be really amazing and

wonderful to take on, that's just not -- we don't have that capacity right now. So it's focused really on -- for us, it's the things that we have to do to meet our budget initiatives for the fiscal year that starts for us in a couple weeks, and then these compliance deadlines that are set by the legislation.

CHAIR VERLON JOHNSON: Thank you.

Sonja.

COMMISSIONER SONJA BJORK: Thank you. This one's for Deanna. I really liked what you said about making sure there are accessible support services for people that get stuck in the way you mentioned. They didn't have the right format for their document. You're sitting there, and you know they meet the eligibility requirements.

So what about escalation pathways? Do people have to request a state fair hearing in order to get through the process sometimes? Or is your organization able to escalate things to somebody who can make a decision for someone, and how long does that take?

Thank you.

DEANNA WILLIAMS: Yes. So we do have the opportunity to do a fair hearing request. I tried not to

make it my first goal, because the process for waiting on that fair hearing, for you to get a court date to show up, to plead your case, that can take days, months sometimes, depending on how their scheduling in their fair hearing department is going.

Now, second, that we do work with our collaborative partners. We have Georgia Legal Services and Georgia Legal Aid, and they are also listed on the denial form when a person receives their denial notice or notice of decision that says they've been denied. So if they would like help with their fair hearing, it does leave a few agencies where they can contact, again, two of which who are collaborative partners with us who I'll make the referral to after reviewing the application.

But for me, I just take the first initiative, especially if I review the application or I've submitted it. And based on their state requirements, they should meet the requirements, I take the next step to send it over to their customer service to let them know. And then I provide an explanation to let them know, hey, this client does meet the hours they have submitted with the household. Per the system, it's showing they're only calculating one

person, but this is a household of three. So there's an error with their processing in their application. Can someone please review?

Typically after submitting that, that goes to a supervisor who we work with, with the state, who then reviews the case. And typically, they'll get a notice or call the client within a few days to let them know that their application has been approved.

COMMISSIONER SONJA BJORK: Thank you.

DEANNA WILLIAMS: You're welcome.

CHAIR VERLON JOHNSON: All right. Thank you.

Jami and then it looks like Heidi.

COMMISSIONER JAMI SNYDER: Thanks so much for joining us today. My first question is actually for Melisa and Jen. Curious to know from either of you, have you been able to estimate the cost associated with implementation at this point?

MELISA BYRD: We have preliminary costs really focused just on the systems component, but not -- I would not say that we are at the place where we've looked across the board towards, like, are there workforce issues like caseworker and other supports that we might need. So

that's where we're at. It's on the lower end.

We have an, like I said before, in-house eligibility system and in-house operations and maintenance. So we expect that we'll take on a good bit of the work in-house, and right now our costs are on the lower end.

DR. JENNIFER STROHECKER: And I'll say we've worked with our governor's office and our lawmakers to create fiscal impacts for the whole bill and to assess what that will be.

Overall, interestingly, you know, it actually results in a bit of a cost savings due to some of the estimates of enrollment change and the reduction in the taxes. So as a state, new costs are certainly associated with this.

I think, like Melisa, we've begun the work, and we've charted out high-level or even semi-granular estimates, but I think some of it is still sitting on a bit of our outcomes with the decisions we're awaiting from direction with CMS, if that makes sense.

So I think from a system, we do a lot of our work in-house as well. So for us, it's, you know, our staff, and we have our own -- we actually even have an in-house

eREP eligibility system. So we don't vendor that out, which is a cost savings for the state of Utah as well. So that does help those cost impacts, but certainly, we've begun looking at personnel as well as system impacts.

MELISA BYRD: And one thing, just to follow up, Jami, I think it's important to note, you know, obviously every state's eligibility system is going to be in a different place. If we -- you know, we finally went fully live with our new integrated system, I think it was in 2021. If we were still in our legacy system, that cost estimate would be totally different, right? You know, it would -- I would expect it would just be ginormous to use, you know, a technical term there. But it would be a very different situation, right?

And so that -- so I think you will see, you know, variance across the states for those that will be implementing this and really dependent or -- on where, what capacity their current eligibility system has today.

COMMISSIONER JAMI SNYDER: Yeah. Yeah, that's a great point.

One other quick question, Verlon, if you don't mind, actually for Jess. I'm kind of curious to know more

about the income verification as a service tool that you talked about. I think -- did you say they're piloting it in Louisiana?

JESSICA KAHN: The CMS one?

COMMISSIONER JAMI SNYDER: Yeah, yeah. Just if you can talk to us about the tool, if there are any early kind of results from Louisiana and whether you think other states are maybe going to consider using the tool as well.

JESSICA KAHN: Yeah. To take a step back, a survey was launched, and I think this information is in the Commissioner's packet, but just to say it for everyone else's benefit, a survey was launched to the universe, the marketplace of these SaaS solution vendors that I mentioned, eight, nine, ten of them, to ask them what functionality they are going to offer. How are they doing pricing? Are they going to bring data sources, use data sources? My very bad analogy for this is when you're buying a refrigerator and you look at Consumer Reports to see all the features of all the different refrigerators, and you still have to decide what fits in your kitchen and what's your budget and how much you care about the ice maker. But, like, at least you have something to start

with. So that's what that survey is meant to do, just give you quick specs.

The results are coming in this week, and that'll be made public to states, to everybody who wants them. CMS's solution was one of the ones that sent outreach, and they did respond because they are there as a consideration like everyone else. And so Louisiana is best poised to talk about the solution. What they were piloting it for was if they -- if they tried to verify your income and it came back beyond the reasonable compatibility period and they sent you an RFI, then there was a QR code where you could log in with that QR code. And it took you to this app. It takes roughly six minutes.

They found it very user-friendly, and they had very high uptake. But again, it's a small number of people who are using that. So CMS is definitely leaning into it and would like to -- as I understand it, not to speak for them, but from what I understand, to make that more broadly available.

There are -- I think they're talking to another set of states to be the next set of pilots. So they're going to add more pilot states to the mix and maybe then

also expand how it's used. Ultimately, a tool like that is best used to be part of initial application and the renewal packet, right? Not just part of the RFI process, if you're looking at your eligibility journey, so that people can provide that income information if they're a gig worker in particularly -- in particular upfront.

But there are a number of vendors out there who are doing this. Some of them are open source. Some of them are for profit, not for profit. Again, it's a very wide range. States will have to make those decisions, not the least of which will be what's the procurement path they have to get to any of these because sometimes that trumps functionality as, you know, where can I buy the fridge?

So I suspect CMS will be sharing more information about that service. It's being run out of the -- Amy Gleason's DOGE team.

COMMISSIONER JAMI SNYDER: Okay. Great. Thanks, Jen, Jess.

CHAIR VERLON JOHNSON: Thank you.

And then we have Heidi and I think Bob.

COMMISSIONER HEIDI ALLEN: Hi. Thank you so much for this panel. It's been really, really enlightening.

I think I have two questions. My first question is for Melisa and your role as the director -- or the president of the board of directors for NASMD. My question is this: What happens if the impact is worse than we thought it would be?

And the reason this comes to mind is that in Georgia, which is new people coming in, enrollment was significantly lower than was expected, significantly lower. And people are, you know, attributing that to work requirements.

And then in Arkansas, there was this acceleration of disenrollment. You know, for the first couple of months, it seemed like, oh, okay, it's this. And then, you know, two months later, it was way higher, which is what caused it to stop.

And I know that Jess said that everybody's in a better place now than they were back then, and so maybe we wouldn't anticipate that.

But what systems do we have in place if we find that disenrollment is big and way bigger than we thought and really quick and way quicker than we thought? How is that information going to be aggregated up to the national

level so that Congress and CMS really understand what's happening?

MELISA BYRD: Well, I think from the association perspective and where I think the association is so valuable for Medicaid directors today, is that, you know, they can really -- they do a fantastic job of the issue spotting.

So I think -- and when I was in a different role a long time ago in an association, it was a kind of like if you start to see it two or three times, you know, it might be a trend, and you can raise that up. And in this case, it can be raised very quickly with CMS, with our federal regulators, if we see something that's, you know, where we need some additional support.

But I think that would be whether it's enrollment issues or systems issues across the board. I think that's where we -- you know, the association can convene any states having challenges or whatnot and then again bring in our federal counterparts so that we can have those conversations and look at a holistically where it's necessary, and when it's a one-off, you know, make those connections, but let the state and the federal government

work together hand-in-hand.

So I think it's really kind of more of what the association really does every day, just, you know, changes depending on the issue area.

COMMISSIONER HEIDI ALLEN: So if I understand correctly, then what you're saying, it will probably be anecdotal rather than necessarily data informed?

MELISA BYRD: I don't know. I'm just trying to think of where and how the association operates today. It -- you know, the states aren't -- there isn't a formal reporting. That's not the role of the association to take that kind of information.

COMMISSIONER HEIDI ALLEN: Yeah.

MELISA BYRD: It's more -- you know, it is, again, the issue spotting and whatnot. So if we get to that point, then I'm sure -- and there's, you know, support that states need, then I'm sure the association will step in as needed. But I'm not really going to get ahead of that and assume that it will be, you know, something that doesn't work well.

I think our experience from unwinding is that the states can really step up when there's a concerted effort

and make sure that we do the best we can for the folks we serve at that time.

COMMISSIONER HEIDI ALLEN: Yeah. Thank you so much.

And my second question is that looking at the new waiver requests as they pertain to work requirements, it seems like work requirements are the floor, but there's like a ceiling too. And in particular, I'm thinking about Arkansas who are now linking meeting personal health goals with work requirements. And I'm not sure what that means. Do we anticipate that other elements could be added to this eligibility related to work?

And then, you know, thinking about Utah -- and, Jennifer, maybe you could answer this -- specifically, Utah is now seeking to attach lockout periods to coverage related to not meeting work requirements. And so I'm interested in these, you know, lockout periods. I assume personal health goals. Actually, I don't even know at all what that means. But do we anticipate that other kind of configurations might enter into the work requirement space as part of things that people have to do or consequences of not doing it that could have really, you know, significant

impacts on people's enrollment?

DR. JENNIFER STROHECKER: Yeah. Thank you for the question.

And I'll just say your first question is what keeps me up at night because of the -- we know that the person still resides in the state, right? And as we meet with our lawmakers and our other stakeholders, the person still lives in the state of Utah, even if they're enrolled in Medicaid or not. And so I do think the work is great and the cost to the program and the impacts to the individual and potential cost to the state would be severely impacted by that, as you know.

And just in reference to the 1115 waiver that Utah did submit in early July, I'll just state so that maybe I can mention that we do not plan to implement that waiver. There are states who do plan to implement their waivers, but Utah used the waiver as the language was moving its way through, and the bill was being drafted and working its way through Congress.

I think there was a time that Utah felt that there was another pathway that potentially had lower member impacts with regard to at least even one key thing is you

enroll in Medicaid, and then you can fulfill the work requirements. And I had previously mentioned our alignment with SNAP.

While that lockout was there, Utah does not have the intent of actually pursuing that 1115 waiver now that the bill has moved into law, and that will be what we align to. And so I'll just say that that is where Utah stands with regard to implementing any of our 1115 waiver language.

CHAIR VERLON JOHNSON: All right. Thank you.

And then, Bob, I think you had the last question.

VICE CHAIR ROBERT DUNCAN: All right. I too want to thank our panelists. Appreciate what you do each and every day for those that Medicaid is serving.

Deanna, I've been very impressed to hear your comments on the work in Georgia, and so the question I have for you, to get to the point where you are now, I know you guys have filed an extension, but how long did it take you to get to this point to where you've got that process and procedures in place? And then what recommendations would you have for other states who are looking to model after what you've done in Georgia and the success there?

DEANNA WILLIAMS: Okay. Now, as I think the other lady just stated now, it hasn't been as successful as we would like it to be. The enrollees are very low in comparison to what was previously stated Georgia would have enrolled. But it has been a work in progress since the program rolled out, I believe, July 1st of 2023. So there have been a lot of changes with requests to the state about fixing the website to make sure that it's more functional.

Just like I stated, a lot of the updates most recently happened as of May. So now the website for them to apply is available and accessible on a cell phone, which the previous website was not as helpful or functioning using a cell phone or other devices. You had to use a computer so that you could see it clearly or get assistance from someone like myself.

But it has been a work in progress, and I would say the state, when they noticed that outreach was very important and impactful, they started to do their own outreach as well. And they also provide Pathways office hours for us. So for organizations who are assisting in this role, they provide training and open an office hour for us to ask questions to make sure that we're assisting

our clients the best way possible and that we have the resources to help them going forward.

VICE CHAIR ROBERT DUNCAN: Thank you.

Any recommendations for the states that have not been started since 2023?

DEANNA WILLIAMS: Yes. I would definitely recommend that you start ahead of time.

I know with Georgia, we have -- well, Georgia the state has spent a lot of money on trying to fix the system and the contractors to make sure that gateway is now working properly. That's what majority of the funding went towards in their awareness campaign, so definitely figuring out your budget and where you're going to spend your dollars to make sure that you have the capacity to help the clients, because I don't think as much funding was used for state workers so that they'll have enough caseworkers for the caseload. That was one of the things we've seen early on. Not having enough caseworkers will slow down the process. Even if you had 100,000 applications come in, if you don't have the staff to process it, it slows down their eligibility to getting health insurance in that process.

So I would definitely say go ahead to start that

model and what it looks like for your state and then making sure that your system works appropriately for your clients.

VICE CHAIR ROBERT DUNCAN: Thank you so much. Appreciate it.

CHAIR VERLON JOHNSON: Yeah. Thank you. That was great sage advice for sure.

Any other questions before we again say thank you to the panelists for this outstanding discussion?

[No response.]

CHAIR VERLON JOHNSON: Okay. Seeing none.

Well, thank you all so much. This was very helpful. We know you're all busy, but to hear your passion and your knowledge has been very helpful. So thank you all.

DEANNA WILLIAMS: Thank you for having me.

CHAIR VERLON JOHNSON: Okay. So we do have a few minutes to talk amongst ourselves. So we can open it up to questions.

And, Melinda or Janice, anything you want to say before we start?

[No response.]

CHAIR VERLON JOHNSON: Okay. Any additional

questions or thoughts? John? He said no.

Dennis.

COMMISSIONER DENNIS HEAPHY: What's going through my head is like cost-benefit analysis and how much money is going to go into trying to get folks into employ volunteers and all those things. And if not a high percentage of folks do, then that's the cost that's going to be incredible for the state.

And then beyond that, this direct cost, there's the overall cost of the -- if these folks aren't on Medicaid, the hospital's going to meet that cost. And it's just kind of -- it's not that the costs are going to have to go -- are going to be somewhere. And prevention's going to go out the window, and all these other things are going to be there. So I'm like -- I'm just -- like, my head is actually spinning.

So yeah. So I just -- that's what's going through my head as I was listening to the presentation. I don't know if that's a comment or a question.

CHAIR VERLON JOHNSON: No, that's a good comment for us to think about, I think.

Heidi.

COMMISSIONER HEIDI ALLEN: I, you know, really appreciate the panel. It was really -- I learned so much.

But I'm just kind of holding this tension that in this bill, it's a cost. It's a budget-reducing initiative that's substantial, and it's based on the assumption that there will be significant disenrollment. And what we understand about people on Medicaid is that seven out of ten of them are working, and we also know that the ones that aren't working are probably not working because they exist in a categorical exemption.

And so the premise that this is going to save the amount of money that's projected to me is connected to this disenrollment that will impact people who are eligible.

I mean, I don't think the numbers line up where we can find the people who actually are on Medicaid, don't meet an exemption and aren't working. Like, that number, I don't think from data supports the amount of disenrollment and the amount of money saved. And so how is that tension navigated?

And I also -- I just don't see the national strategy for understanding what is going to happen, like, how we're going to know that people are disenrolling, who

shouldn't be disenrolling from not a state or an anecdotal level, but from an empirical level, from a data level, and then how we know what happens to their health and what the health impacts are.

And so I feel like there's a lot of work that needs to happen there, and I don't know where that work is going to happen. So I would love it if we could continue to think about how MACPAC fits in that, what data is available for us to use, how timely it could be.

Yeah. So that's my thoughts.

CHAIR VERLON JOHNSON: Good points. Thank you. Others? Tim.

COMMISSIONER TIMOTHY HILL: First, let me associate myself with the comments from Heidi, particularly on the evaluation. I think one of the detriments of this not being a demonstration is not having the requirement to do a large-scale evaluation. I think we should definitely put ourselves out there as having a request and a need to do that analysis and understanding over time.

But back to kind of the nuts and bolts, I could not help but reflect, listening to Jess, in particular, talk about eligibility as a service and the efficiencies

that can be gained by API integrations and using existing data sources. And she made it clear, that CMS has had this guidance in place for eight years for states to be able to utilize efficient ways to use these data tools.

And reflecting on the Marketplace startup, and reflecting on changes to Medicaid eligibility over time, what seems to drive the cost, and what seems to drive the hiccups are states having a desire, because they're states and they're states programs, to really customize and have different rules across, whether it's eligibility systems or the exceptions, or how they're going to do the process.

And I think to the extent that, you know, back to Heidi's point about a national strategy, we're not sort of trying to reach out to states, or CMS is not trying to reach out to states to say, look, there is a floor here that you can buy, that you can sort of implement, that you can do efficiently, and that has the least undue impact on beneficiaries, if you don't do a ton of exceptions, if you don't do a lot of workarounds.

So I'm just interested to see how that plays out over time, what states are wanting to do kind of unique things to what the requirements are.

CHAIR VERLON JOHNSON: Thank you, Tim. Anne.

COMMISSIONER ANNE KARL: Yeah, just building on that point, I was struck, in Jess' comment, saying you need to get started now on identifying what data sources you need, what vendors there are to help you with those data sources, and then getting those contacts in place. And I was just thinking, if I was in a state's shoes, one, having the technological expertise to assess the different vendors, that feels really hard. And then, two, the procurement process is just such a nightmare in many states, and just thinking about that. And just wondering if there is some way that even if CMS was pre-vetting some of the tools, I don't even know how you get around the state procurement requirements to say, like, oh, this has gotten the Good Housekeeping Seal of Approval from CMS.

So anyway, I'm just sort of pondering that. But that feels really daunting, I thought, Jess' comment that the MOU process takes longer than the tech build I think is true and just a little scary.

CHAIR VERLON JOHNSON: Sonja.

COMMISSIONER SONJA BJORK: In my mind I was thinking of three categories of challenges right now, and I

don't know if we can dig into these and see what is the hardest thing that the states are going to be facing. So is it the technology build, all that is involved in that? Is it the legal barriers that were mentioned? Some agencies don't talk to each other. They think they can't.

And then there's the beneficiary consent part. One of the exemptions is if you're a residential treatment program. There are a lot of rules about sharing information if someone is receiving substance abuse disorder treatment. So do you somehow have to change your application for or have the member agree that these parties can talk to each other so that the eligibility part can move forward?

