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COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:00 a.m.]

CHAIR VERLON JOHNSON: All right. Good morning, everyone. I just want to start by welcoming you to our very first Commission meeting of the year, and given the winter storms many parts of the country have recently experienced, I also want to say that I hope you, your families, and your team are safe. And we're especially glad you're able to join us today.

So we do have a full agenda, and much of today's discussion obviously reflects many of the issues that are central to the Medicaid program. We're going to talk about accountability, access to care, how policies translate into real experiences for beneficiaries, families, and providers, which is most important. So you'll hear some presentations and discussions on a range of topics, including managed care oversight, services for children and youth, workforce challenges, and transitions of care.

And so we're going to kick off the day with a discussion on state and federal tools for ensuring accountability in Medicaid managed care organizations. Our team will walk through key findings and draft policy

options intended to strengthen oversight and improve transparency.

And so with that, I'm going to turn it over to Chris and Holly, so over to you all. Thank you.

STATE AND FEDERAL TOOLS FOR ENSURING ACCOUNTABILITY OF MEDICAID MANAGED CARE ORGANIZATIONS (MCOs): POLICY OPTIONS

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

Today Chris and I are going to present policy options for state and federal tools for ensuring accountability of Medicaid managed care organizations, or MCOs. This builds on the findings most recently presented at the December 2025 meeting.

First, we'll walk through background on Medicaid managed care accountability and provide a reminder of the oversight requirements at both the federal and state level. Next, we will review our key findings from the environmental scan, stakeholder interviews, and Managed Care Program Annual Report, or MCPAR, analysis. We then present the three policy options for Commissioner consideration and conclude with next steps.

Managed care is the predominant Medicaid delivery system in most states. Almost three-quarters of Medicaid beneficiaries are enrolled in comprehensive, full-risk managed care, and managed care capitation payments accounted for more than half of Medicaid benefit spending in fiscal year 2023.

States contract with MCOs, selecting them through a competitive procurement, a request for proposal, or a noncompetitive application process.

States are primarily in charge of managing their procurements, and federal requirements are minimal. CMS does have some direct oversight responsibilities. They must approve states' actuarial rate certifications with MCOs, and they must also review and approve state Medicaid agency contracts with MCOs to ensure they include all the requirements specified in federal regulations.

CMS has authority to deny federal match on capitation payments for noncompliance with federal requirements and can deny federal match for new enrollees upon recommendation from the state Medicaid agency.

CMS also does have the authority to independently perform any of the enforcement functions normally assigned

to the state under the denial-of-payment process and may refer such cases to the Office of the Inspector General, which may impose additional civil monetary penalties on the MCO.

The Social Security Act specifies that states may not enter into contracts with MCOs unless the state has established a process for intermediate sanctions. States must establish intermediate sanctions for specific instances in which the MCO acts or fails to act. However, imposing sanctions is entirely within the state Medicaid agency's discretion.

States also have the authority to impose additional sanctions under state law or regulation to address noncompliance.

Now I'll turn to our findings from the study.

We conducted an environmental scan of federal rules and managed care contracts, as well as stakeholder interviews with state Medicaid agency officials, MCO representatives, federal agencies, trade associations, and national experts. We also reviewed and analyzed the MCPARs submitted for performance year 2023, which is September 2023 through August 2024, and it represented 34 states.

From our analysis, we identified limitations to CMS's managed care oversight authority and opportunities to improve the use of performance data for MCO accountability.

Our first key finding is that while CMS has broad authority to ensure that state Medicaid managed care programs are structured to be compliant with federal requirements, it has fewer tools to directly address specific MCO deficiencies compared to the tools available in fee-for-service Medicaid.

In fee-for-service, CMS can withhold, defer, or disallow federal match on specific services or claims, in whole or in part, which allows CMS to levy a penalty that is in proportion to the severity of noncompliance. Under current law, CMS can defer federal matching funds only for the entire amount of the capitation payment made to the managed care plan. But in practice, CMS rarely uses this authority because withholding funding for the entire capitation payment can disrupt the financing of all beneficiary care provided through the managed care plan and not just the particular issue that needs to be addressed. As such, it is challenging for CMS to address noncompliance in the same proportional manner that is available in fee-

for-service.

For our next finding, we found that MCPAR data on accountability tools need clarification and standardization. Federal regulation specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the state or other formal or informal intervention with a contracted MCO to improve performance.

However, the current MCPAR instructions do not provide sufficient clarity on what constitutes informal interventions or how to report various accountability actions. For example, it is unclear whether states should report activities such as verbal warnings during routine monitoring calls, requests for additional data or information about compliance issues before formal intervention, informal performance improvement discussions, or liquidated damages. This broad language leaves room for interpretation regarding which specific oversight actions states should report on their MCPARs and how to categorize them.

States currently vary in what they report on the MCPARs. Based on our analysis on the number and type of

sanctions reported in this study, it is likely that states are not reporting all compliance actions. Overall, we found that the MCPARs echoed interview findings that states are more likely to take intermediary steps such as corrective action plans, or CAPs, before levying monetary penalties. However, we do not see many compliance letter actions being reported, which may indicate states are not reporting the full range of formal and informal actions.

As another example, one state did not report any liquidated damages in their MCPAR sanctions, but according to the state's managed care compliance action report, the state levied approximately $34 million in liquidated damages for that performance year.

This discrepancy in reporting likely reflects a difference in how the state and CMS view liquidated damages. In its definitions on their compliance report, the state says that it does not intend liquidated damages to be in the nature of a penalty, but they are intended to be an estimate of the projected financial loss and damage resulting from the plan's non-performance. As such, the state does not appear to view liquidated damages as a sanction.

We also found that states need better tools and guidance to assess performance across multiple data sources. Although MCOs are required to report performance data across a variety of sources, such as MCPARs, external quality reviews, and the forthcoming Quality Rating System (effective 2028), these are not always available in a centralized location nor provided in a format that is conducive for analysis that links across plans and states.

These data are not publicly available in a comprehensive or user-friendly format that states can easily leverage during the procurement process or that beneficiaries can use to inform their choice of MCO.

Stakeholders noted it can be challenging to compare MCOs if each state and plan highlights different metrics. Compiling information across the sources would provide a more holistic view of plan performance that could improve how states account for prior performance during procurement and conduct ongoing oversight.

Based on these findings, we developed three policy options for the Commission's consideration. These policy options seek to address the gaps we identified in federal oversight authority, data quality and

accessibility, and guidance to support state procurement and monitoring practices.

Policy Option 1 is that Congress should amend Section 1903(m) of the Social Security Act to allow CMS to withhold, defer, or disallow federal match for all or part of the managed care capitation payments. Under this option, Congress would authorize CMS to withhold, defer, or disallow federal match proportional to the severity of the noncompliance rather than requiring CMS to withhold federal match on the entire capitation payment. The authority would only apply to noncompliance with existing federal requirements specified in statute or federal regulations. It would not expand the areas for which CMS could withhold, defer, or disallow federal match.

Similar to the withhold, defer, or disallowance decisions on the fee-for-service side, any CMS action would be subject to reconsideration and appeal if states disagree with this decision.

Current federal authority only allows CMS to withhold, defer, or disallow the federal match on the entire capitation payment to an MCO, which is an extreme measure that can disrupt the financing of all beneficiary

care provided through the managed care plan.

As indicated during our federal interviews, this limitation makes it difficult for CMS to use its enforcement authority proportionally to address specific deficiencies. CMS has attempted to address this gap in the past. The option for partial deferrals or disallowances in managed care was proposed in the 2016 Managed Care Rule but withdrawn because of a lack of clear statutory authority.

If enacted, this option would equalize the tools available across fee-for-service and managed care. For example, current access requirements highlight this difference between CMS authority and fee-for-service compared to managed care.

The fee-for-service access regulations include specific provisions for a CAP and specific authority to reduce the federal match for noncompliance with access requirements through a cross-reference to a broader deferral authority that can be applied in whole or in part.

In comparison, the managed care regulations have provisions for a remedy plan to address access issues when managed care plans fail to meet access standards, but there is no specific deferral authority included in the managed

care regulations.

States would still retain their primary role in enforcing MCO contract requirements and performance standards, but CMS would have more leverage and flexibility to address serious compliance issues with federal requirements when state enforcement is insufficient.

MCOs could face reductions in capitation revenue if CMS determines that a portion of the capitation payment should be withheld or deferred due to noncompliance. However, this targeted approach would allow for proportional oversight without disrupting the entire plan's financing and beneficiaries' access to care, and plans would have additional incentive to work with states to address compliance issues promptly.