A lot of us have been working on these challenges locally, just so that you can get case management in place. Now, this is a bigger deal. People could lose their entire eligibility if these systems don't talk. And yet, of course we're protective of mental health data and substance abuse disorder treatment data.

So I was thinking about those three big barriers. I didn't mention cost. I mean, I just think that's going to be so hard for the states as they make their selection

on which pathway to go, and train staff or hire staff. So I guess we have a lot of research to do. So thank you.

CHAIR VERLON JOHNSON: Thank you. Anyone else? Mike.

COMMISSIONER MICHAEL NARDONE: So I just wanted to echo the desire to have some sort of monitoring or evaluation of this work. You know, there were arguments on both sides around community engagement requirements, can they be helpful, in terms of the individual. And are they a good thing? A bad thing? But I think just kind of having that basic information would really be helpful moving forward. And the 1115 process kind of gives us that ability to do that, but it doesn't seem like that's built in here, and I think we should be talking about what that might look like.

I was thinking about, also understanding kind of the cumulative effects of some of the changes that are in the H.R. 1. You know, when you talk about the oversight of community engagement, talk about some of the additional redeterminations that will be required, six months, and we didn't even talk about the impacts of SNAP on eligibility workforce. I think we need to understand and look at what

are the cumulative impacts of all that going forward.

And a couple of people that we listened to, what I heard a little bit, and I was kind of thinking about, is, you know, if I was in a Medicaid director's shoes right now, this would be an all-hands-on-deck thing, to get done by the end of next year. And I do worry about some of the opportunity costs around things, other things that might not be happening. It's kind of hard to get a handle on that. But I was kind of thinking about that as I was listening to the speakers, in terms of what are some of the other priorities. You know, we heard that, well, there are going to be some things we just have to say no to. And I just wonder what those things will be, and one of the things that I would be worried about as a Medicaid director.

CHAIR VERLON JOHNSON: Good call. Anyone else?

[No response.]

CHAIR VERLON JOHNSON: Melinda and Janice, I know we're going to come back next month, so maybe an idea of what that might look like, for sure. But I think we heard a lot about monitoring the evaluation, obviously when the programs take effect, but maybe what it looks like, too, on

the pre side, as we're building this out, which we should be thinking about as Commissioners, as we see these things happening.

But again, thank you so much. I know we spent a lot of time on it, but I think it was definitely time well spent, and people here seemed to have really appreciated that to. So thank you both.

CHAIR VERLON JOHNSON: All right. So with that, we can go into public comment. We will open it up. We do invite people in the audience to raise your hand. Well, online. Oh, Tricia, you have your hand up. Please introduce yourself when we call on you, and the organization you represent. And we ask that your comments be kept to three minutes, please.

So with that we will first turn it over to Tricia.

PUBLIC COMMENT

* TRICIA BROOKS: Hi, Verlon, and hello to my fellow Commissioners, although I am no longer on the Commission. I am Tricia Brooks. I am a researcher professor at the Georgetown University Center for Children and Families.

And I just wanted to pick up more specifically on the comments made monitoring and evaluation, because I absolutely agree with Tim and Heidi about concern of displacement of people who are eligible simply because of the red tape that this presents.

So when you get down into the nitty-gritty a little bit, the Secretary has talked about radical transparency when it comes to knowing what you eat. Well, we need radical transparency here to know what really is going to happen at the end of the day. And we don't have good disenrollment codes that would give us a sense of what is happening. The Maximizing Enrollment project that was a collaborative effort with states, philanthropically funded, many years ago, came out with a set of disenrollment codes that could be standardized.

And one of the reasons I think this is really important is that let's say someone, an expansion adult, who is close to the limit of 138, has had an increase or a new job. So they get their renewal, and they know they're not eligible any longer, so they don't respond to the RFI at all. Is that going to be coded as a procedural disenrollment, or is that going to be sent over to the

Marketplace to say this person never complied with work requirements, even though they didn't give income or anything else, and therefore they're not eligible for PTCs. So when that person goes over to the Marketplace they're prevented from accessing coverage there.

So I think it's going to be very critical that there be some guidance from CMS and a pathway for states to distinguish between someone who is procedurally disenrolled that is missing things other than work requirements or community engagement, and that it would be only failing that part of the eligibility process that would send over something to the Marketplace to say you're not eligible for PTCs either.

So I encourage the Commission to continue working on this and talking about it. It's going to be a huge build for all of the states, and I think there was a very optimistic presentation made by the panel. And I hope that some states will be in that position. But certainly it won't be all states, and there will be eligible people, and probably people who have more health needs, that are displaced with this provision. Thank you.

CHAIR VERLON JOHNSON: Thank you, Tricia, and it

was very good to hear your voice.

Any other comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. Seeing none, I do want to remind you that if you have additional comments at any time you can go to our website. The email is on the screen, as well. And we are going to adjourn right now for lunch, and we will see you back at 2 p.m. Eastern time. Thank you so much.

* [Whereupon, at 12:30 p.m., the meeting was recessed, to reconvene at 2:00 p.m. this same day.]

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AFTERNOON SESSION

AFTERNOON SESSION

[2:03 p.m.]

CHAIR VERLON JOHNSON: Welcome back from lunch. Let's go ahead and kick off our first session this afternoon about strengthening the HCBS workforce through better payment policies.

Katherine is joining us, and she's bringing back her recommendation for us to consider. And so I'll turn it over to you, Katherine.

MEDICAID PAYMENT POLICIES TO SUPPORT THE HOME- AND COMMUNITY-BASED SERVICES (HCBS) WORKFORCE: DRAFT RECOMMENDATION

* KATHERINE ROGERS: Good afternoon, everyone. Thank you, Verlon, for that introduction.

So, as promised, I'm back with more on how Medicaid payment policies for home- and community-based services, or HCBS, can be leveraged to support a robust and sufficient HCBS workforce and promote access to HCBS.

As Verlon mentioned, today's presentation includes a draft recommendation for the Commission's consideration and for a vote at next month's meeting.

So this afternoon, I'll provide a refresher on the project's history and our study findings related to the HCBS rate-setting process within states and the required data inputs. I'll review the draft recommendation, the rationale, and implications, before turning it over to the Commission for your discussion and feedback.

So this work has spanned two phases of research and is now entering its third analytical cycle. We begin with seeking to better understand how Medicaid HCBS payment rates influence or inform the HCBS workforce. We sought to establish payment principles for HCBS rates that promote efficiency in payment, promote a sufficient workforce, and increase access to HCBS.

These phases of work have included a review of 1915(c) waiver documentation and the payment policies described therein as well as interviews and a technical expert panel.

There is a compendium of those waiver payment policies that lives on the MACPAC website. It was published in January 2024, and there is also now an issue brief that was published just last month in the publication section of our website.

When the Commission last met, we presented a draft policy option, and your feedback in that meeting has shaped the draft recommendation accordingly.

With that, I'll cover some background before we get to the draft recommendation language.

We rely on MACPAC's provider payment framework to assess how Medicaid payment policies can be used to address the goals of the program. Medicaid statutory objectives for provider payments include economy and efficiency, what is paid and through what methods, and access and quality of what we can obtain from provider payments.

HCBS payment rate methods, models, and rates vary widely across service types, but those models generally rely on several key components of the service model and the data for those inputs.

Because many HCBS are labor-driven, in general, worker salary or wages are the largest component of any HCBS payment rate, although there are a number of other inputs which you can see on this slide.

So tying these two pieces together, I'll mention a couple of unifying points our work has distilled for us. The stability of the HCBS workforce is an important factor

in ensuring access to HCBS. Payment is a clear lever for Medicaid programs to attract workforce capacity.

Stakeholders cite wages and worker reimbursement as an influence on workforce participation, and to set effective appropriate rates, states need access to wage data that are readily available, accurate, and precise.

With that in mind, our findings have led us to three payment principles, which we've shared in prior presentations and which I'll note here.

So HCBS payment rates should promote an adequate workforce and efficient use of resources. 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 HCBS payment rates should be reviewed for adequacy at a regular interval using the tools that are available, such as rate studies, indexing, or rebasing.

The findings that led us to those fundamental principles have underscored 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. Today there is no

one data source that reflects or captures all Medicaid worker wages across states and HCBS programs.

So next, I'll walk through the detailed findings that led us to draw these conclusions.

In our compendium of 1915(c) rate methodologies, we found the majority of states use data from the Bureau of Labor Statistics, or BLS, as a source. Though a majority report using that, many are using other sources which are listed here, and state policies also play a role. States may tie their wage inputs to living or minimum wage laws or things like staffing ratios.

BLS data, while a critical source of information for state rate-setting activities, do present certain challenges. This is primarily because they are designed to describe the labor market writ large rather than a Medicaid-specific labor ecosystem.

The data cover a very wide array of job types and sectors, and even the health care-specific occupation classifications are many and diverse. These include HCBS-relevant occupations, such as personal care aides, but these occupations might be employed in a variety of sectors, settings, and employers. As a result, the wages

that are reflected in these data are paid by a host of payers, not exclusive to Medicaid, in different labor markets and different settings.

Also, comparatively small occupational groups or sectors, such as direct support professionals employed by providers serving individuals with intellectual disabilities 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 those sectors.

The 2024 Ensuring Access to Medicaid Services final rule requires certain 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 mean states must publish their average fee-for-service hourly rates for indicated services, and 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 do include a couple of key confounders and are not required to be published, and they do not result in the publication of average wage rates, which is the piece of the data that states most report that they need in the rate-setting process.

So where that leads us next, as I noted earlier, states need timely, accurate, available data to develop or update rates, and there is no single data source that captures wages for all HCBS worker types across states and programs.

Findings from our interview and technical expert panel show the importance of wage data in setting rates. Stakeholders acknowledge wage data alone are not sufficient for developing payment rates that address workforce shortages, and wage levels reflect existing workforce structures and budget constraints.

That said, our state participants emphasize that robust, accurate, and timely wage data provide them with a critical starting point for building HCBS rates that promote an adequate workforce.

We heard from multiple state participants that the lack of HCBS-specific wage data creates challenges for

states, and we heard specifically that more granular service and job class data would help states build wage assumptions that reflect nuances and operations of their programs.

While our participants acknowledged that state resource constraints can make rate adjustments difficult in some cases, they also noted that robust data are a critical tool for demonstrating the need for rate adjustments to state legislatures and to CMS.

As I mentioned previously, many states report relying on the BLS data as an input in HCBS rate setting, but clearly the BLS data brings certain challenges, generally linked to the nature of BLS as a data source for a system that is bigger than the Medicaid program.

Again, there's no specific job code for HCBS workers. BLS data do not include all Medicaid HCBS worker types, and existing job classifications necessarily include in the data non-Medicaid workers.

In the absence of more specific BLS job classifications, states may try to approximate what workers are paid by blending different BLS codes together, and states may also turn to their own internal data collection

activities to fill gaps in BLS data, which can create for them additional administrative burden.

The access rule will generate new data. These new provisions do not address the specific gaps we've identified through this research. While the rule requires states to report payment rates and compensation percentages for certain services, it does not require states to report average wages, which is the information that states rely on when building these rates.

The rule also does not require compensation data to be reported publicly, which is important given that states are often competing in direct care worker labor markets across state borders.

And finally, the rule requires compensation data for all direct care workers to be averaged and reported by service.

The CMS's definition of direct care workers includes a broad range of job classes, including home health aides and licensed practical nurses, who are paid a wide range of average wages, and this method may confound those data.

So given that background, I'll turn to our draft

recommendation language. Specifically, we propose the Secretary of the Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to require states to report on a biannual basis, hourly wages paid to home- and community-based services workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service, including mean, median, and range, and for each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to by licensed nurses and other direct care workers and by rural versus urban settings. CMS should build on existing related data collection activities and publish data in a public repository on the CMS website.

Because we found that 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, the existing data falls short.

Both BLS data and upcoming reporting via access rule requirements offer important inputs but don't fully

meet the precise need of states, which is access to timely, accurate, and granular data specific to Medicaid services and job classes.

With this recommendation, states could 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.

Leveraging existing data collection activities will permit CMS and the states to identify opportunities to build on rather than duplicate any other related data collection and reporting. And note that this recommendation does not dictate what assumptions, methods, or processes states may or must use to develop payment rates or what their payment levels should be. These data would instead create a resource that states are looking for while allowing them to maintain flexibility in their rate-setting approaches.

This tool might even allow states to reduce or eliminate other state-specific or state-led data collection activities in support of their own rate-setting processes.

So as far as the downstream implications of this recommendation, the Congressional Budget Office estimates

no impact to federal spending. States will receive data and resources that support improved rate-setting activities. While this may require building on existing data collection mechanisms, such as that required under the access rule provisions, it could have the effect of allowing states to sunset other data collection activities, such as provider surveys.

There is no expected direct impact immediately to enrollees, but of course, this recommendation is designed to promote a robust HCBS workforce, which ideally leads to increased or improved access to HCBS for enrolled participants.

There's also no expected direct impact to health plans either, but changes made in payment rates on the fee-for-service side may have downstream effects for payment under managed care models.

Providers may see minimal immediate direct impact, though additional reporting may be required of them.

So before I turn the microphone back to the Chair, I'll note again that this draft recommendation is slated for a vote at next month's meeting. Next month,

I'll also present a draft chapter reflecting the full complement of data collection and analysis that has led us here for discussion today.

I have just a couple questions I'd like to pose here, there on the screen. Are there suggested refinements to the language? Are there additional considerations to cover in the rationale for the recommendation, or are there other implications to the recommendation not considered here?

So during our discussion, I'll flip to the recommendation language again, so we have it front and center. And with that, I will turn it back over to the Chair.

CHAIR VERLON JOHNSON: Thank you, Katherine. That was very helpful in particularly outlining the kind of questions you want us to consider for sure.

So yes. So we are back at the draft recommendation. It's in front of you there, and so I will turn to the Commissioners to see if you feel like we got the detail right, the candidness is okay, and of course, the questions that Katherine specifically asked us to think about, to answer those.

So I'll open the floor.

COMMISSIONER PATTI KILLINGSWORTH: Verlon, my little hand is not working. So just my hand is up.

COMMISSIONER APRIL HARTMAN: I had a quick question. Some states will pay a family member that's caring for the family. Is that included in this? Will that be included in this data collection?

KATHERINE ROGERS: Some states do that in two different ways. In some places, family members may be employed by provider agencies, which is typically contemplated in the -- for example, in the access rule requirements as well.

There are also self-direction programs. I don't -- previously, we haven't contemplated disentangling those in this recommendation, but just making that distinction between what's required under the access rule reporting. But I can take that back as well.

CHAIR VERLON JOHNSON: Thank you.

Carolyn.

COMMISSIONER CAROLYN INGRAM: Yeah, I really struggle with the recommendation language because I don't think it gets to what we're trying to say, which is what is

a way to get more money to individuals in home care settings. And from the panels that we heard the people speaking about things, not just hourly wages, but also health care or time off or things like that.

So I really struggle also that this is going to be something more that states are going to have to do. I realize we asked about the cost to the federal government. I worry more about the pressure on states with everything else going on.

So the changes I'd recommend is to take out the language about making it biannually, making it maybe annually instead. I'd like to hear from folks why we decided to include the language around mean, median, and range. Why don't we just say average or the mean? I'm not sure why we need all of those things in there. So I would recommend taking those out and basically giving some more flexibility probably to CMS to build this out the way they think it would be easiest for states to report it.

Again, I struggle because I don't think it really -- once this gets reported, I feel like states will see it, but I don't know how that's going to help change the wage that might be paid in New Hampshire, for example, versus

Virginia with there's so many different factors. They're dealing with what's available legislatively, what other programs might be in place for home care workers, what other benefits can they be given. And so I just struggle with it. Sticking a report on is just causing more administrative costs. It's not really getting to what we need.

So I'd recommend we just make it more flexible if we were really going to go forward with the language. Thank you.

CHAIR VERLON JOHNSON: All right. Thanks, Carolyn.

Patti.

What? Oh, I'm sorry. Did you -- Katherine, did you want to address anything that Carolyn said? Okay.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Katherine, I was just hoping you could help me understand a little bit or make sure I understand about the intersection of our recommendations and the requirements of the access rule.

So since the access rule is going forward, if we were to make these recommendations and the Secretary were

to make the directive, how would our recommendations intersect? Would then they both be required? Would we expect to see a revision to the rule? I'm just trying to make sure that we're refining and not duplicating sort of reporting requirements. And I don't really quite understand how they all fit together.

KATHERINE ROGERS: So as written, this is designed to require data that are not currently required to be reported under the access rule but to build on existing data collection efforts. And so as CMS implements data collection for those related pieces of the access rule, hoping that, as you said, that this is adding -- or this is relating to but not duplicating those data.

And I would just note, I think the distinction is these are things that are not already required to be reported under those provisions, but they are clearly -- you know, they are very related, and so it seems like a natural alignment.

COMMISSIONER PATTI KILLINGSWORTH: That's helpful. Thank you.

I just want to go on record as saying, I do think the data is important. I think it's really hard to make

good policy decisions without really understanding the current lay of the land, and I think in most states that's data that's not available, at least in a way that can really support good public policy.

So my concern is twofold. One is administrative burden, which Carolyn has already raised, and I certainly always agree with that. We want to minimize burden where we can.

But I also think that if we begin to collect data, it needs to be done in such a thoughtful way so that at the end of the day, states really have the data, CMS has the data, we have the data that's really, again, needed from a public policy perspective. So we could require a lot of things and still not have what we need to make good decisions.

So maybe this additional time between now and when we actually vote on a recommendation, we can just make sure that we've honed in on that as much as we can to get what is needed, no more than what is needed, and in the least administratively burdensome way.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti.

Let's see. Heidi.

COMMISSIONER HEIDI ALLEN: Hi. Thank you for this. I want to go on record supporting this recommendation.

I agree with Carolyn that the justification for biannual isn't clear in the document, why that over annual, but I disagree with the idea of just providing the mean. The median and the range help us interpret the mean and understand the distribution, which is really important, and particularly when you start to look at the distribution in different sectors, it really gives you a sense of, you know, really what we're trying to get at, which is are people making enough money to want to do this work?

So thank you for this, and I look forward to seeing it in October.

CHAIR VERLON JOHNSON: Thank you, Heidi.

John.

COMMISSIONER JOHN McCARTHY: I guess where I struggle with this one is when we said there's no cost on this one, because there would have to be a cost for providers to be reporting this data in some way, shape, or form. Especially if it's twice a year, they would have to

report that.

So I would assume then states would have to pick up the increased rates to cover the cost of doing some of these things. Otherwise they're going to -- you know, the response will be employees won't be able to make as much money.