By providing CMS with an enforcement tool that can be used proportionally, this option could lead a more consistent enforcement of federal requirements that protect beneficiary access and quality of care in a similar manner across both fee-for-service and managed care.

For the second policy option, CMS should provide clarification and guidance to support MCPAR data accessibility and completeness. Under this option, CMS

would provide clarification and guidance on which types of accountability tools should be reported on the MCPARs and how to report them consistently. This guidance could be provided through updated MCPAR instructions, technical assistance resources, or a combination of these approaches.

Specifically, CMS should clarify reporting requirements for liquidated damages, informal interventions that states may use before escalating to formal sanctions, and other accountability actions that are in response to plan noncompliance.

Current federal regulation specifies that the MCPAR must include the results of any sanctions or corrective action plans imposed by the state or other formal or informal intervention with a contracted MCO of improved performance.

However, as identified in our analysis, states are likely reporting incomplete or inconsistent data, and it is not clear that states share the same definitions of sanctions and informal interventions as we highlighted in our example of liquidated damages.

Our stakeholder interviews found that states commonly use informal accountability actions before

escalating to formal sanctions, but it is unclear whether and how these informal interventions should be captured in the MCPAR.

MCPARs are still in the early years of implementation. So states may still be getting used to the reporting requirements, making this an opportune time to provide additional guidance and standardization.

This option would require CMS to identify where additional clarification and standardization are needed on the MCPARs. CMS would then need to develop and disseminate updated instructions, data definitions, and potentially a standardized reporting template through technical assistance materials, MCPAR instruction updates, or sub-regulatory guidance.

States already collect information on their accountability actions and are required to submit this information on MCPARs. The primary change would be more specific guidance on what and how to report, rather than requiring states to collect new information. However, some states may need to adjust their internal tracking systems or processes to ensure they are capturing all required information consistently.

As noted by MCO representatives from our interviews, plans want any public reporting of sanctions information to include appropriate context, particularly regarding sanctions that are under appeal.

More clarity and standardization in definitions and requirements would reduce variation that is solely due to state reporting and provide a more comparable assessment of plan performance across states.

For our final policy option, we specify that CMS should issue guidance and/or toolkits on how to effectively use available data to assess plan performance. This option creates an opportunity for CMS to provide guidance on how states can use these different sources together to link information across plans and states to provide an overall view of plan performance.

Potential examples of guidance and tools that CMS could provide include technical guidance on data linkages, such as linking plan identifiers across data sources so various MCO performance data can be connected and analyzed together; a past performance assessment framework for creating comprehensive performance assessments that draw from multiple data sources and recommend metrics to

consider; a procurement evaluation toolkit, such as potential evaluation criteria, scoring rubrics, and templates that demonstrate how to consider and weigh MCO past performance during procurement; a state learning collaborative for states to discuss effective use of performance data, share procurement practices, and identify common challenges in assessing MCO performance; and potentially reporting guidance and technical assistance on making performance data more publicly accessible in user-friendly formats.

So states currently struggle to access and use multiple sources of MCO performance data together effectively. Several interviewees suggested that CMS could help states by developing better tools to access and compare MCO performance data across state lines.

National experts noted that while the MCPAR is a good first step in collecting plan-level data, understanding MCO performance across states remains difficult. They suggested that CMS could do more to help state Medicaid agencies better understand MCO performance in other states, such as a comprehensive, up-to-date database or dashboard that allows states to understand what

sanctions look like across the country.

Federal and national experts agree that public reporting of MCO performance, including sanctions, is an important tool for driving improvements in performance and better outcomes for enrollees, but emphasize that it needs to be in an accessible, understandable format to be effective.

In our March 2025 report to Congress, the Commission made recommendations on external quality reviews, or EQRs, including the need to reduce areas of duplication with other federal quality and oversight reporting requirements, create a more standardized structure in the annual technical report that summarizes EQR findings, and identify key takeaways on plan performance.

This option would build on that prior recommendation by not only improving the usability of EQR reports, but assisting states in combining the information with other federal reports on managed care quality and oversight.

This option would provide states with a more complete picture of plan performance and could improve

their ability to procure high-performing plans and implement more effective accountability provisions in contracts. States would have a consistent source to assess prior performance across plans and states to use during procurement, and states could benchmark their program's performance compared to other states in terms of outcomes and compliance and identify gaps in their oversight practices or identify emerging issues in other states.