So, you know, I think this is a tough one, because when we talked about this before, I had said in doing rate setting in this area, this information can definitely be used by a state to set rates. On the other hand, you don't have to have this information to set rates. So it's back to like, what are we using it for? And so I'm just still struggling on this recommendation, and I don't have any new words for you to use but still just struggling if this is the right direction to go.

CHAIR VERLON JOHNSON: Doug.

COMMISSIONER DOUG BROWN: Biannual like twice a year or every other year?

CHAIR VERLON JOHNSON: Twice a year, right?

KATHERINE ROGERS: Every two years.

CHAIR VERLON JOHNSON: Every two years. Okay, there we go. I thought it was every --

COMMISSIONER DOUG BROWN: [Speaking off microphone.]

CHAIR VERLON JOHNSON: Yeah.

KATHERINE ROGERS: Okay. We'll take that back.

CHAIR VERLON JOHNSON: Okay. Thank you.

Thanks, Doug, for bringing that up.

Michael.

COMMISSIONER MICHAEL NARDONE: I just -- I had a question, and I just want to make sure I'm understanding what this is proposing. I was under the -- what I understood is that some of this was really to build off of the requirements that are currently in the access rule.

So the requirements around when the reports come in, which I thought was every two years, was based off of what's required of states in the access rule, and that those categories that you've chosen are specifically related to the categories that are identified in the access rule.

So I just wanted to be clear because I am also always cognizant of what the administrative impact of some of these changes might be. But what I -- in my reading and my understanding of this, I think what I was understanding

is that this information, to a great extent, really flows from information that states would also already have to do in order to put together -- in order to report pursuant to the access rule. So I just want to make sure that that's -- I'm understanding that.

KATHERINE ROGERS: I can, you know, just say that, again, our intent was to the extent possible, and this is in part up to how CMS designs the reporting templates or requirements for the access rule, but to facilitate, as much as possible, reporting that minimizes the administrative burden and indeed relies on data that's being collected for -- to the extent possible, again, data that's being collected for another purpose.

COMMISSIONER MICHAEL NARDONE: But is it more of a math exercise? Because they're collecting the data on -- they're collecting the data to be able to report on, you know, how much -- what the reimbursement rate is for these various services? Or is it really like a full-blown collection activity that has to happen at the state level? That's what I'm trying to understand a little bit in terms of what the workload would be.

KATHERINE ROGERS: I think, prospectively, if a

data collection mechanism can be designed that collects all the information sufficient to do both at once, that's the most efficient mechanism.

We've left some flexibility in here, and so that would ostensibly be up to CMS in the design and implementation of data collection activities across these multiple data collection exercises.

But I would agree with you that there are pieces of data that would be used in both, and why not collect them at the same time in the most efficient way possible, so that you can answer both the measures reported through the access rule and these other data that would be helpful to states?

CHAIR VERLON JOHNSON: Do you have a follow-up question, Mike?

COMMISSIONER MICHAEL NARDONE: No. Thank you.

COMMISSIONER DENNIS HEAPHY: That was really helpful for me.

I support the recommendation. The one thing I -- what is the burden on states to do this twice a year versus once a year? What's the value of having it twice a year versus once a year?

KATHERINE ROGERS: I think partly that also links back to the question of, is this being reported through data collection?

COMMISSIONER DENNIS HEAPHY: Anyway, so why not just report it out? Yes, I got it. That makes sense. So they're doing it anyway. Just report it out. Yeah, then I think biannual is good. Twice a year is fine. Thank you.

CHAIR VERLON JOHNSON: Thanks, Dennis.

Anne.

COMMISSIONER ANNE KARL: Yeah. I just wanted to make sure I was tracking that because it seemed like when we were talking about biannual, do we actually mean -- can we just -- do we mean every six months? Was that what you intended? Because biannual, like when you have a biennium budget, which a lot of states have, that's for two years. So I just wasn't -- I assumed that it meant every six months, but then I got confused by the conversation.

KATHERINE ROGERS: Given this conversation, I'm concerned that I'm speaking for myself, but I intend -- like, I read biannual in here every two years.

COMMISSIONER ANNE KARL: Okay.

COMMISSIONER DENNIS HEAPHY: Oh.

COMMISSIONER ANNE KARL: So --

KATHERINE ROGERS: Because there seems to be widespread disagreement on this point. So I apologize for that confusion.

COMMISSIONER ANNE KARL: And then my other question is -- I think what you were saying in response to Mike is really helpful, but a lot is like the "to the extent possible" is doing a lot of the work in that conversation, you know, where it's sort of saying -- because, again, I think everyone agrees if they're -- or it seems reasonable to say, if they're already collecting data, all we're doing is, like, a slightly different cut of data that they already have. And it would make it markedly more useful, then this is great. If instead it's like a completely separate exercise, then that feels hard.

And my reading of it was that the view was that you're -- they're not really collecting more information. It's -- or it's quite close to what there is, but I think I'm not fully understanding when you say "to the extent possible," how much overlap we have. And the answer might be, well, we don't know until CMS puts out its guidance to be able to do that crosswalk, but I feel like that could be

helpful too.

EXECUTIVE DIRECTOR KATE MASSEY: Katherine, could I just make sure that I clarify and that we're on the same page in terms of the notion of what this is doing to build upon the access rule?

So if I'm understanding correctly, per the access rule, beginning in July, 2026, states are required to publish average fee-for-service hourly rates for many of the same labor categories that we're talking about here.

I think there was one critical missing component in the access rule requirements, which was there was no guarantee on behalf of CMS that those data would be made public and available to states. So there was one critical issue that we were fixing, which was the public availability of those data that would increase the usability of those data specifically for rate setting, as we had inquired.

I think the second issue is that beginning in July 2028, states are required to collect data regarding the percentage of Medicaid payments also for certain types of HCBS services, and that there may have been opportunities, especially given the data gaps that we had

identified through our work in the context of rate setting, where there might be enhancements also kind of tying back to our evidence base, where CMS might be able to talk about maybe a different way of presenting those percentages or presenting data that they were already collecting that would, again, leverage and kind of maximize the use of those data for the purposes of state rate setting.

So can you just confirm? Is my understanding correct, and am I kind of recalling our previous work correctly?

KATHERINE ROGERS: Yes. So there are -- and if you -- I guess, I think I can -- there may be some of this on the slides, but just in terms of what's captured on -- this might have it. There's an earlier -- here it is.

So -- and I expect this is, in part, speaking to Kate's point, building on these requirements that there are data here that are related to, but not fully reaching the extent of, the need that we've identified through our data collection but trying to lean on these requirements so that this could leverage the data that are being captured and build in what additional calculations or -- Kate also mentioned making the data publicly available rather than

collected by CMS and not publicly available.

Hopefully that helps.

CHAIR VERLON JOHNSON: Adrienne.

COMMISSIONER ADRIENNE McFADDEN: Yeah. Katherine, I just have, hopefully, a simple question. I think I'm -- in my brain, I'm having difficulty wondering if this is a complete data set, if we have the hourly wages, but we don't necessarily have the hours that are worked. Is that something that's collected elsewhere that would be paired with this in order to have a more complete picture? Because it may not make a huge difference if someone's making a significant hourly wage and they're working 10 hours a week versus someone who's making much, much lower and working 40 hours a week, and so just wondering if there's an element that's missing to make a complete picture on the wages.

KATHERINE ROGERS: So you're thinking how hourly wages turn into like annual wages. I can take that back.

CHAIR VERLON JOHNSON: All right. Any other comments or questions?

I struggle to where we are at this point, honestly. So it's -- I mean, it sounds like that's -- you

know, we have some clarification in terms of some of the definitions that we're using for sure. And I know, Katherine, you'll come back with that.

It also sounds like that we recognize that making sure that we have the data, it could potentially help with some of the gaps in data that we already have. It's important, but it also could be a reporting left for some of the states, which seems to be a concern of most folks.

I'm trying to -- what else do you have, Katherine, that you heard from the Commissioners?

KATHERINE ROGERS: I think all of this was helpful feedback.

CHAIR VERLON JOHNSON: Okay.

KATHERINE ROGERS: I'm trying to think if there's anything else I missed. I think I'm okay.

CHAIR VERLON JOHNSON: Heidi?

COMMISSIONER HEIDI ALLEN: I mean, do you want to get a sense for the temperature of the room about like -- I love the temperature in this room today, actually. I'm happily warm. Would that be helpful --

CHAIR VERLON JOHNSON: Yes.

COMMISSIONER HEIDI ALLEN: -- to kind of get a

sense of people who are, you know, with the conversation of clarifying the timeline, who would be in support?

CHAIR VERLON JOHNSON: Yeah. So, I mean, is there an idea? I mean, who at this point -- I guess at this point is completely not supportive because there's too many gaps in understanding. Okay. All right.

So, Katherine, let's go back then and let's kind of clarify what we have in terms of some of the questions that are out there, and then let's see where we can get to.

Does that make sense, Kate, for the next meeting.

But it was a very good conversation, and I appreciate you all really leaning into this for sure.

KATHERINE ROGERS: All right. Thank you all.

CHAIR VERLON JOHNSON: All right. Thank you.

VICE CHAIR ROBERT DUNCAN: All right. Up next we are going to do our continued work on behavioral health, and we've got Anu, Melinda, and I think Janice is also joining.

Welcome, and who's going to take the lead? All right, Anu, go ahead.

BACKGROUND ON BEHAVIORAL HEALTH IN MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

* ANUPAMA WARRIER: Thank you, and good afternoon. Today I will be introducing a forthcoming data analysis that will examine behavioral health utilization and spending in Medicaid and CHIP. This session is meant to lay a foundation for future discussions of the analysis by providing an overview of behavioral health and relevant policies.

I'll begin by providing background information on the topic of behavioral health in Medicaid and CHIP, followed by a discussion of prior MACPAC data analysis in this area and work to be accomplished during this analytic cycle, along with some other considerations for our analysis. I'll conclude with next steps.

Behavioral health conditions include both mental health conditions and substance use disorders, or SUDs. Co-occurring disorders refer to the coexistence of a mental health disorder and an SUD. In addition, behavioral health conditions are often co-occurring with other types of conditions such as intellectual and developmental disabilities, or I/DD.

Medicaid covers nearly one-third of adults with mental health disorders and around one-fifth of adults with

an SUD.

There is no federal or standardized definition for behavioral health services. Moreover, state definitions and coverage of behavioral health services can vary widely. This is because federal law makes certain behavioral health services mandatory and others optional for adults enrolled in Medicaid. Some examples of mandatory services include medically necessary inpatient hospital services, outpatient hospital services, and rural health clinic services. Examples of optional services include case management, respite, and certified community behavioral health clinic, or CCBHC, services.

Medicaid beneficiaries can receive behavioral health services in a number of care settings which fall under roughly four categories: inpatient or ED settings, outpatient settings, residential settings, and community settings.

Slide 6 highlights two key authorities in the provision of behavioral health services. The EPSDT requirement mandates coverage of all medically necessary Medicaid-coverable services for youth under age 21 enrolled in Medicaid, even if the state has opted not to include

those services in the state plan. EPSDT is not specific to behavioral health conditions but is important to ensuring behavioral health access. States with separate CHIP programs are required to provide behavioral health services to their CHIP enrollees but are not subject to the EPSDT requirements. However, states often provide EPSDT in their separate CHIP programs.

States can use state plan authorities to cover key behavioral health services for children as well as adults. For example, Section 9813 of the American Rescue Plan Act of 2021 introduced a new state plan option that offers states an enhanced federal match if they provide qualifying community-based mobile crisis intervention services. So far, CMS has approved 20 of these state plan amendments.

Next, we'll discuss the IMD exclusion policy, which affects where behavioral health services can and cannot be provided. The IMD exclusion prohibits Medicaid payment for any individual under 65 in an IMD, which is defined as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care with persons

with mental diseases."

There are some exceptions to the IMD exclusion which give the option to states and managed care plans to pay for services delivered in IMDs. The psych under 21 benefit allows states to cover services for youth under 21 delivered in psychiatric hospitals, psychiatric units of general hospitals, or psychiatric residential treatment facilities, or PRTFs. Although this is an optional benefit, states must cover treatment in a PRTF if an EPSDT assessment determines it is medically necessary.

For non-elderly adults, states may cover services in IMDs under a state plan option for beneficiaries with an SUD as well as the "in lieu of" services authority in managed care.

Finally, Section 1115 demonstrations permit states to pay for short-term, inpatient, and residential SUD treatment services in IMDs. States may also use Section 1115 demonstration authority to receive federal financial participation for providing behavioral health in other scenarios, which I'll discuss on the next slide.

Currently there are three Section 1115 demonstrations that include a focus on behavioral health.

The first is the SUD demonstration that has been adopted by many states as a way to receive federal matching funds for enrollees retrieving treatment in IMDs. These demonstrations aim to improve access to a full continuum of care for SUD, among other goals. As of August 2025, 37 states and D.C. have received approval for their waivers.

The second is a demonstration opportunity to allow states to provide care for people with serious mental illness or serious emotional disturbance in IMDs. Sixteen states and D.C. have received approval so far for these demonstrations.

The third is a demonstration opportunity to provide Medicaid pre-release services for the reentry population. The minimum benefit package includes medication-assisted treatment for all types of SUDs, and for this demonstration, 19 states have received approval so far.

And finally, there is a CCBHC demonstration, which was originally created by Congress in 2014, and has been extended and expanded several times since. The demonstration provides federal funding for participating states to reimburse CCBHCs, which are entities that provide

rapid response, individual assessment, and crisis resolution by trained mental health and SUD treatment professionals, deployed to the location of the person in crisis. In total, 19 states and D.C. have currently or formerly participated in the demonstration.

States can also use Section 1915(b) and 1915(c) waivers to provide behavioral health services to their beneficiaries. 1915(b) waivers provides with the flexibility to implement and modify their managed care delivery systems by allowing CMS to waive certain statutory requirements for comparability, statewideness, and freedom of choice.

States can use 1915(c) waivers to provide home and community-based services as an alternative to care in institutional settings. States may operate several 1915(c) waivers, and may target them to specific groups, including children and adults with behavioral health needs.

Behavioral health services in 1915(c) waivers for children and adults may include respite care, peer support, intensive in-home services, crisis services, supported employment, and day treatment.

Medicaid enrollees can receive behavioral health

services through fee-for-service or managed care. Most states provide behavioral health services through managed care as opposed to fee-for-service, and three of the eight states that use a fee-for-service delivery system also use primary care case management.

Managed care arrangements fall under two categories: comprehensive risk-based managed care, offered through managed care organizations, or MCOs, and limited benefit plans, which can include prepaid inpatient health plans and prepaid ambulatory health plans. States can also choose to use a blend of the two systems in their approach to behavioral health service delivery.

While MACPAC has published over a decade of work on behavioral health, today I'll focus on one chapter, published in the June 2015 Report to Congress. This chapter used 2011 Medicaid claims data to examine the prevalence of behavioral health conditions, use of services, and expenditures for these services. This report found that in 2011, 1 in 5 Medicaid beneficiaries had a behavioral health diagnosis, but accounted for almost half of total Medicaid expenditures. It also found that 16 percent of non-dually eligible enrollees under age 65 had a

mental health diagnosis, and 4 percent had an SUD diagnosis.

Of course, that information is now over a decade old, which is why the Commission is updating this work. The purpose of our forthcoming analysis is to update and expand upon the June 2015 chapter, using 2023 T-MSIS enrollment and claims data.

This analysis will aim to answer the following questions. First, what are the demographic characteristics of Medicaid enrollees with behavioral health diagnoses? Second, what is their total spending? What is their spending and utilization of, specifically, behavioral health services, and how does that differ by beneficiary characteristics and delivery system? Third, how many enrollees used acute behavioral health care and how many used behavioral health services in other care settings, like residential settings or outpatient settings?

The upcoming analysis aims to explore enrollee utilization and spending by these key variables. We are hoping to be able to stratify by certain demographics, such as age, race and ethnicity, gender, and whether the enrollee lives in an urban or rural location. Other

patient characteristics that may be important to consider are dual eligible status and eligibility group.

We can also look at utilization and spending based on whether the enrollee had a mental health condition, an SUD, or an I/DD, which is often co-occurring with behavioral health conditions. We can also look at co-occurrences between mental health and SUD or a combination of all three condition categories.

We also plan to look at spending by whether the enrollee is receiving coverage for that service through a fee-for-service delivery system or a managed care arrangement. And please keep in mind that we are still monitoring and assessing the data quality of the analytic output, and therefore we may not be able to report on some of these stratifications.

Importantly, the data we are using to answer these questions come with certain limitations to consider. First, T-MSIS data cannot be used to identify enrollees with a behavioral health condition who did not seek treatment or received treatment not paid for by Medicaid and CHIP. As a result, using claims data to estimate the prevalence of certain behavioral health conditions could

result in an underestimate.

Second, when relevant diagnosis codes are missing from a claim, we can identify the service type but not the reason for receiving that service. And this can be important when we are trying to isolate behavioral health spending from total spending, for example.

Another consideration for us is how our work compares to other recent work in behavioral health. Last month, CMS issued its first-ever data book on behavioral health using T-MSIS data from 2022. Previous data books, which are statutorily required every year, had only provided information on SUDs. We will compare our methodology to the CMS methodology to identify where we align and where we differ.

During this meeting we welcome your questions and thoughts on the direction of our research. Specifically, are there certain factors that should be considered when we are analyzing the data? Is there any background information that you think is particularly important for contextualizing the findings?

Looking ahead, we plan to return in future meetings to present preliminary findings from the T-MSIS

claims data analysis. After the new year, we will begin putting together a publication containing descriptive findings from the analysis. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you. Commissioners, any comments? Questions? Heidi.

COMMISSIONER HEIDI ALLEN: Hi. Thank you. I'm very excited about this work. I quickly reviewed the chapter from 2015, and it has a lot of descriptive data on enrollee characteristics and diagnoses, which I think is really helpful. And I thought it was helpful the way that they brought it by dual eligible status, age.

But it doesn't really have anything about utilization, other than cost. So spend is interesting, but it doesn't have anything about the type of providers they were seeing, any of the CPT codes for different types of, you know, behavioral health services. It doesn't distinguish between substance use and other behavior -- well, because it doesn't provide anything on you, so you can't really tell. They're put together.

So I'd love to see us advance what was done in 2015 for a more sophisticated analysis that differentiates substance use disorder from other behavioral health. And I

think it's really helpful to know the spend, but I would have provided it separately for those.

But most importantly, I would really like to see the types of care that people in different age categories and with different diagnoses have access to. It seems like the care that somebody with SMI [serious mental illness] gets should look different than somebody -- you know, one of the things that's really common in the 2015 report is high incidence of episodic mood disorders. Are they getting in to see a therapist? I have no idea whether or not people who have -- you know, it's an evidence-based treatment that is shown to be as efficacious as psychopharmacology, and I have no idea whether or not somebody on Medicaid can go see a therapist. So that would be super, super helpful for me. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi. All right, Patti.