This option would not necessarily increase the administrative burden on states because this guidance would focus on helping states make better use of data they are already required to collect and report. State participation in learning collaboratives or use of CMS toolkits would be voluntary, allowing states to engage based on their capacity. However, there could be some administrative costs for individual states to implement the guidance and develop new analytic tools to combine these data in a publicly available, usable format, such as a dashboard. Performance data that are more publicly available and readily accessible can improve the ability of all stakeholders to assess plan performance and make informed decisions.

The staff would appreciate Commissioner feedback on the interview findings and the areas for potential policy options. If Commissioners are interested in pursuing policy options, staff will return to present recommendation language at our next meeting. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you, Holly and Chris. I think that was very helpful. This work really raises a number of important questions, and I expect a thoughtful discussion from my fellow Commissioners.

So let's go ahead and stay on the next slide, I think, that has policy options. Do we have that? Okay, we may not. There we go. There are the policy options.

So Commissioners, we're going to welcome your reactions. Think about what stands out to you, what concerns you, and think about the relative strengths of these approaches. And I would also say as you look at the different options which do you see as most important to pursue, and are there some considerations that you think staff should keep in mind as this work continues.

So with that let's open up the floor for questions.

Lucy, I cannot see the Commissioners.

EXECUTIVE DIRECTOR KATHERINE MASSEY: Verlon, while we get that sorted out, Angelo is first in queue.

CHAIR VERLON JOHNSON: Okay. All right. Perfect. Angelo?

COMMISSIONER ANGELO GIARDINO: Thank you. First of all, thank you for this really thoughtful analysis of managed care oversight.

I'd like to speak in support of policy options 2 and 3, because I think that's consistent with our MACPAC approach to really facilitating the collection of useful data that allows program leaders, advocates, the public, legislators, regulators, to understand the program better.

I have significant concerns around policy option 1, for the following reasons. One, I fundamentally believe that Medicaid is a joint federal-state program, and I'm not supportive of an approach that marches down a dominant federalization of the program. So I think we should honor, start at Medicaid in 65, and keep it a joint state-federal program.

Second, I think the fact that three-quarters of the nation's Medicaid is in managed care suggests that managed care has something to offer. And part what it has

to offer is organizational capacity to work with state leaders to manage a state population that they know best. And I really am concerned if there is a federal authority introduced that allows additional micromanagement of a program that would weaken the ability of state leaders to work with state organizations to manage that state's population.

And the example I would use is I manage a department of 1,200 people, and when you have 1,200 people, every once in a while, somebody at a meeting doesn't exactly perform the way you want. So I stop by their office, and I informally let them know that their performance could improve. And 95 percent of the time, that concerning behavior never surfaces again.

If I had to tell the Dean's Office every time I stopped by the person's office and informally offer them feedback, it would be onerous, and it would introduce a problem in the relationship that I'm trying to develop with the team that I'm managing. I view it similar to the state leaders informally correcting managed care organizations.

So I think we need to honor the joint federal-state identity of the Medicaid program. I think we have to

trust our state leaders to manage managed care with the toolbox of informal correction.

So again, I will just conclude, 2 and 3 really make sense to me because it systematizes how we look at the programs. So I speak in support of 2 and 3, support of the federalization in 1. Thank you.

CHAIR VERLON JOHNSON: Thank you, Angelo. Tim.

COMMISSIONER TIMOTHY HILL: Thanks, Verlon. I suspect I may be a minority of the hands here as we go down. As with Angelo, I am full supportive of options 2 and 3 in terms of reporting and helping folks understand the data that's being reported and how it's collected.

In terms of option 1, I stand in support. I completely understand Angelo's point about the state-federal relationship. I guess from my perspective, this introduces a level of precision and flexibility that doesn't exist now. And I, speaking from my own experience, can remember experiences, even though it is a partnership, there are instances where either plans are out of compliance in a particular area and there's not 100 percent agreement or there's not 100 percent compliance being engaged between the state and the plan. And having the

ability to say, we're not going to defer the entire amount to a particular plan, particularly when a plan can cover so many people in a broad set of services, but we're going to target that issue that we know that is an issue, whether it's home health or transitions for kids or hospital payments.

To be able to have that flexibility and target compliance actions where they are needed, to me just adds another toolbox. It doesn't create more federalization of the program, as I think Angelo is alluding to, but does give more flexibility for CMS to target an area that needs to be targeted that perhaps they're not getting as much attention as they need to from a state or from a plan.