COMMISSIONER PATTI KILLINGSWORTH: I have lots of random thoughts, which I'll try to communicate in a succinct way. So, glad to see that we'll break it down by kids versus adults and by some of the specific populations.

I do want to reinforce some of the importance of

making sure that we identify the spend even if there is not a diagnostic code that would sort of identify a specific behavioral health condition. I think that's particularly an issue for the I/DD population, where a lot of the services that they receive on the behavioral health side are not linked to a diagnosis, a behavioral health diagnosis.

And the slide deck said that we talked about the services that are provided through B and C waivers, and I want to be sure that we're going to pick up those behavioral health services, because there are a fair number, especially for the I/DD population, of things like behavior therapy or ABAs [Applied Behavior Analysis] that are delivered through 1915(c) or even 1115 demonstration waivers and just making sure that we're not missing those buckets of spend, behavioral respite would be another.

A little bit concerned that we're going to miss some things that are kind of delivered through hybrid service delivery. Mobile crisis a great example, where sometimes there are grants given to community mental health providers or where a state agency may actually take on the role of delivering mobile crisis services.

We're just not going to pick up everything. So maybe there's an opportunity to dig in a little bit deeper on some of those more targeted areas that tend to not operate in ways that we can pick that up through claims data.

Let's see what else I missed, really quickly. Oh, I think the other thing is just noting that a lot of times it's hard to identify what exactly is included in a behavioral health service. For example, a lot of times mental health case management can include this real continuum of things that are provide from sort of typical case management to even in-person assistance. So it's really hard to be able to know. So just being attuned to that as we look at the data, if we're trying to figure out like what are people actually getting for the dollars that are being spent.

That's it for me. Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Patti. Jenny?

JANICE LLANOS-VELAZQUEZ: Oh, Patti. Sorry. I just wanted to respond to something Patti said. I just want to clarify that we won't be stratifying by waiver type when we're looking at behavioral health services the way

the analysis is currently structured. We can't capture that right now, but that's something that we could potentially look into for the future.

COMMISSIONER PATTI KILLINGSWORTH: But will you have the data? So will you have 1915(c) waiver claims and services that are delivered through 1915(c) waivers but are behavioral health in nature?

JANICE LLANOS-VELAZQUEZ: As it is structured right now, no.

COMMISSIONER PATTI KILLINGSWORTH: Oh, okay. That's sad.

JANICE LLANOS-VELAZQUEZ: It's something we can look into for the future, because, you know, building off of the HCBS data run we do have a way to pick up those claims. It just wasn't one of the stratifiers that we selected for this analysis, but something we can take back and see if we can add it back in.

COMMISSIONER PATTI KILLINGSWORTH: Okay -- recognize that we'll miss a significant part of how services are delivered, especially to like individuals with intellectual and developmental disabilities, I think.

EXECUTIVE DIRECTOR KATHERINE MASSEY: Janice, can

you remind everyone, actually, how we are stratifying within T-MSIS?

JANICE LLANOS-VELAZQUEZ: Yes. So we're looking at demographic characteristics at the beneficiary level, and then at the delivery system level we're looking at fee-for-service or managed care. So it's not that the 1915(c) waiver claims aren't included in the analysis. They are just not separately identified.

VICE CHAIR ROBERT DUNCAN: Thank you, Janice. All right, now Jenny, then Adrienne.

COMMISSIONER JENNIFER GERSTORFF: As part of the scope of the current analysis are ABA therapies included in your definition of behavioral health?

JANICE LLANOS-VELAZQUEZ: It's one of the services that we've considered looking at, but haven't assessed the quality of the data. So it's something we can take back and determine if it's something we can report on.

COMMISSIONER JENNIFER GERSTORFF: Yeah, I think given the growth of those services over the last several years, it would be very helpful to look at that and isolate it.

VICE CHAIR ROBERT DUNCAN: Thank you, Jenny.

Adrienne, then Tim.

COMMISSIONER ADRIENNE MCFADDEN: Yeah. So the danger of going after all these really smart Commissioners is they repeat things that you wanted to say, so I would like to echo what Jenny just brought up around the ABA services, and also what Heidi talked about with the types of care that are being utilized by the individuals.

And then maybe as a future note, it would be really interesting to me to have an additional stratification for SMI versus the other mental health category versus putting them in the same bucket.

VICE CHAIR ROBERT DUNCAN: Thanks, Adrienne. Tim, then Madam Chairwoman.

COMMISSIONER TIMOTHY HILL: So if I'm not framing this question right or not, I'm super excited about this and I think it's really important. I'm reflecting on the last chapter is 10 years old, right, and just thinking about the current context of some of the analysis we see, when you see growth in diagnosis codes over time.

So I think as you do the analysis, it's not so much about the analysis of the data but contextually, the world has changed in 10 years, about the stigma associated

with mental illness, the ability and the eagerness to report diagnosis, to even access services. I'm guessing you're going to see a growth, right, and I would hate that growth to be solely, well, the Medicaid population has gotten sicker. That may be the case, but it also may be the case that the system is now addressing issues that have always been there, but now the system is ready to sort of take those folks on. So having some of that treatment, I think, is going to be important.

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

CHAIR VERLON JOHNSON: What happened to Madam Chairwoman?

VICE CHAIR ROBERT DUNCAN: Madam Chairwoman. Excuse me.

CHAIR VERLON JOHNSON: First, I want to thank you all for this. Janice and Melinda, it's great to see you, and it is wonderful, Anu, for you to come up here. This is your first time, and you've done a great job. I just wanted to stress that out.

So I will say, I think my questions are already answered, but I couldn't figure out how to lower my hand.

So I will just a little bit maybe kind of repeat it, and it really is more about the access piece of it for me. You know, are there specific benefit or enforcement issues that we should be flagging when we think about coverage exists on paper but utilization, I think, has been mentioned already, maybe blocked by other things I think would be helpful, if that's something we could do.

And then also which populations see the widest access gaps. You know, when I think about postpartum depression, what's involved with reentry and things like that, you know, is there a difference. But understanding, too, the key variables we've already kind of pointed out, your assessment of the 1115 waivers and things like that. But just things I'd be curious about, for sure. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman. All right. Doug, then Jami, then Dennis.

COMMISSIONER DOUG BROWN: Thank you. My questions have also been answered except for this one. I know that you're going to do a comparison with the CMS book that was put out in 2022. I just want to point out that -- and your data is going to be from '23, which is great. In '23, the Consolidated Appropriations Act went

through, which opened up access to SUD meds from doctors, no longer need an X-DEA number. Providers could be trained and then used as some more providers are available.

I'm hoping to see, or I'd like to see the delta between kind of what the volume of scripts going through in the data was in '22 compared to '23, when you look at that, to see if that made a difference, to the degree that you can kind of flesh that out, since we're working on that MOUD project. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Doug. Jami, then Dennis.

COMMISSIONER JAMI SNYDER: Thanks so much for this important work. I'm going to echo Jenny's sentiment around the inclusion of ABA services. Also I think maybe Patti mentioned including crisis services, including mobile crisis as well as crisis stabilization. And then finally, I would be interested, too, because a lot of states now are focusing time and energy on peer support services, so I'd love to see an analysis of peer support services in your review.

VICE CHAIR ROBERT DUNCAN: Thanks, Jami. All right, Dennis, then Patti.

COMMISSIONER DENNIS HEAPHY: If it's possible I'd love to see data collected about folks who communicate using American Sign Language and these systems, that's available in T-MSIS. And also folks with physical disabilities. I'm part of a research project right now that's looking at alcohol use, and they have chosen different folks with spinal cord injuries or traumatic brain injuries as part of the population that they're examining right now.

In terms of services, I've got a whole list of services I'll send you -- acute treatment for substance use disorder, intensive community-based acute treatment for children and adolescents. There's a whole list. I'll just send them to you. Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Dennis. Patti, then Mike.

COMMISSIONER PATTI KILLINGSWORTH: Doug just jogged my memory about another note that I had made and didn't say anything about, and that is picking up the pharmaceutical spend. Because so much of the treatment I feel like revolves around, sometimes appropriate and sometimes inappropriate, use of pharmaceuticals. And so I

would love to see that as a part of the overall data, as well. Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Patti. Mike.

COMMISSIONER MICHAEL NARDONE: Just a quick question. Will this also pick up the total cost of care, or is it just focused specifically on behavioral health spend?

ANUPAMA WARRIER: So we will have spending split up, the total spend for that beneficiary as well as what we have determined to be behavioral health spending, as well.

COMMISSIONER MICHAEL NARDONE: Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Mike. Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: If not, I have a question. As I look to echo the sentiments of Heidi and Mike, you just hit on one of my points, as well. And you can tell me it's impossible to distinguish. But it's one thing to have spend. It's another if you're spending for the right service. And I'm using a case where we have children that come into our hospital with mental health needs. We're able to house them, keep them safe, but we're

not providing the right service. So there is a Medicaid spend for that, but they're not getting the appropriate treatment. Are we able to break down to see, in the spend, is it based on the right services, at the right place, the delivery system, or not?

JANICE LLANOS-VELAZQUEZ: Yeah, unfortunately using claims data we're limited in being able to determine what's medically appropriate versus what isn't. So it is just kind of spend based on what's on the diagnosis.

VICE CHAIR ROBERT DUNCAN: That's what I was afraid of. Thanks. I appreciate it. Dennis?

COMMISSIONER DENNIS HEAPHY: Is it possible to see, by state, which states spent more money on diversionary services versus hospitalizations, so you can actually look at where the spend is, and if it's less expensive to folks on diversionary versus hospitalizations?

JANICE LLANOS-VELAZQUEZ: What was that first service?

COMMISSIONER DENNIS HEAPHY: Oh, to look at the spend by state on diversionary versus hospitalizations.

JANICE LLANOS-VELAZQUEZ: Yeah, so we can look by state at hospitalization, and are you saying outpatient?

COMMISSIONER DENNIS HEAPHY: Yeah, outpatient services.

JANICE LLANOS-VELAZQUEZ: Yeah, yeah, yeah. We can look at that.

COMMISSIONER DENNIS HEAPHY: But like specific diversionary services. Either way, can you pinpoint certain services, like the ones I was talking about before, that Patti also mentioned, specific services?

JANICE LLANOS-VELAZQUEZ: It's something we can take back. We're looking at care settings, mainly, but it's something that we can look at, if we can look at types of services.

VICE CHAIR ROBERT DUNCAN: Thank you. Heidi.

COMMISSIONER HEIDI ALLEN: So I just want to make sure that we can differentiate volume from spend, because when you're just looking at spend, it's really hard to see that value proposition. Hospitalization is obviously very expensive, but people may be getting a lot of outpatient behavioral health care. But if you don't know how many visits it represents then it's really hard to interpret if it's bigger or smaller than inpatient. So something like number of hospitalizations, number of outpatient visits,

kind of thing, would be great. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi. Anyone else? This was fantastic work. Thank you. I think we gave you enough to fill your calendar for the next couple of years.

So now we will transition to another one of my favorite topics -- oh, we've got a break? That's even a better topic. So we'll take a break and be back at 3:15.

* [Recess.]

VICE CHAIR ROBERT DUNCAN: All right. We are back, and we've got Linn and Ava joining us to discuss children and youth with special health care needs coverage. This is a follow-up to Phase 1 of the work, where they've done a federal and state policy scan. And so we look forward to hearing what you found and the process that it takes. Thank you.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS COVERAGE TRANSITIONS: FEDERAL AND STATE POLICY SCAN FINDINGS

* LINN JENNINGS: Good afternoon, Commissioners. Today we'll be introducing our work on children and youth with special health care needs and their transitions to

child to adult Medicaid coverage. And as Bob just shared, this is the second phase of our work focused on children and youth with special health care needs and their transitions to adulthood.

Last year we focused on the transition from pediatric to adult care and published our findings and four recommendations in the June 2025 Report to Congress. And during last year's work cycle the Commission expressed the importance of continuing this work and examining this transition from child to adult Medicaid eligibility.

For this work we're examining the transition to adult Medicaid coverage and how it may overlap with other age-related transitions, including the age-18 SSI redetermination and the transition between child-only and adult Section 1915(c) HCBS waivers. And with this work we aim to understand the transition processes and factors that facilitate the seamlessness of these transitions and support children and youth with special health care needs in maintaining their coverage.

Today I'll start by going through our project aims, and then I'll provide background on Medicaid-covered children and youth with special health care needs, and

summarize key federal Medicaid and SSI redetermination requirements. Then Ava will go through or describe how these federal requirements apply to the transition to adult Medicaid coverage and the transition from child-only to adult HCBS waivers. And then we will wrap up with next steps.

For the second phase of work, as I said we're examining the transition to adult Medicaid coverage and how it overlaps with the age-18 SSI redetermination and the waiver enrollment transition. And we're examining federal Medicaid requirements for states renewing coverage for youth aging out of child Medicaid eligibility and how these policies interact with SSA, and the Medicaid enrollment process related to transition planning. We are also examining federal authorities states can use to improve the seamlessness of these transition and continuity of coverage, challenges beneficiaries experience with these transitions, and barriers to transitioning to adult Medicaid that could be addressed in federal Medicaid policy.

And also as we did with our first phase of work, we focused on a subset of children and youth with special

health care needs, focusing on those who are eligible through SSI-related pathways and the TEFRA, or Katie Beckett pathway for children with disabilities, either through a state plan or a waiver, and children who qualified to receive an institutional level of care.

To inform this work we conducted a federal and state policy scan, conducted stakeholder interviews, and also conducted an analysis of transitions to adult Medicaid coverage using T-MSIS data. This month we'll present our federal and state policy scan findings.

Almost half of children and youth with special health care needs are covered by Medicaid or a combination of Medicaid and private coverage. And states can cover children and youth with special health care needs both on the basis of income or disability. And it is estimated that about 15 percent of children and youth with special health care needs are eligible for Medicaid on the basis of disability, and the other 85 percent are eligible through another Medicaid pathway. And those eligible on the basis of disability are enrolled through disability pathways, which can include SSI-related pathways or state optional disability pathways, including the Katie Beckett pathway.

Focusing first on SSI-related pathways, states are required to cover individuals who receive SSI as a mandatory eligibility group. In general, most individuals who are eligible for and receive SSI payments through SSA are enrolled in Medicaid and then enrolled in one of these SSI-related pathways.

However, Congress has afforded states with some flexibilities related to how the SSI disability determination relates to Medicaid eligibility. And so there are three approaches that states can take when determining Medicaid eligibility on the basis of disability for SSI recipients.

The majority of states are called 1634 states, which refers to Section 1634 of the Social Security Act, and allows SSA to enter into an agreement with state Medicaid agencies to determine Medicaid eligibility for individuals who are eligible for SSI. And in these states, determination of SSI confers Medicaid eligibility, so individuals don't have to apply separately to be enrolled in Medicaid.

There are also SSI criteria states, where Medicaid programs use the SSI disability determination to

determine Medicaid eligibility, but individuals have to apply separately to be enrolled.

And then there are states that are call 209(b) states, which refers to Section 209(b) of the Act amendments of 1972. And this allows states to use the Medicaid eligibility criteria that are more restrictive than the SSI program criteria. In these states, individuals who are eligible for SSI have to separately apply to Medicaid.

There are also state optional disability-related pathways, and one of these is the TEFRA state plan pathway, which is also referred to as the Katie Beckett state plan option. This can cover children with disabilities up to age 19 whose family income would otherwise be too high to qualify for Medicaid or SSI. Some states also use a similar option, using at 1915(c) HCBS waiver.

States have the option to use waiver authorities and state plan options to provide HCBS. In our state policy scan we focused on waivers that limit eligibility to children only. In our state scan we identified 51 age-limited child-only 1915(c) waivers across 34 states, and 28 states have a Katie Beckett-like waiver that covers

children who qualified to receive an institutional level of care but whose family income exceeds the income eligibility.

When Medicaid-covered children and youth with special health care needs approach adulthood, they need to be redetermined for Medicaid to maintain coverage as an adult, and depending on whether they received SSI as a child, they may need to be redetermined or apply for SSI as an adult. And further, those who are enrolled in or aging out of a child-only 1915(c) waiver may need to enroll in an all-ages or adult waiver to maintain access to those same services.

Medicaid statute and its implementing regulations do not include specific requirements for children and youth with special health care needs who are transitioning to adult Medicaid eligibility, but there are federal Medicaid requirements and guidance that apply to those navigating these transitions. In these next few slide I will review those requirements.

States are required to provide 12 months of continuous eligibility for all Medicaid- and CHIP-covered children under age 19, and in advance of turning 19, state

Medicaid agency will conduct an annual redetermination. For all beneficiary redeterminations, states must first attempt to confirm ongoing eligibility using reliable information available to the agency without requiring information from the individual, known as ex parte renewal.

Federal rules also specify the next steps and circumstances in which states cannot redetermine beneficiary eligibility on ex parte basis. So if additional information is needed, the state must notify the beneficiary and provide a renewal form for them to provide that information. If the state identifies information that will lead to a termination or a change in eligibility, the state is required to contact the beneficiary and offer them an opportunity to provide new information prior to making changes to the eligibility.

Additionally, prior to termination, states must consider all bases for eligibility.

For individuals who are eligible for Medicaid on the basis of disability, the redetermination process includes the state confirming the disability determination in accordance with 1634, SSI criteria, and 209(b) rules.

Individuals who are determined eligible for SSI

as a child have to have their SSI eligibility redetermined at age 18 if they want to continue to receive SSI benefits as an adult. And this redetermination process must be initiated within a year after turning 18, by SSA. SSA is required to notify children with SSI in advance of their age-18 redetermination so they can prepare.

The SSI criteria for determining whether an individual has a disability differs for children and adults. For children, a disability is determined based on functional limitations, and the functional abilities of children are compared to those of children without impairments. For adults, the disability determination is based on the ability to work and perform substantial, gainful activity, and only the adult's income and assets are counted.

Due to these differences in child and adult disability eligibility criteria, not all individuals who are eligible as a child will be eligible as an adult. Data from 2023 shows that 48 percent of children who were redetermined at age 18 were eligible as adults, and of those who were not determined eligible, 42 percent appealed.

States operating an age-limited 1915(c) HCBS waiver must provide transition planning for beneficiaries enrolled in these waivers, and transition planning may include identifying and informing individuals about public programs and waivers that they might qualify for and providing them with priority consideration for other state waivers. However, the guidance doesn't specify or prescribe specific parameters related to the Medicaid redeterminations and continuity of coverage.

Findings from our review of child-only 1915(c) HCBS waivers identified variation in how far in advance this transition planning begins, who is responsible for supporting beneficiaries and their families during the transition of coverage, and what types of supports they might provide. Some states also specify the use of reserve capacity for individuals who are transitioning from one waiver to another, and may also reserve capacity specifically for individuals who are aging out of a child-only waiver.

And I will turn it over to Ava.