I completely understand that we always want to proceed with sort of progressive enforcement. I'm completely on board with the analogy of trying to get plans into compliance, trying to get states into compliance. But having the ability to target, just as we do in fee-for-service. In fee-for-service, if there's a particular provider, there's a particular set of services that are an issue, we don't disallow. We don't defer the entire fee-for-service payment to a state. We just defer that amount,

or CMS, excuse me, just defers that amount.

I think with the appropriate guardrails and appropriate understanding I think it provides the program itself with a really important new tool.

CHAIR VERLON JOHNSON: Thank you, Tim. I appreciate it. Jami.

COMMISSIONER JAMI SNYDER: Thanks so much, Holly, for the overview on this really important topic. Along with Tim and Angelo, I'm in full agreement with option 2 and 3.

I actually just have a question about the first policy option. I would like to better understand what would trigger kind of CMS intervention in terms of withholding match. And specifically, I'd like to better understand sort of how CMS's intervention would occur related to the severity of the compliance issue. Is there a certain level of severity which would compel CMS to intervene and withhold match?

And then I'd like to better understand, too, is the intent when CMS gets involved to interject themselves when they feel like a state is not pursuing the type of compliance action that they need to or sanction that they

need to for an MCO, or is it to kind of layer on top of the state's activity and to further compel the MCO to comply?

So I just would love some clarification on those two items.

HOLLY SALTRELLI: Yeah. So I think that regarding the comparison to fee-for-service -- so again, we are kind of looking for some data from CMS for the fee-for-service program to understand how it's being used there, and we can get back to you on that. And regarding kind of the, right now the access rule that we discussed and the example for that policy option really kind of points out the discrepancy in how it works. So right now the remedy plans versus the CAP, but there's no escalation authority for managed care like there is in the fee-for-service option.

And regarding when and how they would use it, that is something that, as we think about shaping a recommendation, that could kind of go as the scaffolding. But as we emphasize there would be no new requirements that would be allowing CMS to withhold in a different way.

And Chris, I'll let you chime in, as well.

CHRIS PARK: Yeah, just to jump in, in the

preamble to the managed care rule, when they are discussing their remedy plan, they do have the ability to withhold federal match, but based on statutory authority they would only be able to do that on the entire capitation payment for an individual.

So this would be an example of where CMS could more target the specific deficiency of access issues. So if it was, and using the example of home health, they could potentially just withhold the federal match on the portion of the capitation payment associated with home health, or some other metric.

On the fee-for-service side, in the access provisions, a lot of it is tied to reporting. So CMS there has said they are not going to necessarily withhold the federal match on the entire amount that was paid for that particular service, but would tie it to what they estimate as the administrative cost of reporting for that particular service.

So there would be ways for CMS to fine-tune this more specifically to what they think is an appropriate financial penalty versus withholding the federal match on the entire capitation payment.

CHAIR VERLON JOHNSON: Is that helpful, Jami?

COMMISSIONER JAMI SNYDER: It is. I mean, it sounds like, Chris, if I'm understanding you correctly, that CMS has a fair bit of flexibility in terms of when they intervene and decide to withhold match, right?

CHRIS PARK: Yes. At least on the fee-for-service side they have authority to withhold all or in part, and based on that specific example, the fee-for-service access rule, they have chosen a specific way to do it for reporting issues.

COMMISSIONER JAMI SNYDER: Mm-hmm. Do you anticipate that allowing some flexibility here for CMS, that they would get involved when they feel like a state is not taking the necessary compliance action, or do you feel like maybe it's both, they would sort of layer on top of the state sanction or compliance action to further influence the managed care organization?

CHRIS PARK: Yeah, our intent here would be for the states to hold the primary authority to sanction, deal with compliance issues with the plan, because they are the primary holders of the contract. But within the federal-state partnership, CMS should, they already do have the

authority to withhold federal match in the program on the cap payment. But this would allow them to be a little bit more targeted.

As an example -- again, we're going back to the managed care access rule provisions, because they're very discreet. You know, CMS has implemented a remedy plan, and if that remedy plan does not kind of result in, you know, the access meeting the standards, then they can extend it for another year. But after that, CMS's only option is just to, I guess, maybe keep extending it or to withhold the federal match on the entire cap payment. So that's a place where we think is a good example of where CMS could outline an incremental approach of kind of like how states work with plans with a CAP, before going to financial penalties. That CMS could institute like a remedy plan, and then ultimately, if they still are not satisfied that the plans are meeting the standards, then go to the deferral.