* AVA WILLIAMS: Thanks, Linn, and hi, Commissioners. In this section I'm going to talk about the

transition from child to adult Medicaid coverage and the transition from child-only to adult 1915(c) HCBS waivers, and how these processes can vary among child eligibility categories.

This figure provides a high-level overview of the Medicaid eligibility, including SSI redetermination and waiver enrollment processes, and how these three transitions relate to one another. The next two slides will zoom in on each of these boxes and provide a more in-depth explanation for each process.

Children and youth with special health care needs experience multiple transitions as they approach adulthood. The blue Medicaid eligibility box shows that for children and youth with special health care needs to remain enrolled in Medicaid as adults they go through a Medicaid redetermination, and may also go through an SSI redetermination.

For example, some beneficiaries may be enrolled in SSI, and in order to remain enrolled in SSI as an adult, have to be redetermined at 18.

The green waiver enrollment box shows that some children and youth with special health care needs are

enrolled in a child-only HCBS waiver, and when individuals age out of a child-only waiver they can transition to an adult one.

The arrow between the Medicaid eligibility and waiver enrollment boxes represents how these transitions often overlap and their outcomes can affect each other. For example, if a beneficiary loses SSI eligibility as an adult, this will affect their Medicaid eligibility. Also, waiver enrollment transitions can affect the beneficiary's Medicaid eligibility and eligibility pathway. For example, a Medicaid waiver can confer eligibility for individuals with higher income by waiving certain Medicaid eligibility requirements.

This figures zooms in on the Medicaid eligibility box from the prior figure and focuses on the Medicaid and SSI redetermination processes and how they interact during the transition to adult Medicaid. These arrows are meant to show the order in which these steps occur and not the timeline in which they occur. Additionally, the seamlessness of the transitions from child to adult Medicaid coverage can vary, depending on a number of factors that are visualized in this figure.

In this figure, the left column shows two groups of Medicaid-covered children, those who are enrolled in the SSI-related pathway and eligible for SSI, and those who are enrolled in another disability-related pathway. The center column shows the transition process and how the Medicaid and SSI redetermination processes may overlap. The right column shows the outcome after the redetermination.

For example, as shown in the first row, beneficiaries who are enrolled in SSI as a child need to undergo an age-18 redetermination process. During this process, their application is pending, which has no effect on their Medicaid coverage.

As shown in the right column, if a beneficiary remains SSI eligible as an adult, they remain enrolled in Medicaid on the basis of disability, and most likely on the same SSI pathway. If they are determined ineligible for SSI, the right column shows that the state is required to first attempt to confirm ongoing eligibility on an ex parte basis and consider all basis for eligibility.

The second row shows that beneficiaries who are not enrolled in SSI as a child may choose to enroll as an adult. If they are determined eligible for SSI as an

adult, they can transition to an SSI-related pathway, and if they are determined ineligible for SSI as an adult, or choose not to apply as an adult, a state is required to attempt to confirm ongoing eligibility on an ex parte basis, and consider all basis for eligibility.

This figure zooms in on the waiver enrollment box from the first figure, and shows the transition process from a child-only to an adult HCBS waiver and how it interacts with the Medicaid redetermination process The seamlessness of transitioning to an adult waiver can vary, depending on a number of factors that are shown in this figure. Again, these arrows are meant to show the order in which these steps occur and not the timeline in which they occur.

In this figure, the left column shows two types of beneficiaries, those who are enrolled in a child-only waiver and will age out and need to transition to an adult waiver, and those who are not enrolled in a waiver as a child and may choose to apply to one as an adult.

The center column depicts the waiver transition process, followed by the right column that depicts the effect the waiver transition outcome has on the

beneficiary's Medicaid eligibility pathway.

Starting with the first row, if a beneficiary is determined functionally eligible for an adult waiver, they can be enrolled, and as a result of enrollment, as shown in the right column, the beneficiary's Medicaid pathway may or may not change. The second row shows that if a beneficiary is not eligible for an adult waiver they will not enroll, but this does not affect their Medicaid pathway.

Lastly, it is important note that waiver, Medicaid, and SSI transitions can occur concurrently or at different times, so beneficiaries may have previously been redetermined for adult Medicaid before they transition waivers.

Thank you for listening to our presentation today. We ask for your feedback on the state and federal policy scan findings and how they affect the Medicaid redetermination process and the transition between child-only and adult HCBS waivers. We will return in October to present findings from our analysis of these transitions, using T-MSIS data and findings from our stakeholder interviews.

Now I will turn it back to the Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Ava. Thank you, Linn. I think you folks did a really nice job of trying to simplify a very complicated process, from the different states and different actions. So we will open it up with Patti.

COMMISSIONER PATTI KILLINGSWORTH: Linn, Ava, thank you very much. It is a very complicated process, and I think I understand it, and yet, at this time in the afternoon it still feels a little overwhelming, so I appreciate it.

Can you go back to Slide 14 for just one second, because I think there is one important point that I want to call out that is often sort of overlooked. You can be eligible, you can make a functional eligibility criteria for a waiver that covers adults, and still not be enrolled in that waiver if there's not capacity. So it's really the intersection of the 700,000 people who are on waiting lists for these waivers and people who qualify for them but maybe there's not capacity for them to transition into. So we should probably just take that into account.

As you begin to sort of dig into this data, I'm particularly interested in the sort of overall impact to

the Medicaid program, particularly when there are gaps in care related to these transitions. So let's say that we have, you know, youth who roll off of Medicaid during this transition, and then later they come back on. And then what do we actually see in terms of impacts to the Medicaid program as a result of that gap in coverage? Do we see increased costs when they're coming back in? Are they more likely to utilize inpatient services or ED services after they've had a significant gap in care? I know there is some research that points to yes, that's the case, that there are negative implications to the Medicaid program, as well as negative implications to the child and the child's health, which is, again, even more critical. Whatever we can sort of tease out in the data I think would be helpful. Thank you so much.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti. Good points. Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks. I guess I have more a question than anything else. As I was reading this, I kept thinking about kids receiving services in schools and the continuity of care between the services they receive in schools and those outside of schools, and

kids in school until their 22. How does this affect access to services and the continuity of care for those kids that may lose those services?

And I was also intrigued about Oregon, covering kids until they're 26. Because it seems to me, at a minimum they should cover them until they're 22, to get them through school, and the continuity of the services they receive both in and outside of school. And then beyond that, I guess it's up for conversation. But I just need to find out more about what Oregon is doing and how it's working out. But I don't have anything else.

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

COMMISSIONER HEIDI ALLEN: Thank you for this presentation. One of the things that I was trying to do when I was reading the materials and following along with the presentation is do some meaning-making in my head, like trying to put a context of what the family and child's experience is. And it sounds like, you know, you've presented very clearly that depending on whether you maintain your disability status as an adult you can either continue on or you could be put on a waiting list or you

can become uninsured.

And that part seems pretty clear to me, but where I really start to get confused on family experience is if you stay in the program and you move into either a new waiver program or just into adult Medicaid, how do your benefits change? You know, what do you lose access to? Are there things you gain access to? That's just kind of a black box for me, and I'm guessing it probably does depend state by state. But some insight into kind of common differences between adult Medicaid versus child Medicaid for kids with special health care needs would be really helpful, and just me making the importance of these transitions. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi. Anyone else? Yes, Mike.

COMMISSIONER MICHAEL NARDONE: Thank you for this report. I just wanted to highlight and make sure I understood one statistic that was in your report. So 52 percent of the children who are children with special needs are ineligible for SSI as they move to the adult category, and that seems like a really high percentage of people. And putting up any barriers, obviously, is a challenge

here. I'm just wondering, I guess we don't know how many of those kids actually finally get coverage as an adult in another pathway, potentially? I assume we don't have statistics on that, as I assume we don't have statistics on the larger number of people who are aging out from the children's waivers and then potentially going into the adult waiver stream.

So I just want to understand if that's kind of the state of play in terms of the information we have.

LINN JENNINGS: Yeah, so that's correct. The 48 percent who make it and 52 percent, and then I think it's about 42 percent who appeal. Those data from 2023 only kind of show a status, I think, through like six or seven months, kind of looking forward. But I think generally the stat that I've seen is about, like lowers to, I think, closer to like 30 percent or so who don't qualify as an adult. We'll share more next month from like interview findings.

But in general, I think one of the primary issues that came up -- or not issues, but primary differences -- is that the definition for a child qualifying as a disability is different than as an adult. And I think also

there are some differences in terms of some of the children will get support in employment and work. And so some, I think, also lose eligibility as an adult because they are working. But there are a number of different issues, and we'll make sure to share those next month.

Regarding kind of what happens to those who lose SSI, our T-MSIS analysis goes into this a little bit. It's hard to know exactly whether they've lost SSI. We can't look at kind of the SSI status. But our analysis kind of follows when you age out of child Medicaid eligibility do you remain enrolled, do you disenroll, or do you disenroll and return. And then looking at kind of the eligibility pathway that you were as a child and comparing it to the eligibility pathway as an adult.

So I think next month when we show some of those data, hopefully we will get at some of those answers of, well, if you lose SSI as an adult, how many are remaining enrolled after that, and which type of pathway are they going into, a MAGI or a non-MAGI pathway. So we'll get at that a little bit more, if that is what you were getting at.

COMMISSIONER MICHAEL NARDONE: Well, I was

curious as to how many kids fell through the cracks as they move from childhood to adulthood. And I was surprised by how high that number was. I mean, I understand the reason for it, but that seemed like a really high number, and it seemed like it potentially would lead to a fairly significant proportion of those kids not being eligible then as an adult. So I was just trying to understand that a little bit better.

LINN JENNINGS: Yeah, we'll make sure to bring those numbers back next month.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike. That was actually the question I had written down, as well, because that number stood out to me on that.

All right, Dennis.

COMMISSIONER DENNIS HEAPHY: I have similar questions, about what happens to the folks who appeal? What percent of the folks who appeal actually get that overturned and keep their SSI? Is it possible to get that information? And I guess also, is it state-dependent on whether the person gets to keep their Medicaid, if Social Security determines a person is able to work? I'm just confused about how the states' rules may not be

standardized across the country.

AVA WILLIAMS: If I'm understanding your question right, if a beneficiary's status, SSI status, changed to terminated, as we presented, states are required to try to figure out if they are still eligible for any other Medicaid eligibility pathway first with ex parte. And if they are unable to do it through ex parte they may ask the beneficiary for additional information.

COMMISSIONER DENNIS HEAPHY: I think it would be helpful to know what states do, or what percentage of kids fall of Medicaid by state.

LINN JENNINGS: Just to clarify, what percentage of those who are in SSI --

COMMISSIONER DENNIS HEAPHY: Who lose SSI, and then lose Medicaid, as well. I need to clarify my question.

COMMISSIONER HEIDI ALLEN: Well actually, I was going to say that's a really interesting question, because states that have more generous benefits might actually have a higher percentage of people falling off, and how you interpret that it might mean that they've been doing really well by kids. But they do so much better by kids than the

federal government. And so that's a really hard -- I think one thing that I think about is that everybody knows what when you apply for disability you get turned down the first time. You know, they have this whole field of lawyers, that their entire job is to walk you through the denial.

So I think that one of the things you were mentioning, a really important number is what's the end case. What's the end result. Do they end up in a program that allows them to get on Medicare or do they get Medicaid, or does it seem like maybe they're just completely left without resources. Yeah.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis. Thank you, Heidi. Anyone else with questions?

[No response.]

VICE CHAIR ROBERT DUNCAN: If not, Linn, Ava, we look forward to the report next month on some of the questions that we're asking. Again, thank you for the great work. And with that, Madam Chairman, I turn it over to you for public comment.

CHAIR VERLON JOHNSON: All right. Thank you so much. All right. So yes, let's go ahead and go to public comment, which will open now. And we do invite you to

raise your hand if you would like to offer comments. Please make sure you introduce yourself and the organization you represent, and we do ask for you to keep your comments to three minutes or less.

So it looks like right now we have Peggy McManus.

PUBLIC COMMENT

* MS. McMANUS: Yes, thank you so much. Can you hear me?

CHAIR VERLON JOHNSON: We can hear you, Peggy.

MS. McMANUS: Great. Congratulations to the MACPAC team for a really wonderful presentation and for making these slides so clear in such a complicated topic.

I co-direct Got Transition, and these issues are very near and dear to our heart, and we are happy to see that you are now looking at the transitions in coverage.

I also wanted to make the comment that there was a question from one of the Commissioners about the impacts of the utilization changes that happen when changes happen in coverage. And I know there is some nice work being done by Betsy Cliff at the University of Chicago, Illinois, and Elena Chen, who is at Boston Children's Hospital, and I'll send those along to Linn and Ava. Again, they are looking

at Medicaid claims data.

So thank you so much for this work.

CHAIR VERLON JOHNSON: Thank you, peg. We appreciate it. Any other comments?

[No response.]

CHAIR VERLON JOHNSON: All right. Seeing none, remember that you can always submit any comments that you have via our website, and you'll see the email on the screen. But I do want to thank you, Peggy, and all the future ones we'll getting, as well.

And with that we are now adjourned, and we will return tomorrow at 9:30 a.m. I hope everyone has a great evening. Thank you.

* [Whereupon at 3:45 p.m. the meeting was recessed, to reconvene at 9:30 a.m. on Friday, September 19, 2025.]

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PUBLIC SESSION

The Horizon Ballroom
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, September 19, 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
DOUG BROWN, RPH, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
APRIL HARTMAN, MD, FAAP
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
ANNE KARL, JD
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
MICHAEL NARDONE, MPA
JAMI SNYDER, MA

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:30 a.m.]

CHAIR VERLON JOHNSON: Good morning, and welcome back to day two of our MACPAC September meeting. We want to thank you all for our very productive conversations yesterday, and of course those insights will guide our next steps.

As we pick up on day two, we are going to start with health care access for children in foster care, and with that I will turn it over to Audrey, who is our senior analyst. The floor is yours.

HEALTH CARE ACCESS FOR CHILDREN IN FOSTER CARE

* AUDREY NUAMAH: Good morning, Commissioners. During our meeting last April, we presented background information on children and youth in foster care and findings on state approaches to meet the unique health care needs of this population and the challenges states face in doing so. Today I will review the draft chapter for the March 2026 Report to Congress. This is a descriptive chapter that builds on our June 2015 chapter on the intersection of the child welfare system and Medicaid.

The draft chapter provides background information

about children and youth in foster care, their health status, and utilization of health care. Then, it highlights key federal requirements of state child welfare and Medicaid agencies. MACPAC worked with a contractor to conduct a federal policy review, a literature review, and in-depth profiles of seven states. The chapter reviews our findings and highlights challenges and considerations for serving youth in foster care. Staff would welcome feedback on the tone, content, and clarity of the chapter.

Children and youth in the child welfare system, including those in foster care, represent a small but highly vulnerable segment of the Medicaid enrolled population. In 2023, approximately 343,000 children were in foster care in the United States. The chapter provides more demographic information about children and youth in foster care.

The chapter notes that the physical, behavioral, and oral health needs of children in foster care are greater than children in the general Medicaid population. Children in this population experience trauma before, during, and after placement in foster care, and studies show that these traumatic experiences negatively impact

their physical and behavioral health well into adulthood.

For example, 33 percent of children and youth enter into foster care with chronic health conditions, such as asthma, childhood obesity, or developmental delays. Children in foster care are three to four more times likely to have a diagnosis of a mental health disorder, such as depression or anxiety. And 16 percent of children in foster care report having dental cavities or decayed teeth.

Children in foster care also receive fragmented health care when removed from their home and from having several placement changes, which ultimately leads to the lower rates of consistent health care utilization.

The use of psychotropic medications to manage the behavioral and mental health conditions of children in foster care has been a longstanding concern. One study found that these children are three times more likely to be prescribed psychotropic medications and are more likely to be kept on them for a longer period of time.

The chapter details the federal requirements for state child welfare agencies and state Medicaid agencies. As a reminder, the child welfare system encompasses programs intended to preserve families, protect children,

and achieve permanency that includes child abuse and neglect prevention, foster care, and subsidized adoption, though a majority of this chapter is focused on children in foster care.

The Administration for Children and Families, or ACF, within the U.S. Department of Health and Human Services provides federal funds through Title IV of the Social Security Act, to states to operate their child welfare programs via single state agency. Specifically, Title IV-E provides federal funding for child welfare assistance for low-income children who have been removed from their homes, and these children are automatically eligible for Medicaid.

As the legal custodians of children in foster care, state child welfare agencies are responsible for the safety and well-being of children under their care, including health care, but they may not use federal funding under the Title IV-E to do so. Therefore, federal rules require that state child welfare agencies take certain steps to coordinate with state Medicaid programs, such as developing and submitting Child and Family Service Plans, or CFSPs, to ACF. Each state's CFSP must include a health

care oversight and coordination plan, developed by the state child welfare agency, in collaboration with the state Medicaid agency, and in consultation with pediatricians, health care, and child welfare experts. State child welfare agencies must maintain individual case plans with a child's health history and current information for each child they serve.

States rely on a myriad of federal authorities to design and fund Medicaid programs aimed at addressing the unique health care needs of children in foster care. The chapter reviews the ways that children in foster care interact with the Medicaid system.

Children in the child welfare system are eligible for Medicaid through several federal statutory pathways. Children who do not qualify for Title IV-E may be eligible through other Medicaid pathways such as income eligibility, disability or health condition-based eligibility, or through optional eligibility categories. All states are also required to provide Medicaid coverage to youth formerly in foster care until age 26. The 2018 SUPPORT Act made coverage of former foster youth mandatory, even if they aged out of foster care in another state, and this

begins in 2031.

All Medicaid-eligible children, including those in foster care, are entitled to services under the Early and Periodic Screening, Diagnostic, and Treatment requirement, also known as EPSDT. However, one study found that nearly 33 percent of children in foster care enrolled in Medicaid do not receive at least one EPSDT screening, and about 25 percent received at least one required screening late.

State Medicaid agencies must design and implement programs to monitor and manage appropriate use of psychotropic medications by all Medicaid-enrolled children, including those in foster care, and submit program details to CMS as an amendment to their Medicaid state plan.

Finally, states are increasingly enrolling children in foster care and Medicaid managed care, including single, specialty managed care plans.

While child welfare rules state that state child welfare agencies must share medical information about children with Medicaid, the federal Medicaid rules allow, but do not require, state Medicaid agencies to share beneficiary information with other agencies, unless it is

related to establishing eligibility, determining the amount of medical assistance, or providing services for beneficiaries.

Because state Medicaid and child welfare agencies maintain disparate health care data collection systems for children in foster care, this puts these children at risk of overlooked health needs, delayed routine care, interrupted treatments, and misuse of psychotropic medications.

The draft chapter discusses the challenges states face in serving children in foster care system and the range of approaches that states are using to address this.

Federal and state Medicaid and child welfare stakeholders that we interviewed identified collaboration on policy, data sharing, and the implementation of new programs as the ideal approach to serving children in foster care, but this is difficult to achieve. At the federal level, stakeholders reported that this type of interagency coordination occurred on a sporadic basis, mainly due to demands of each individual agency to meet their own federal requirements. The chapter includes some examples of effective collaboration on the state level,

such as how one state established therapeutic foster care programs which involved braided funding. Other states have collaborated to transition children in foster care from fee-for-service or general managed care into specialty managed care.

Stakeholders reported ongoing challenges with effective data sharing. 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 these systems.

There are several factors that affect the health care needs of children and youth in foster care system and then the ability of state agencies to meet these needs. Some of the factors that are described in the chapter are unique to this population, while other factors affect access for all children but may have greater implications for children in foster care.

For example, research indicates that placement in foster care itself and subsequent disruptions in placement negatively affects children's behavioral health and their access to consistent care. While child welfare officials reported their focus is on preserving families and

preventing children from entering foster care, for those children who do enter foster care, stakeholders cited mobile crisis services and therapeutic foster care programs as promising strategies to prevent placement disruptions.

Due to the high prevalence of mental health conditions in this population, experts note that children in foster care need health care providers who are trained in trauma-informed care. To address access to trauma-informed care, several states have established partnerships with specific Medicaid providers to conduct these screenings for children in foster care.

State Medicaid and child welfare officials described difficulty in ensuring timely access to behavioral and oral health care for children in foster care due to provider shortages, especially in rural areas.

The chapter also describes how states are increasingly using a single specialty managed care plan to deliver Medicaid benefits to children in foster care. State and federal officials highlighted the ability of single specialized managed care organizations (MCOs) to implement population-specific initiatives to address the needs of children in foster care, and report population-

specific data and outcomes for children in foster care. These specialized MCOs also implement quality improvement activities focused on increasing health screenings for those in foster care.

Medicaid and child welfare officials, we interviewed in three states utilizing the single specialty MCO model told us that 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 concern regarding enrollees, all as benefits of utilizing a single specialty MCO.

Staff hope to get feedback on the tone, content, and clarity of the draft descriptive chapter. Are there any additional issues that are in the chapter that you would like us to further emphasize or elaborate on?

As a reminder, this chapter will be included in the March 2026 Report to Congress.

Also, I would like to mention that based on your feedback and interest from the April meeting, staff will begin an analysis on states' use of managed care to serve children in foster care, including specialty managed care

plans.

Thank you, and I turn it back to the Chair.

CHAIR VERLON JOHNSON: Thank you so much. That was very helpful and obviously a very important issue, one that I think many of us are very passionate about.

So with that I will turn it to the Commissioners. Again, they are looking for tone and content, any recommendations you think, not specific recommendations, but just recommendations to improve the chapter.

So with that, let's see, we have Patti first up.

COMMISSIONER PATTI KILLINGSWORTH: Audrey, thank you. I think this is really good work, and think the chapter in terms of tone and tenor is good. The content is very good. I have one single, I think, a little bit of additional clarification would be helpful.

We talk both about the average higher per-child Medicaid costs, but then we also talk about lower levels of utilization, like primary care and behavioral health care. So reconciling the higher costs with the lower utilization, I presume that that is higher utilization of more expensive services, more expensive service delivery. But just kind of explaining that, it just left me with a question.

I think overall my concern is I could replay 25 years in Medicaid and have almost the same presentation of this data, the system for children in foster care. And we've made some advances. I do think that managed care offers the promise of some opportunities for better coordination and collaboration. I am interested to see and be able to look into does that actually bear out. I think it does in some cases.

But what concerns me is we kind of talk about improved coordination and collaboration as opportunities, data sharing, new program implementation. But then we say, gosh, the states say this is difficult to achieve. So how do we paint a better picture for these kids? What are our recommendations as a Commission to help support improvements in the system? Are there evidence-based models that are working well?

Are there best practices that we would want to recommend? I know we mentioned mobile crisis, we mentioned therapeutic foster care, we mentioned the real importance of trauma-informed care being available to all these children. But what I don't want is for us to get 20 more years down the road and still be grappling with the same

issues as it relates to this system.

So I'd like for us, maybe as a part of the go-forward analytic cycle, but at least setting the stage for it in the chapter, to think about the so what, right. So this is how things are, and gosh, it's really hard to improve. But we have to find ways to improve, and being able to really home in on some of those recommendations. Thank you again for this work.

CHAIR VERLON JOHNSON: Thank you, Patti. Heidi.

COMMISSIONER HEIDI ALLEN: I really agree with Patti that I think we should seize the opportunity to hint at what innovation might look like.

I thought the chapter was great. I thought it hit so many important notes. I like that it talked about trauma-informed care. But like Patti, I would like to see more emphasis on how managed care could be engaged to solve problems. And one of the things that quickly comes to mind is the fact that it's a unique population that maintains their coverage in Medicaid until age 26. And there's a sentence about aging out, but it's really related to whether or not you can get Medicaid in another state. And I think that the aging out is such an important time for

thinking about ongoing utilization.

I just had my 19-year-old tell me, you know, I've been nagging him about getting a dentist appointment. And I finally called him on a Friday. It's been weeks he's supposed to do it. And he's like, "I'm going to call today to get an appointment for tomorrow." And I was like, oh, my God, there's so many things in that one sentence that show me that you don't understand anything about how health care works. It's Friday. You're not going to get an appointment for weeks, and certainly not on a Saturday. But he really had no idea.

And I think about these kids aging out of the education system, they age out of their foster homes, and they're supposed to know how to use health care. And of course they don't. They don't know how to make appointments. They don't know what care they're supposed to receive. And this is such a prime opportunity for managed care to step in. You know, child welfare probably is not going to take this on. But certainly managed care could. Like how do we prepare people to know how to be an adult consumer of health services in this period of time that they have until they are 26, where they are

continuously insured?

And so I would like to see a few places where we kind of emphasize this opportunity for things to look different and be better, and that's just one that comes to mind. But I think it's a great chapter. Thanks.

CHAIR VERLON JOHNSON: Thank you, Heidi. Angelo.

COMMISSIONER ANGELO GIARDINO: I concur that the tone and the content of the chapter is really excellent, so thank you. It was really well constructed.

Two things I'd like to just ask for our future work, is since this is at a system level, how do we encourage and promote a quality improvement approach to this, and what existing reports, data acquisition efforts exist that could be used?

You know, in previous work related to other topics, we talked about the external quality review organizations (EQROs) and the responsibility for states to evaluate their programs. And I'm just wondering, what can be embedded in that approach so that we can keep an eye on this very, very vulnerable population.

And then you had mentioned that some of the states say that the coordination between the different

agencies that help with these children is difficult, and I just wonder what the interagency agreement framework is for that. And I frequently hear these barriers that people perceive between Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) and all these other things. It just seems to me that that's knowable, and then some states have figured out how to harmonize those. And I wonder if we couldn't help promote some best practices so that states aren't trying to navigate through kind of what's settled in some other states where they have figured out how to do it.

But thank you, and I think this is really great work.

CHAIR VERLON JOHNSON: Thank you, Angelo. Sonja.

COMMISSIONER SONJA BJORK: Thank you. Nice chapter. I had a couple of specific comments.

On page 12, at lines 19 through 22, where you talked about the comprehensive managed care plans not being able to produce foster care-specific data, if you could change it to "some," because I work at a health plan where we are able to produce foster care-specific data, and we provide each county welfare agency with a dashboard about

the children from their county, and if they're getting their Well Child visits, whether they had emergency department visits, other very helpful information. So I just wanted to maybe add a little to that paragraph, that says that there are some states and some health plans that have successfully figured out how to do that.

The second part is on page 18. You have such a nice section on the specialty managed care plans. And I was hoping for an additional paragraph or a section on comprehensive managed care plans, where states have found out some successful pathways. So you don't have to cite California, but I'm going to bring it up as an example. Through changes to the contracts with the managed care plans, and through a comprehensive statewide policy -- it's called California Advancing and Innovating Medi-Cal (CalAIM) -- they have been able to require that the health plans and the county child welfare agencies enter into memorandum of understanding (MOUs). And that's where you can set out the roles and responsibilities. You can require meetings -- in our case it is quarterly -- where the agencies get together and talk about bigger picture issues. But it also creates a pathway to talk about

particular cases that are challenging.

And the way that comes about is each health plan is required to have a staff member that is called the foster care liaison. And in our health plan, because we have 24 counties, which that is a lot of child welfare agencies to work with, of course we can't have just one liaison to work with all the counties. So they have a staff, and those folks are available to attend team meetings and to work on some of these complex cases where multiple agencies are involved.

I mean, you can have a case where, I think you noted it in your chapter, it could involve the regional center. It could involve county behavioral health. It could involve the health plan and the child welfare agency, and then the foster family agency. Of course the family. So you can see how many different parties are involved in some really challenging cases. And this provides a really clear pathway for those conversations to happen.

Each health plan is required to post on their website the name and contact information for the foster care liaison. So even if it's a new social worker or a new foster family, at least they can find out who to contact

and get things rolling.

The specialty managed care plans are a great option for some states, and for other states I just wanted there to be a little bit of information about successful pathways for working with the comprehensive managed care plans.

So thanks a lot, Audrey.

CHAIR VERLON JOHNSON: Thank you. Dennis?

COMMISSIONER DENNIS HEAPHY: Thanks. I love the chapter. I think it was really good. I was wondering, though, I don't know if it would go in this chapter or a future chapter, and that's more emphasis on kids with disabilities. Ten percent of the kids have really complex medical needs, and what happens with those kids when they transition out of foster care. Do they end up in nursing homes?

And also there's a high percentage of these kids that have individualized education plans, and probably transition plans. But the foster care system falls apart at 18, and so what happens to these kids' educational plans? Like who is watching out for these kids? So I think I would like to see something about the need for

states to address. And I did some research and there's no uniformity in how states address this. There have been a couple of lawsuits, actually, and I can share information with you. I don't know if you want to put it in this chapter or for a future chapter.

But it really seems like there's a significant need to really focus on this segment of the foster care population. Thanks.

CHAIR VERLON JOHNSON: Thank you, Dennis. Carolyn.

COMMISSIONER CAROLYN INGRAM: Thank you for putting this together. There is so much work, obviously, in this area, and so you can't, I know, interview everybody and stick everything in.

But one area we talked about in one of the meetings was just the treatment of Native American children in the foster care system, and an acknowledgment, to bounce off of some of what Sonja said, even in states where there are specialty plans, the health plans that are not the specialty plan still have to set programs in place for individuals who decide to be in their plan, if they're not in a specialty plan, if they're Native American in some

cases.

So there's a lot of creation of similar programs and things to link especially those children back to their communities in some way, and I think we should make sure we include something in here about addressing the needs of the Native American population. And I'm happy to share more of that out of the contract in New Mexico, if that's helpful to you. I'm sure Arizona has stuff in their contracts, as well, Washington State, I bet Utah does. And those are states, some of them have specialty plans, but even with that, the what you would call regular managed care plans are still required, as Sonja stated, to have case managers who work with the foster care population.

So I think that there is a lot we are lacking in terms of talking about those. Specialty plans are great, but there is a lot also going on in the other areas, as well.

CHAIR VERLON JOHNSON: Thank you. Any other Commissioners with comments, feedback? I think the ones we got were very, very helpful. Audrey, anything else that you would need from us then? All right. Well, thank you so much. Oh, April.

COMMISSIONER APRIL HARTMAN: Audrey, thank you for that. As a practicing pediatrician, I just want to make a couple of comments. One, being from a state that has a specialty managed care plan, there are pros and cons. I wish I lived in California. It sounds like you have it going really good. But when you have these plans, these kids are high cost, and so a lot of times in order to manage the cost of taking care this population exclusively, there are things that impact the care at our level, which is like a very limited formulary, you know, or having to get prior authorizations for things that just make it more difficult to be able to get the care needed for these kids.

So just keeping in mind that, yes, having a specialty managed care might be good, but they also are trying to manage the cost of these kids that can be very costly, and how are they doing that, is something that's really hard to work around.

The other thing is the majority of kids that I see that are on in foster care, the foster parents are coming in. They've been trained on trauma-informed care so they're trying their best. But they have not been trained on the chronic conditions that a lot of these kids have.

So they bring these kids in, and they're like, "Oh yeah, he has asthma." And it's like, "Okay. Where's their inhaler?" "What inhaler? What's an inhaler? How do I use it?"

There's a piece that's missing in training these parents to take care of these kids that have chronic conditions, whether it's a medical or a behavioral health condition, that needs to be addressed at some level. And it makes it difficult for those of us who are boots on the ground. Thank you.

CHAIR VERLON JOHNSON: Thank you. Thank you, April. Sonja?

COMMISSIONER SONJA BJORK: One additional thing to consider is when we use the term "in foster care," I mean, involvement with child welfare can mean a family maintenance program so that children remain at home and they're getting services. And in way I described how California is approaching it, those families are eligible for extra services and can be the subject of these meetings and all the information that's going on, too. And I know a lot of times we focus on the children who remain in foster care and age out, and boy, that is the most vulnerable

population and the ones that we can track and we can make requirements for when young people age out.

So I just would request, look into whether you want to include in our chapter anyone with child welfare involvement. You know, sometimes people do a voluntary case plan, even before they get to maintenance. And if you would like to include people who are under guardianship, or now they've been adopted. So it could be broad or it could be narrow. I'm not trying to dictate the direction of the chapter, because we might really want to focus on the young people that remain in foster care until they age out. But just to consider the importance of providing all these services to families that are struggling to keep custody of their children. They need special help. They need counseling. They need all the different things that agencies have to work together to ensure. Thank you.

CHAIR VERLON JOHNSON: Thank you. And Patti.

COMMISSIONER PATTI KILLINGSWORTH: I just want to circle back really quickly on April's comments, because I think they were really helpful when we think about a look at models of effective care. And the notion of family-centered foster care and really being able to wrap around

foster families and provide education and support, that enables more stable placement so that kids aren't flipping between placements constantly. And possibly also enables permanency, right. A lot of times kids come into custody because their parents can't meet the needs that they have. So is there a way that through more effective, through better access to care we can support those families in ways that enable permanency back in the home again, and just looking into that. Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti. All right, so again, this was very helpful. Just reminding the Commissioners, if you have additional comments on this chapter, you can submit them to Kate, as well.

All right. Thank you so much, Audrey. We appreciate it.

[Pause.]

CHAIR VERLON JOHNSON: All right. So for our next session, JoAnn, our principal analyst, is joining us to help us characterize -- frame and characterize the health needs of youth in custody or reentering the community and how Medicaid fits.

And so, with that, I will turn it over to JoAnn.

All right. Thank you.

BACKGROUND ON WORK RELATED TO MEDICAID FOR JUSTICE-INVOLVED YOUTH

* JOANN MARTINEZ-SHRIVER: Good morning. Thanks, Verlon. Good morning, Commissioners.

As Kate mentioned, staff introduced work on juvenile justice last September, but since we're picking up this work again, we thought -- and there's been some movement in this area. We thought that a refresher, some background information would be helpful.

For this session, I'll start with a short introduction and framing of the issue. Then I will describe some population characteristics of justice-involved youth. I will then provide a summary of federal Medicaid policies related to incarcerated individuals. And lastly, I will close with next steps and any questions or thoughts that Commissioners have on the information presented.

Justice-involved youth, who I also refer to as "JIY" or just "youth," have some things in common with adults involved in the justice system. This is in terms of the demographic makeup as well as the significant unmet

health need that both populations have.

However, justice-involved youth, JIY, differ from adults in meaningful ways, and this is by virtue of the fact that they're still growing and developing. And they rely on others like parents and guardians for access for a lot of things, which can have implications for their access to health services.

The transition for youth, from incarceration to the community is a critical time for this vulnerable population that can have implications for future system involvement. As such, Medicaid is an important support, particularly since research shows that connecting people with services upon release can improve their outcomes and also reduce recidivism.

Now I'd like to provide a sense of who these youth are and what their health care needs are.

From a single-day count in 2023, there were just over 29,000 youth in correctional facilities across the country. This represents a 73 percent decrease over the past two decades, and almost the same goes for youth held in adult facilities, which declined 78 percent starting in 2008.

There are a number of factors that are attributed to these declines, such as reduced juvenile arrests and sentence lengths, also reforms that prioritize community-based rehabilitation options and diversion, which are interventions that steer youth away from formal processing. And even the COVID-19 pandemic contributed to declines during that time period.

JIY are largely male and older youth, meaning like 15 years old and above. And youth of color, low income, and LGBTQ+ youth are overrepresented in the juvenile justice system.

Despite the declines that I mentioned, there continue to be disparities among youth across all stages of the justice system, and this plays out in youth of color being more likely to be detained, formally prosecuted, referred to juvenile court, and charged as an adult compared to white youth.

And Black youth in particular continue to be overrepresented at 46 percent of carceral placements, despite comprising 15 percent of all youth across the country.

In this line graph, residential placement refers

to JIY who are held in public or private facilities where they've been charged with an offense, or their case has already been adjudicated and they've been placed.

This data from DOJ's National Center for Juvenile Justice shows the number of youth placed in correctional facilities across race and ethnicity since 1997, and you can see the decline in placement over time, but the number of Black youth remains higher than all other groups.

Youth who are involved in the juvenile justice system have high rates of unmet physical and behavioral health needs compared to their peers who are not incarcerated. In terms of physical health, this unmet need ranges from basics like needing childhood immunizations and preventive care to chronic conditions that are either untreated or undertreated.

JIY also frequently have complex and co-morbid health conditions, and in terms of behavioral health needs, it's estimated that most youth in carceral settings have mental health conditions. And JIY have a very high incidence of adverse childhood experiences, with as many as 90 percent of youth having experienced trauma.

There are also some important factors to note

about JIY that not only distinguish them from adults but also have implications for their access to services, such as child development. As I noted at the top, JIY are still physically, cognitively, and emotionally developing. So they need services that meet them where they are, and they also need providers who specialize in treating young people.

Education is another factor to consider. Even if youth are detained, they still have educational needs that should be considered, and this can be a complex issue, as many JIY have had negative experiences with education, which leads them to getting in trouble, skipping school, getting suspended, and all of those factors have some bearing on future or continued justice system involvement.

Also, JIY tend to be multi-system involved, as there is a significant overlap between youth in foster care and those involved in juvenile justice.

These JIY are often referred to as "crossover youth," and there can be, of course, some complexity in navigating both systems.

And then lastly, I wanted to mention parental consent. So youth are dependent on their parents or

guardians for access to health care and consent for medical decision-making. There can be some variation across states in terms of medical consent laws or even within a state, which can complicate getting timely consent and then access to services.

Given the challenging circumstances that these youth face in so many aspects of their lives, I'll turn now to an important support as federal Medicaid policy has been evolving to help smooth transitions from incarceration back to the community.