But our expectation would be similar to how states work with their plans, or more intermediary type of steps, CMS should do the same thing with the states in that regard.

COMMISSIONER JAMI SNYDER: Got it. Thanks, Chris.

CHAIR VERLON JOHNSON: Thank you. Sonja.

COMMISSIONER SONJA BJORK: Thank you, Commissioner Johnson. Well, as usual, the MACPAC staff has done a great job of teeing these up, with great research and analysis. We really appreciate all your hard work, because these are complex issues.

So on policy issue number 1, I think there's a good reason for a difference between fee-for-service and the managed care setting, and that's because the states have contracts with the managed care plans. That's different than the fee-for-service world. So I'm veering away from option number 1. CMS already does have oversight tools, in that they have to approve contracts, they have many different ways that they review every state's Medicaid program and their relationships with their MCOs.

And instead, I very much want to focus on policies 2 and 3, because I think we can strengthen the states' ability to do their oversight activities. First of all, it looks like there are a lot of states that are not doing very well on their reporting, so it's hard for all of

us to get a good view on to what tools are currently being used.

And secondly, I think there are so many opportunities for toolkits and best practices, because some states do a very good job of oversight of their MCOs. In California, there is a very good track record of using informal/formal public reporting, contract provisions, many of these different tools in the oversight of the managed care plans to ensure quality, to ensure access. So let's take some of the good practices from many of the states and help the other states more effectively use those tools.

And as I said in the beginning, there is the contract provisions that each state has with the managed care plans. Perhaps they need some template contract provisions so that they can make sure that they have those tools written within the contracts.

So I'll stop with that, and again, thanks for all the good work.

CHAIR VERLON JOHNSON: Thank you, Sonja. Mike.

COMMISSIONER MICHAEL NARDONE: Hi, Holly and Chris. Thanks for queuing this up for us, these issues.

You know, having sat at CMS, there were a couple

of instances where I thought having the ability to do partial deferrals on managed care would've been helpful, in instances where we felt that provider access wasn't sufficient or when access issues were not being appropriately addressed.

But having said that, I have a concern with this first one, this first recommendation, because it does seem like this is a fairly broad, just written fairly broadly in terms of what the authority could be to withhold, defer, disallow federal match. And I think without clear guardrails around when this authority could be used to support the goals of the program, and I think MACPAC is particularly concerned about, like around access, I would have some concerns about supporting.

I also kind of think, Chris, I mean, some of those remedial steps that you talked about would be helpful, but I don't see those written into the recommendation. So it's not really clear. Maybe that's what we would like to see happen, but that's not embodied in the recommendation as I see it. So I think that if we were moving forward with this recommendation, I would like to see that addressed, built in.

You know, I'm just wondering if the comparison that's used between fee-for-service and managed care is really accurate. Because when I was reading the materials, we were talking about, well, this authority could be used for CFR 438, which is basically the entire breadth of managed care rules that govern the program. And there are a lot of requirements in there. So I wouldn't want to see cherry-picking of that, of what those requirements were. I think we would want to understand what the guardrails were.

And then on the fee-for-service side, I think you've picked out a fairly specific area, access, where the limitations on, if I'm understanding it right, the limitations are fairly well kind of set out in terms of what you can sanction and what you cannot sanction. So I'm a little concerned there's a false equivalency there, that we don't quite understand fully, you know, is there really parity if you're looking at the full scope of the managed care rules versus kind of that instance with respect to the access rule. So that gives me pause on number 1.

On number 2, I generally am very supportive of more clarity. I'm understanding, I guess, that informal interventions are part of what is required to be reported

under MCPAR. So my concern with informal interventions, I guess, is similar to what Angelo was discussing. It would seem to be an instance where that informal interventions, the bar would have to set relatively high, because otherwise a state that does a very good job of managing their managed care plans, you know, I would basically have quarterly meetings, and I would informally be telling the plans, "Hey, this is what you should be doing." If I had to report at every one of those instances it would just be unmanageable, and it wouldn't be helpful, and it also wouldn't be accurate. It wouldn't be a fair picture. And it kind of goes to the context that you raised. Part of it is also about how -- you know, it might not give a really good picture.

So, you know, I don't know if there's an opportunity to provide a little bit more context around what would be helpful there, but I'm concerned about how informal interventions would be defined in terms of these recommendations.

And then I guess the third point is, I don't want to lose sight of, and I think you mention it, you know, I think a big step here is QRS, and that's supposed to be in

effect in 2028. So I want to make sure that when we're talking about how to effectively use data, I mean, that's going to be, hopefully, a source where we can compare plans across the states, on a standardized set of metrics. But I do see the value, and if states are saying they see the value, I would agree that kind of having a way to tie these together would be helpful. And I would assume you would be referencing kind of some of the steps we also talked about with EQROs last year, around having that data in a more usable framework and being able to tie those together, I think would be a good thing.

So again, just in summary, I have real concerns about 1, but can see myself getting to a yes on 2 and 3, and think they would be helpful.

CHAIR VERLON JOHNSON: All right. Thank you. That is helpful. Heidi.

COMMISSIONER HEIDI ALLEN: So many wonderful things have already been said, so I'll try to just narrow it on a lot of agreement with fellow Commissioners, particularly around 2 and 3. I feel a lot of support for that.

Mike's point is well taken, though, that

understanding the difference between an informal nudge versus a notice of expectation and change, I think how that's defined is really important so that states, especially in relation to option 3, so states who are really actively involved then don't end up looking like they have worse plans than other states where there's been less involvement. So I would love that kind of clarification for number 2. I'm very enthusiastically in support of option 3. And I have mixed feelings, like him, for option 1.

I think what's really important, that's not super clear to me, is if a federal intervention is limited to only what is already contractually agreed on between the MCO and the state, and not something that can be imposed or changed based on federal preferences. So many states innovate in these contracts. They may have a really wonderful program for doulas. I wouldn't want to see the federal government decide we don't like doulas, so we're going to withhold capitation.

And I don't know if that's possible, but I think that what I hear from a lot of Commissioners is this is a big change, and we want to make sure that there aren't any

spillover effects on the way that states are trying to innovate. At the same time, you know, we want to make sure that, and particularly related to access, that states are ensuring that beneficiaries have access.

So those are my thoughts. I feel a little concerned about 1, and I'm very supportive of 2 and 3.

CHAIR VERLON JOHNSON: Thank you, Heidi. Carolyn.

COMMISSIONER CAROLYN INGRAM: Thank you.

And I'd, like my fellow Commissioners, you know, support us diving into 2 and 3 and moving some of those pieces forward, but have -- can't support the Policy Option No. 1, as it's outlined here.

I know this was said by one of the other fellow Commissioners, but the contracts that are let to oversee managed care in states are between the state and the managed care entity. There are a lot of enforcement tools in those contracts and in state statutes that provide for corrective actions, sanctions, penalties, and those are levied often.

My concern about this is that you bring in a third party who doesn't know what's going on at the state

level, and the risk is that it could be very arbitrary in terms of what is put into place and not really understanding what's going on at the state level. You could inadvertently disrupt access to care. You could stop provider payments. You could disrupt services to high-risk, high-need populations in rural communities, and especially with -- not managed care companies risk even, just a company being able to exist, depending on what was done there.

I think we have to go back to some of Commissioner comments that Angelo brought up at the beginning that states have this responsibility. That's part of the relationship back with the federal government. They know what's going on in their state. They know what access to care issues they have. They know what plan performance issues they have, and that's their responsibility to implement those contracts and to manage them properly so that they don't harm access to care, especially in rural communities; they don't harm high-risk populations. And I think bringing in a third entity that doesn't know what's going on on the ground puts at risk those things.

CMS has tools already that they implement in states to withhold payments to states and FMAP to states if they're disturbed about something. So I think we need to rethink this if we're trying to do something. What are we really trying to get at? Start back first with getting the more clarification on the reporting before we consider an option that's outlined in Option 1 and withdraw that when we move forward.

So thank you. Thanks for the consideration.

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

Doug?

COMMISSIONER DOUG BROWN: Thank you.

I'm in the same kind of camp as Mike and Tim on No. 1, certainly need some guard rails around this piece and would be anxious to see what the staff comes up with as far as guard rails around No. 1.

For Nos. 2 and 3, I think I'd want to make sure that we understand some cautions around the reporting that goes on between states around compliance and penalties that are in those state contracts and the penalties that are associated with those contracts in the MCOs, because they

can vary state to state, and states will report or penalize vendors at different rates for the same service in different states. And the compliance factor, for example, in a pharmacy system, they might say the uptime has to be 99 percent. In another state, it might be 99.9 percent, except for the maintenance window, right? And if you're inside or outside those penalties or those ranges might be different, you might experience penalties in one state.