But before this shift, Medicaid paid for very few services for incarcerated individuals. Historically, federal Medicaid policy prohibits payment for health services for inmates of public institutions, including juvenile facilities, except when an inmate is admitted for inpatient care for over 24 hours. Then Medicaid would kick in. Even with this exclusion, Medicaid is an important source of coverage for JIY in the community.

Shifts in this longstanding Medicaid policy were ushered in by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) and later the Consolidated

Appropriations Act in 2023.

First, the SUPPORT Act, which prohibits states from terminating Medicaid eligibility for eligible youth who become inmates of a public institution. Rather, states are directed to suspend coverage during confinement instead. And suspending coverage can be done through an eligibility suspension, where the youth's eligibility is essentially paused, and they cannot receive Medicaid coverage, and the federal match is not available. Or it can be done through a benefit suspension, where the youth continues to be enrolled in Medicaid, but coverage is limited to inpatient services for at least 24 hours, as we mentioned. Either way, the goal of suspension is to facilitate more timely reinstatement of Medicaid coverage upon release and then, of course, quicker connection to services.

The SUPPORT Act also directed HHS through CMS to issue guidance on opportunities for states to provide pre-release Medicaid services to incarcerated adults and youth. This would be through a reentry Section 1115 demonstration waiver, and under such a demonstration, pre-release services can be provided up to 90 days before release and

include case management, medication-assisted treatment services, and a 30-day supply of medication, at a minimum.

Then the Consolidated Appropriations Act, or CAA 2023 required states to provide services specifically to JIY, and I will touch upon that. But before that, I want to talk a little bit about the waivers -- I'm sorry. Demonstrations.

In Anu's presentation yesterday, she noted that 19 states have approved reentry demonstrations. Fourteen of these include youth in their covered population, and six of the states with pending demonstrations include youth.

As you can see on the table, most of the states opted to provide pre-release coverage up to 90 days, and also, most are providing additional benefits beyond the mandated services, such as lab and radiology, treatment for hepatitis C, peer support services, things like that.

Then under the CAA 2023, states must provide certain screenings and diagnostic services to eligible youth 30 days prior to release, as well as targeted case management for 30 days before release and for at least 30 days after release. So states are in the process of implementing this requirement, which went into effect at

the beginning of this year, just in January.

And to help states comply and also manage some of the operational complexities of doing so, the Consolidated Appropriations Act in 2024 authorized four-year planning grants for states' activities to provide these services. And examples of activities that grant funds could be used for include --

I'm sorry. Advance. Sorry.

Examples of activities the grant funds could be used for include, like, establishing automated systems for claim processing or prior authorization protocols or investing in information technology to enable bi-directional information sharing for care coordination.

CMS awarded these grants just this year. So it will be interesting to see how states use them and to promote continuity of care and transition JIY into the community.

So next steps, I welcome Commissioner questions or thoughts on the background information I presented so far, and we'll return next month to share findings from the interviews.

Thank you.

CHAIR VERLON JOHNSON: Thank you, JoAnn. That was very, very helpful.

I will open it up for Commissioner questions or comments. Okay. There we go. Anne.

COMMISSIONER ANNE KARL: Thank you so much. This was so helpful, and I really appreciate the work that went into it.

just had a question about -- and maybe this is something you'll say. We've done the interviews, and we'll be coming back with the findings. But I would love to hear more about how states are doing implementing some of the SUPPORT Act and CAA and the waivers for that matter.

My understanding is it's been a little complicated to pull off, as you might not be surprised. So I would just love to hear more about states' experience with that.

JOANN MARTINEZ-SHRIVER: Yes, great. Thank you.

CHAIR VERLON JOHNSON: Dennis.

COMMISSIONER DENNIS HEAPHY: At least 30 percent of these kids have disabilities, and so I'm wondering -- and we're talking about Medicaid here. But there's such an integration between schools and health in this cohort. So

I'm wondering, are there MCOs that do a good job in connecting with schools and working to ensure the kid has their individualized education plan in place or -- because some of the kids in the school-to-prison pipeline were treated as thugs rather than -- or criminals, rather than recognizing they actually have disabilities. And so is there a way to actually integrate into what you write the issue of the lack of these kids being identified as having disabilities and the issue not being addressed in the schools themselves?

I don't know if that's appropriate for this or not, but it seems to me -- I'm frustrated with the fact that there should be some connection between what's happening in the schools, what's happening in health care, and there's just not.

JOANN MARTINEZ-SHRIVER: I agree. I think that we will touch upon it in findings, because education is definitely a part of it. And you're right. I mean, even having a disability can be a risk factor for juvenile justice as well. So thank you for that comment.

CHAIR VERLON JOHNSON: Yeah. I mean, just to add on to that, I mean, what's the data flow rate when we think

about that, too, from the IEP, 504, and all of that? That'd be helpful for sure.

COMMISSIONER DENNIS HEAPHY: Yep.

CHAIR VERLON JOHNSON: All right. Jami.

COMMISSIONER JAMI SNYDER: Yeah. Thank you for this important work.

I'm going to tag on to something Anne mentioned about sort of state experience. I'm really interested in what states are doing to assess the readiness of correctional facilities to participate in reentry activities and specifically their readiness and ability to really collaborate with Medicaid agencies, with managed care organizations, with community-based providers. I know that's an important piece of the equation, and we'd just love to hear more about that.

CHAIR VERLON JOHNSON: Thank you, Jami.

Anyone else? Mike.

COMMISSIONER MICHAEL NARDONE: Thank you for this presentation. It was very helpful.

I just wanted to reflect on something that I was thinking about as I was reading this chapter and reading particularly the factoid about 50 percent of the children

who are in justice-involved are also in the Child Welfare Survey System.

So I guess I'm not sure I know exactly how to do this, but I think I worry a little bit sometimes when we silo populations and say, okay, here is justice-involved youth, and this is what our recommendation is there, and here's child welfare, and here's what we do here. So I guess I'd like to maybe make sure that as you're evolving this work that there's good kind of linkages with the work on child welfare and vice versa.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Mike.

Other comments, thoughts, suggestions? April.

COMMISSIONER APRIL HARTMAN: I would also be interested -- thank you for that report. I would also be interested in knowing a little bit about what safety protocols are in place, because I think a lot of what is barriers to access is around safety, and so that it would be interesting to know who's handled that well and maybe if there's something that can be shared with others.

CHAIR VERLON JOHNSON: Thank you, April.

All right. JoAnn, was that helpful in terms of

the feedback you needed?

JOANN MARTINEZ-SHRIVER: Absolutely. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you so much. We appreciate it.

All right. I'll turn it over to Bob for the next session.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman.

We have Tamara coming up next to follow up on some of our work around HCBS and ARPA, the implementation investments of those funds and what's working. I ask the Commissioners as they listen to think through specific themes or topics that might be of interest as they look to put an issue brief out.

[Pause.]

VICE CHAIR ROBERT DUNCAN: Tamara is gathering her stuff.

[Pause.]

VICE CHAIR ROBERT DUNCAN: Good morning, Tamara. Welcome. We look forward to hearing what is taking place as you monitor the HCBS ARPA investments.

IMPLEMENTATION OF INCREASED FEDERAL MEDICAL

ASSISTANCE PERCENTAGE FOR HCBS UNDER THE AMERICAN RESCUE PLAN (ARPA): KEY TAKEAWAYS

* TAMARA HUSON: Thank you. Good morning. Sorry for the slight delay.

Okay. So today I'm going to provide a summary of MACPAC's monitoring work on Section 9817 of the American Rescue Plan Act, which provided states with a large infusion of funding to support home- and community-based services.

So first, I'll provide some background on the legislation, the guidance, and state activities. Then I'll walk through some of our lessons learned.

So let's start with a quick refresher of what was in the legislation. So ARPA was signed into law on March 11th, 2021, during the COVID-19 public health emergency. This was a very large piece of legislation, but today we're focusing on Section 9817, which used a temporary increase in the FMAP to generate reinvestment funds for states to support the provision of HCBS.

The FMAP was increased by 10 percentage points for certain HCBS expenditures -- for example, home health care, personal care, and case management -- that occurred

during the one-year period from April 1, 2021, through March 31, 2022.

To receive the increased FMAP, states had to use the federal funds to supplement, not supplant, their state funding for HCBS, and they were required to implement certain activities, specifically one or more activities to enhance, expand, or strengthen Medicaid HCBS.

The funding generated by the FMAP increase is estimated to have provided an additional $37 billion in state and federal funds for state-driven HCBS reinvestment activities, which is the largest infusion of one-time funding to support HCBS in recent history.

So to talk a little bit about guidance. So Section 9817 of ARPA actually lacked specificity in terms of how CMS should implement the law or how states should operationalize the new funding. It did not establish parameters around spending timelines or reporting requirements for states using the reinvestment funds. It also did not appropriate additional funds for CMS to implement the law.

Despite this, however, CMS issued guidance in the form of two State Medicaid Director letters, the first

published on May 13, 2021, and the second on June 3, 2022.

In the first SMD letter, CMS laid out the program requirements. It emphasized that states should use ARPA funds for activities that enhance, expand, or strengthen HCBS, such as by providing new or additional HCBS services and streamlining application and enrollment processes. The letter also noted that activities that are administrative in nature were not eligible for the increased FMAP, such as administrative claiming for activities performed by No Wrong Door systems.

It also laid out the maintenance of effort requirements, or MOE requirements, and these were that states, one, not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021; two, preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services in effect as of April 1, 2021; and three, maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

CMS guidance also required states to submit spending plans to the agency for approval to include details on how they would spend their ARPA funding.

Initial plans had to be submitted by July 31, 2021.

Then states had to submit quarterly spending reports and semi-annual narratives on their progress toward meeting their spending goals throughout their full implementation period.

CMS originally gave states until March 31, 2024, to spend the ARPA funds but extended that deadline by a year in the June 2022 SMD letter. Some states expended all of their funds by the March 2025 deadline or even earlier, while other states have requested additional time. CMS has granted extensions to 24 states, with the longest approved extension ending on April -- sorry -- not April -- September 30, 2026.

So according to a report from CMS on state spending, as of the quarter ending December 31, 2023, across all 50 states and D.C., more than 1,400 activities were proposed. And the five most common types of activities are those that are shown on the slide, and that includes workforce recruitment and retention, workforce training, quality improvement, reducing or eliminating HCBS waiting lists, and developing cross-system partnerships.

Since ARPA was enacted, MACPAC has been

monitoring state efforts to spend the funds and working to understand state experiences with implementation. MACPAC's monitoring approach included informal interviews with officials from CMS, states, and other stakeholders, as well as document reviews. For example, in 2023, MACPAC staff reviewed the first and second quarter fiscal year 2023 spending plans and narratives for all 50 states and D.C. for select information. We've also reviewed documents from other organizations, including CMS and ADvancing States, who have undertaken more comprehensive tracking activities.

MACPAC did not set out to duplicate those efforts and instead focused on convening experts to discuss ARPA implementation as it was happening.

MACPAC convened two panels, one in January 2023 and the other in January 2024, and panelists across those two included officials from four states, two policy experts, and a CMS official. And I'll note that transcripts from those meetings are available on MACPAC's website.

So the following findings that I'm about to share draw from these various monitoring activities.

Okay. So I'm going to talk through some of the

implementation challenges that we've heard about, as well as lessons learned. Our findings are broadly grouped into three areas: one, timing constraints; two, lack of advanced planning or requirements for evaluations; and three, an interest from states in sustaining their investments by making some initiatives permanent.

So to start with timing, we've heard a number of issues. So again, as a reminder, ARPA was signed into law on March 11th, CMS issued its guidance on May 13th, and then states had to submit their initial spending plans by July 31st, 2021. The short time frame made it challenging for states to draft comprehensive plans, and many states ended up including initiatives in their plans that they had not fully fleshed out.

State officials had limited time to consult with their governors' offices, legislatures, providers, beneficiaries, and other stakeholders. In many cases, state officials needed legislative approval for their ARPA initiatives, since the Medicaid agency was obligating state financial resources. The sequencing of the spending plan deadlines with state legislative calendars meant that some plans included initiatives that did not receive necessary

state legislative approval.

States that already had strategic plans, multi-sector plans on aging, rate studies, or other such shovel-ready projects were better positioned to include more complex initiatives or to add more initiatives to their plans.

CMS staff, similar to state staff, worked under compressed timelines to issue guidance and approve state spending plans. CMS issued guidance within two months of ARPA's enactment. Then they had to review and approve all the spending plans, which included iterative discussions with states to understand initiatives and ensure that they adhered to requirements such as the MOE.

For some states, CMS's strict interpretation of the MOE requirements prevented them from enacting certain changes, such as updating assessment tools or rate methodologies. It also impacted some states' decisions about timing, such as if they decided to take the extension to 2025.

The compressed timelines also limited CMS's capacity to streamline operations, which could have made submission, review, and approval of state spending plans

more efficient.

States were allowed to make changes to their spending plans after receiving initial approval, and many states did so multiple times. And those changes required additional discussions with CMS.

CMS officials also noted that with more time, they would have created standardized reporting templates for states. Every state's spending and narrative reports were formatted differently, which slowed down CMS review and made summarizing across all states more challenging.

States had to plan, implement, and in some cases, evaluate initiatives all within the three-year implementation period. Some states had to hire additional staff, which prompted considerations regarding whether to hire permanent employees or use contractors, as well as considerations around timelines for hiring those new staff or modifying existing contracts or developing new solicitations.

States also had to build in time to complete documents, like a waiver and state plan amendments, and receive CMS approval.

As I noted previously, almost half of states

needed additional time beyond March 2025 to fully expend all of their ARPA funds. States requested extensions for a variety of reasons. Some states invested in up-front planning, engaging stakeholders, and waiting for legislative approval, which then delayed the implementation of activities. States also made changes to their plans throughout the implementation period because they realized aspects of their plans were not feasible or because they received different legislative direction that caused them to change course. Some activities, such as IT or other infrastructure investments, also needed more time to be completed.

And I will also note that as of July 2025, CMS officials shared with us that most states with extensions only had one or two activities that were not yet completed. The majority of initiatives are complete, and funds have been expended.

Okay. To turn to talking about evaluations. So to gauge the effectiveness of ARPA-funded activities, many states conducted evaluations financed as part of their spending plans. Section 9817 of ARPA, however, did not include a requirement for states or CMS to evaluate

activities, and CMS guidance does not mention program evaluation.

In 2023, MACPAC staff reviewed a number of plans specifically for evaluation activities and found that many states had plans to evaluate pilot programs or a small number of activities included in their ARPA plans. Few states intended to evaluate their entire ARPA plans.

We heard that state staff capacity was stretched to incorporate some evaluation responsibilities. Robust evaluations typically use third-party evaluators, such as contractors or public universities, but generally states are using less formal methods and relying on state staff to run data and evaluate ARPA initiatives.

We also heard concerns with the short time frame to conduct evaluations using ARPA funds. States that included evaluation activities in their spending plans had to complete those evaluations by the end of the spending period, meaning that some evaluations overlapped with the implementation period or covered a shorter period of time than originally envisioned.

This also meant that in many states, evaluation results did not align with state legislative and budgetary

cycles, which may have affected some programs if officials did not have the data or results to justify the continuation of activities to appropriators.

Some states also noted challenges with collecting baseline data or with having adequate data collection methods ready to go in the short time frame before implementation.

And then finally, in states with many initiatives targeting the same activity type, such as those targeting the direct care workforce shortage, states encountered difficulty in isolating the impact of each initiative.

Okay. Finally, to talk about sustainability. So CMS guidance notes that in the narratives, states should explain how they intend to sustain such activities but does not give any specific parameters on how states should demonstrate sustainability.

As part of our 2023 review of spending plans and narratives, we found that about two-thirds of all states included detail on the sustainability of some or all of their ARPA initiatives.

And as noted by the CMS official in our January 2024 panel, states are sustaining about one-third of

activities that bolster the direct care workforce, such as payment rate increases, worker registries, and training programs. This official also noted that activities that required large upfront investments that states could finance through ARPA, like new or enhanced information systems, are more easily sustained than those that require ongoing funding.

Panelists expressed a strong desire to use ARPA funding to improve their state's HCBS infrastructure and make lasting changes. This included more complicated and time-intensive initiatives, such as reviewing and reforming Section 1915(c) waivers, investing in technology, adding additional Section 1915(c) waiver slots and reducing waiting lists, and adding specific services, such as behavioral health services.

Due to the time-limited nature of the ARPA funding and the ongoing PHE, however, some funding went toward immediate relief, while other funding was dedicated to longer-term initiatives. In particular, states wanted to get immediate relief to direct care workers and use funds for things like one-time bonuses.

Okay. Then to finish with next steps, our

immediate next step is to publish an issue brief summarizing our monitoring activities and lessons learned, and so today it would be helpful to hear from Commissioners if there's any particular lessons learned that you would like us to see further emphasized in the issue brief.

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

VICE CHAIR ROBERT DUNCAN: Thank you, Tamara. Appreciate it. I think there were a lot of lessons learned in that process.

Let's go to Patti first, please.

COMMISSIONER PATTI KILLINGSWORTH: Thank you, Tamara. Really, really good information.

So I think if I -- and correct me if I'm wrong, but I think if you were to sort of succinctly summarize it, it would be some really good things happened. It was not without a lot of pain, and it could have been better if we had done some things differently. Is that a fair sort of super brief synopsis?

TAMARA HUSON: For being very brief, yes, I think so.

COMMISSIONER PATTI KILLINGSWORTH: Okay. I know it's oversimplifying, but -- so I don't want the message to

be "Oh gosh, this was a waste of money. We should never do this again," right? I never want to look a gift horse in the mouth, and I will say I was at the state when this money became available. I was developing those plans. So I lived through these experiences.

And so I think really emphasizing the "so what." So if another opportunity presents itself in the future, what would we want to do differently? What would we hope Congress would do differently to make sure that we really -- states can really maximize the opportunity before them?

And I think part of that would be just sort of an -- overarching one-time investments are not the optimal way to really improve the system overall. It's not that it's not valuable, but longer-term investments that really allow states to use the dollars over time, I think is probably a more optimal use of funding if you're really looking for long-term improvements in the system.

I would say, too, I think the funding was well-intentioned but probably didn't take into account enough of the sort of practical operational challenges at both the state and federal level, things like budget cycles and time for states to really work through with their governor's

office and with their legislatures, how to make sure that these investments could be sustainable for the long term.

So in Tennessee, we were able, just by virtue of how our budget cycle worked and, quite frankly, a really responsive governor's office and legislature to get approval upfront as the part of the state's budget for the long-term sustainability of most of our investments. So all of the money that went into workforce improvements and wage increases, all of the money that went into waiting list reductions, all of that was approved to be sustainable for the long term.

That didn't work for everybody. If you have a legislative cycle that is -- I think, "biennial" has become the term that we've kicked around. But every other year, then there's no way potentially to be able to make that work, so just sort of thinking through those things.

And then I do think being able to be more thoughtful about evaluations and really being able to measure the "so what." So is this really having the impact that we hoped it would have on the workforce in terms of improving access to services for people, you know, to the extent that dollars went to waiting list reductions? I

mean, that's a pretty easy-- it had impact. But other sorts of initiatives that states undertook and really being able to measure those, and I think it's just really hard to do when you are limiting so significantly the time frame that states have to operate in.

So I'd like for us to kind of focus, I guess, in the issue brief in the -- how it informs potential future opportunities, highlighting some of the really good things that happened, but also noting ways that it could be better.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti. And you took my question about, well, the lessons learned as far as there were good things, but what could we have done differently to make it better?

With that, I'll go to Mike, then Heidi, then Dennis.

COMMISSIONER MICHAEL NARDONE: I would agree with Patti's comments. I think that what's very useful about this work -- so thank you for that -- is kind of leading the way to some of the things we would like to see in future initiatives, whether or not it's some of the

comments yesterday around community work engagement, community work requirements, or the new provisions in the legislation around the rural transformation grants. Like, what are some of the things you would like to see built into those initiatives? And this really kind of help -- leads the way to that.

I did also feel, which I don't want to paraphrase what Patty said, because she says it much more eloquently than I do, but just to say that I think there also were a lot of good things that came out of the funding, and I would, you know, hate for -- you know, I think it's important to highlight those, because I think -- or at least talk about some of the things that will be sustained into the future by states, because I think that, you know, this was, despite all of the issues that were raised, an important source of funding to help build some of the infrastructure, whether or not it was around, you know -- even when it was just an immediate, you know, one-time source of funding.

So I just think I would like to make sure that if we're -- in doing the issue brief, that there was some balance around that in terms of also highlighting some of

the positive things and some of the positive lessons learned.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike.

Heidi.

COMMISSIONER HEIDI ALLEN: You know, Patti already said this, but I want to kind of emphasize that, you know, so often we struggle here in MACPAC about feeling like states are very overburdened and, you know, we shouldn't be asking for mandatory data collection, we shouldn't be requiring evaluations. And yet I think this is a perfect example of where I think we suspect a lot of good was done, but it's just really, really difficult to capture and take those lessons and use them in the future when we have more limited funds and we want to make targeted changes. You know, you really want to say, okay, what gave us the biggest bang for the buck? And when we don't ask for evaluations and we don't mandate data collections, we find ourselves in situations where we can't answer basic questions about the program.

And I think it also makes us very vulnerable to these kind of broad assertions that there's not enough transparency in Medicaid, that there's all this money spent

and we can't say how.

And so I just -- you know, as like a big-picture thing for our Commission, you know, while we always want to be cognizant of the burden that we're placing on states, we also need to be cognizant that we make them very vulnerable when we don't have data that supports how money was spent in an efficient and effective way. So that's kind of the big lesson for me.

VICE CHAIR ROBERT DUNCAN: Thanks, Heidi.

Dennis, then Jami.

COMMISSIONER DENNIS HEAPHY: There are several things. Provide states the opportunity to do like a quick gap analysis and look at what are their priorities, because I don't think states often have that opportunity to look at, like, if we have this money, where are we going to spend it today? And so that was an opportunity that I think would help us to better understand moving forward how do states actually determine what their priorities are.

In terms of the projects themselves, the investments in home and direct care workers and the one-time increase in pays, all those sorts of things, it would be really helpful to see how those worked in states to

reduce reductions in access to home-based services. I think that's where a lot of the money went, and that might have been the biggest bang for the buck. So better understanding that.

And then I think just seeing, like, what some creative things did, states did, like California did an initiative to create a dashboard, and what did other states do as well? I think any best practices stand out, but I do think the workforce piece is critical here.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Jami.

COMMISSIONER JAMI SNYDER: Yeah, I would just echo the sentiments of several of my fellow Commissioners.

I was there on the ground in Arizona, like Patti, when we developed the plan in an abbreviated time frame. I think it prompted us to pursue some really important initiatives that we had been contemplating for years, and it gave us the funding to do so.

But the abbreviated time frame for both the development of the plan and the execution of the initiatives was so challenging that I felt like we weren't as thoughtful as maybe we would have liked to have been in

terms of, for instance, soliciting stakeholder input to ensure that not only the plan and the initiatives articulated in the plan were reflective of community need, but also the way in which we were pursuing them was consistent with community need.

I think that states, frankly, did the best that they could, given the parameters that were set forth and the timeline that was available. But I think going into the future, this is something that policymakers should think about as they work to support Medicaid programs and support some of these important efforts. In particular, in the home- and community-based services space, it's just important to think about, for instance, the timeline associated with those efforts and ensuring that states have the appropriate time available to establish plans that are going to be meaningful, more meaningful long term.

VICE CHAIR ROBERT DUNCAN: Thank you, Jami.

Tim, I saw your hand go up. You still --

COMMISSIONER TIMOTHY HILL: Yep.

And I just -- sort of reflecting on this, thinking about the broader context and wondering if there's something more general we can say, right, setting aside the

struggles and the start-up around HCBS, this was, at the time, a response to a crisis and Congress and CMS putting a lot of money on the table to help states get through what was a crisis, not unlike what was done after the housing crisis with some of the investments that were made in Medicaid.

And so I wonder if there's a broader picture or a broader set of recommendations or discussion that could be made for Congress and for -- not that they'd ever listen to us all the time, but broader recommendations on how to structure these kind of emergency investments or crisis-related investments such that they really are going to pay off over time.

VICE CHAIR ROBERT DUNCAN: Thank you, Tim.

John.

COMMISSIONER JOHN McCARTHY: I just want to reiterate what Tim said, because I think in these situations, Congress is trying to solve a problem. They can only move so fast, too. And I don't want us to look like we do some evaluation that looks negative on something or positive.

But even with the rural health transformation

funds that we see, these are very short time frames, and so if there's something we can look at, like lessons learned, Tamara, just from a standpoint of timing on these things, from a standpoint of is it best that it's all the money up front or over a period of time so that you can do a few more things, or it's staged, so it's like you get one chunk of money for, like Jami was saying, certain ideas, and then there's a second round that you can go to versus you've got to turn a plan in all up front, and then all your funding is tied to that.

CMS did a very good job, I would argue, of allowing states to then make adjustments to those plans as they went forward. So it's how do you tie those things where you've got a crisis and you need to get funding out, but at the same time, you want to see some type of return on investment for those dollars.

VICE CHAIR ROBERT DUNCAN: Thank you, John.

Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: Seeing none, Tamara, again, I think great work. I think, you know, sitting here, the themes were quickly as, you know, what

recommendations we would recommend if another crisis occurs and Congress acts, how we would recommend steps to do that. But I also think highlighting the positive outcomes and the good things that did come out of this, because I want to echo my fellow Commissioners' comments, there were a lot of actually good things that took place from this work in a short period of time. So thank you for the work.

If you need anything else, let us know.

All right. Now we will transition to our last session of the day. We'll talk about MMP, Medicare-Medicaid Plan Transition. This is a follow-up to our last discussion. And so we have Michelle and Kirstin joining us to walk us through. Good morning, and welcome, ladies.

MEDICARE-MEDICAID PLAN TRANSITION

* MICHELLE CONWAY: Good morning. We'll be closing out the meeting today with an update on the Medicare-Medicaid Plan transition, this time focusing on what we heard from our stakeholder interviews about procurement, information technology, enrollment, and stakeholder engagement. And as a reminder, we last updated the Commission on this topic in April 2025.

I'll start with some background on the transition

and what we've presented to the Commission previously as part of our MMP monitoring work, and I'll walk through some high-level findings we heard from state and CMS colleagues on procurement, IT system changes, enrollment, and stakeholder engagement.

Starting with some background, the Centers for Medicare and Medicaid Services launched the Financial Alignment Initiative, or FAI, demonstration in 2012. States were able to test several models as part of the demonstration, but most states chose the capitated Medicare-Medicaid Plan, or MMP, model. Both states and CMS make capitation payments to MMPs to cover essentially all Medicare and Medicaid benefits through a single entity.

The MMPs have three-way contracts with CMS and the state, which allow for integrated federal and state oversight, integrated medical loss ratios, and several other unique elements.

In 2022 rulemaking, CMS announced its decision to sunset the FAI demonstration, noting that a number of the features of the MMPs had already been carried over into Medicare Advantage duel-eligible special needs plans, or D-SNPs, and evaluations of the demonstration found mixed

results, and did not show clear effects on improving quality or reducing spending. CMS allowed the remaining participating FAI states until the end of 2025 to turn the MMP enrollees into integrated D-SNPs.

As part of the Commission's interest in integrated care models for dually eligible individuals, we have been monitoring the transition using the framework included in our June 2023 Report to Congress, with four components: stakeholder engagement, Medicaid managed care procurement, IT system changes, and enrollment. We spoke with four of the eight remaining FAI states this summer, along with CMS, as part of this monitoring work.

Beginning with procurement, we learned from our interviews that all demonstrations are expected to transition on time for January 1, 2026, with one exception. States that underwent procurements have wrapped up their plan selection process and are moving forward with their transitions. Several of these states faced bid protests that caused delays in their process, and in some cases temporarily prevented the states from communicating with health plan bidders.

In our interview with CMS, CMS officials noted

that procurement is a particularly tricky aspect of integrated care, since states rules and timelines differ and often do not align with Medicare Advantage application timelines.

At the time of our interviews with states this summer, state officials were focused on plan readiness review activities, with those activities either underway or already completed.

In terms of benefits, they will largely remain the same for beneficiaries transitioning from an MMP to an integrated D-SNP, with CMS and states noting that they aim to make the transition process as seamless as possible for beneficiaries.

Turning now to IT system changes and enrollment. States had shared, back in 2022, as they were beginning to plan their transitions, that the transition to D-SNPs would require significant IT system updates, primarily to facilitate enrollment into the new integrated plans. During the demonstration, a state enrollment broker enrolled dually eligible individuals into MMPs, with both Medicare and Medicaid enrollments happening simultaneously.

With integrated D-SNPs, the plan initiates the

enrollment and works with CMS to effectuate Medicare enrollment and with the state to effectuate Medicaid enrollment, a different process from the demonstration with a different role for the state.

Despite these changes, states were confident about adjusting to D-SNP enrollment processes. They noted that they had been receiving helpful technical assistance from CMS for several years at this point. CMS officials also did not express any concerns with states' ability to take on new enrollment processes.

In terms of the actual enrollment transitions from MMPs into D-SNPs, in most cases MMP enrollees will automatically transition into an integrated D-SNP offered by the same parent organization. Most of the existing MMPs will be offering integrated D-SNPs in 2026, either through winning a procurement or offering a plan in a state that accepts any willing and qualified plan, with a handful of exceptions. In those cases, if an MMP enrollee's plan is not offering an integrated D-SNP in 2026, the enrollee will receive a nonrenewal notice with information about their plan options for the following year, including the other integrated D-SNPs in the state.

Finally, something we heard from both states and CMS as an issue they were actively working to address. In an integrated D-SNP, as we mentioned on the previous side, the Medicare and Medicaid enrollments do not happen simultaneously. This creates the potential for a temporary misalignment, when a Medicare enrollment might be effective on the first of the month but there may be a lag in the Medicaid enrollment because of cutoff dates in state systems, for example.

All the states we spoke with said they were taking steps to avoid this lag between Medicare and Medicaid enrollments, including making system changes to avoid this issue in their new integrated D-SNP programs.

Next, stakeholder engagement. We previously presented to the Commission on FAI stakeholder engagement processes for their transitions back in December 2023, when states were gathering feedback from beneficiaries, providers, and health plans on the design of their new integrated D-SNP programs. As the end of the demonstrations approach, states are once again planning for stakeholder engagement, to ensure all stakeholders are aware of and prepared for the transition, including the

impacted beneficiaries themselves.

States are taking differing approaches to beneficiary communication as part of the transition. Some are limiting the amount of notices sent to MMP enrollees, to reduce confusion, especially in states where all MMP enrollees will transition into a D-SNP offered by the same parent organization. Other states are opting for additional enrollee communication, such as requiring plans to send a letter explaining the transition in addition to the CMS-required Annual Notice of Change.

States are also working with plans and advocates to prepare for the transition. For example, they are conducting trainings on certain aspects of the new integrated D-SNP programs, such as a training for plans on home and community-based waiver services.

States are also creating new guidance and policy documents for the new programs, like an operations manual for health plans and a Medicaid provider manual chapter dedicated to the new integrated D-SNP.

Finally, as next steps, we will plan to continue to monitor the transitions as the end of the year approaches, and with that I will turn it back to the

Commission. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Michelle. All right, Commissioners. Any questions or thoughts on the next steps? Carolyn.

COMMISSIONER CAROLYN INGRAM: Yeah, thank you for looking at this. I think there are quite a few areas that need a little bit more research or investigation in terms of what's happening with the transitions and the continuing goal towards really trying to integrate care, that are being, I guess, hampered in some areas. And one specifically is now the kind of popping up of what we used to call lookalike plans before, that were shut down.

Unfortunately, in states in your report you talk about how there are smooth transitions into health plans. If they continue to be there, they will continue to get the same services, and that is really not the case in certain states. The lookalike plans who didn't win the bids are popping up, so people are getting enrolled and confused, because they think they are going to get an integrated product but they are not. They are getting a product that is actually not integrated at all.

So I think that is one area we should look into,

to see if there are ways to ensure that all the work that was done to actually integrate care and coordinate care and benefits on the ground continues in some way, rather than incentivizing brokers and health plans to pull people out of that system into something that's not an integrated product.

The other area I would stress that we continue to look at around, it's a small thing, but it's marketing. It's really confusing, all these plans, to members and enrollees, as you can imagine, trying to understand them. And the marketing timelines between Medicare and Medicaid are still different in states. The guidelines are still different. If there is some way that that could be better integrated in terms of an approach, now that we have undone this MMP and had lessons learned about integrated marketing materials, you're running into a lot of those things. So there is, again, still confusion, I think, on the ground around dealing with that and how the marketing is handled. And education back with brokers in the community in those areas.

And then lastly is just the financing and looking at integrated financing approaches. Unfortunately, undoing

the MMP really got rid of any ability to actually integrate the Medicare and Medicaid financing structures. And a lot of states don't have expertise on the ground, as we've talked about them being so busy and overloaded with people who actually understand Medicare financing and how that works. And so I question how we're even looking towards all the money-saving opportunities that are there, if you're not really looking at how you're going to integrate what Medicare is paying for back with Medicaid.

So I will pause there. There are probably quite a few other areas, but I'll let some of the other Commissioners speak.

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

COMMISSIONER DENNIS HEAPHY: I agree with everything that Carolyn said, and it's going to be very daunting for folks who are dual eligible. Because a state was doing everything before, and now everything is going to be left to the market and brokers, and are they going to look like real plans or not. So it's a huge issue.

And also, we were told that SMACs would take care of the issues we are already concerned about, about the

integrity of the D-SNP, transitioning from the MMP to the D-SNP. Creating the SMACs is really difficult for the states, and they are getting pushback from the plans, as well. So it's not as straightforward.

I think the biggest loss really is that integration between CMS and Medicare and Medicaid, and that transparency, the contracting transparency. Like Carolyn, there's a lot more I could say, but it's a much larger issue, concern. It's much more complex than at least we were led to believe. It's much more complex than we were led to believe, the transition, as we have a lot of concerns, even that's just if there was an 1115 waiver that we'd apply for, and an 1115 waiver was denied. So what does that mean about all those services that were available in the MMP? Will they disappear, or will they actually have to be provided in different ways? Yeah, so it's not as simple as many people thought it would be.

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

COMMISSIONER PATTI KILLINGSWORTH: Just being super practical in terms of things that I would like for us to know, to be able to really monitor the transition. I

mean, one would just be sort of raw numbers of members who were in the MMPs, how many of them truly made it into an integrated arrangement versus those that didn't. What was sort of the fall-off there? And by integrated I'm really talking about FIDE or HIDE models, and nothing less than that.

I think continuity of provides really matters as well as continuity of benefits. So for how many of those people did they lose benefit they are no longer available to them because of the MMPs going away, how many of them potentially lost access to current providers as a result of this transition, particularly if they did not end up in a plan that's owned by the same parent company that operated their MMP plan.

And then finally, beneficiary experience. How does this feel to people to move from a model that, you know, wasn't perfect but it was more integrated than anything that we had, and now to kind of go to the next best thing that we have available to us, which is the D-SNP platform, and what does that feel like to people, and what do we need to do to try to make that experience feel truly as integrated as possible. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti. Any other questions or thoughts? Yes, Mike.

COMMISSIONER MICHAEL NARDONE: Can I just ask, you mentioned that there's one state that isn't going to be ready for January 1st, and I'm just wondering, are you able to say any more about what's happening in that instance and what some of the issues are? I'm just not familiar with it.

MICHELLE CONWAY: That's somewhat still in flux. I think we will follow up when that information is made public.

COMMISSIONER MICHAEL NARDONE: Okay. Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Mike. Dennis, did you have another --

COMMISSIONER DENNIS HEAPHY: There's going to be an importance for the ombudsman programs around the country, and the ombudsman can be great for tracking consumer experience. And states should leverage the ombudsmen out there and also the SHIP programs. The SHIP programs really play an important role, so states should elevate SHIP and let beneficiaries know to not just take the word of the broker, but to actually go to the SHIP

counselor to get some real information.

And also, I believe Massachusetts is going to be sending out a letter to let folks know about the change and what it is going to mean to them. I can give you a copy of the letter once it comes out.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis. Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: So, Michelle, Kirstin, do you think you've got enough clarity?

KIRSTIN BLOM: Yeah, I think we're good. Thank you.

VICE CHAIR ROBERT DUNCAN: All right. Thank you. Madam Chairwoman, I turn it back over to you.

CHAIR VERLON JOHNSON: All right. Thank you again for a great session on this one.

All right. So now we're going to go ahead and turn it to public comments. We will open it up. We invite people to raise your hand if you'd like to offer comments. When you do, please remember to introduce yourself and the organization that you represent. And we also ask that you keep your comments to three minutes or less.

[No response.]

PUBLIC COMMENTS

* CHAIR VERLON JOHNSON: Okay. It looks like we do not have comments today, but I do want to remind individuals that if you do have comments later to feel free to send them in via our website or the email address that you see on the screen.

And I also want to thank you all for a great two days. We hope that you all learned, as we did, as well, of some great topics that of importance to the Medicaid space. And we also want to make sure that you are aware that our next meeting is scheduled for October 30th and 31st. Yes, that is Halloween, for those who do celebrate. We will be looking forward to seeing you all.

And now the meeting is adjourned. Thank you so much. Have a great weekend.

* [Whereupon, at 11:04 a.m., the meeting was adjourned.]