But if the reporting isn't detailed to the level of what the criteria is and then the penalty, you end up potentially skewing a certain service that makes a company look poor in one state, but for another state, it may be absolutely fine. And so there's some concern there I have about these data, and it's important that as the data is collected, that it be aggregated in a way and described in a way to make sure that the services are considered or in consideration of how those penalties are assessed in those cases.

So appreciate the opportunity here. Thank you.

CHAIR VERLON JOHNSON: All right. Thanks. Appreciate it, Doug.

Patti and then April.

COMMISSIONER PATTI KILLINGSWORTH: I think you're saying emerging themes, so I'll try to keep my comments fairly brief.

Certainly support accountability really at all levels of the system, and so with regard to No. 1, share many of the same concerns that have already been expressed. I feel like this is -- it's an overreach of federal oversight, which really should be with the entity with whom they maintain a contract, which is the state, and then the state having responsibility with the entity with whom they maintain a contract in turn, which is with the managed care organization.

I absolutely think that if a state is not properly overseeing, that CMS can and should address that, but with the state and not have direct oversight of sanctions over the managed care organizations. I just think that supplants the state's responsibility and the state's authority to be able to manage those contracts, and quite frankly, just have the ability to do that so much better. They're closer to the issues. They know the state's priorities and goals, and it really is effective oversight is an ongoing process. It's not like a step in

and slap hands. It's like I'm there every day and really partnering together.

We used to call our relationships "accountable partnerships," and those partnerships are supported by contracts. And they need to -- we need to follow that at the appropriate levels.

With respect to 2 and 3, also like my fellow Commissioners, I'm generally supportive, but share some of the same concerns that have been expressed, particularly by Mike and Angelo, just around contextual understanding of data.

I do think if we're going to receive data, we need to be using the data. We need to try to make it as understandable as possible while recognizing real state differences in requirements and oversight.

In Tennessee, we were -- we had a reputation for really overseeing health plans tightly and for having really high contractual expectations, and so sometimes when you see, you know, a large number of sanctions, you don't really know if that's so much about poor performance or about higher expectations and sort of where -- and a greater willingness to leverage those penalties when

necessary to meet those higher expectations. So an apple is not an apple. Every state's Medicaid program is different as we know, and so it is very hard to compare performance among states.

Now, that said, within a state, there should generally be some ability to be able to compare data, although that really requires very prescriptive definitions around things like, you know, what counts as an appeal, what counts as a complaint, and making sure that all health plans are reporting those things in the same way for that data to be useful to beneficiaries for really assessing health plan performance.

But generally supportive of 2 and 3, would want to be cautious with regard to the reporting of kind of ongoing informal oversight that should happen as a course of doing business and not kind of as an enforcement mechanism per se, not doing something that might reduce a willingness to really use those informal mechanisms. I think that would have negative unintended consequences on the system.

Thank you.

CHAIR VERLON JOHNSON: Great. Thank you, Patti.

April, then Jenny, then Dennis. We're going to stop with Dennis. So, April?

COMMISSIONER APRIL HARTMAN: I'm still new to this. So this is kind of a question, I think, to my fellow Commissioners. I guess the question I have is, do you think Policy No. 1 undermines some of the authority of the state to hold the MCOs accountable? It seems to me that if the state is trying to hold the managed care accountable, if those managed care organizations know that if they don't work with the state, it can be elevated to CMS who will then withhold the whole FMAP, it seems like to me that gives a lot more power to the state, because that managed care organization has to work with them. They don't want it elevated.

And I just wonder if giving a partial ability to withhold FMAP would undermine some of that power that the state has to hold the managed care organizations accountable.

CHAIR VERLON JOHNSON: Tim, can you jump on in and answer the question?

COMMISSIONER TIMOTHY HILL: Yeah, I mean, I'll just -- from my perspective, I think the opposite occurs,

right, in those instances where it's a -- the CMS has a giant sledgehammer, and that giant sledgehammer is withholding or deferring an entire -- the plan's entire managed care capitation payment. And I think there's, in some respects, a game of chicken, where whether it's the state or the plan. It's like CMS isn't going to withhold the entire capitation payment. They would create access issues across the board as opposed to if CMS had the ability, all things being equal, to withhold or defer only a portion or that portion that affects whatever the issue is in an instant, that might create more incentive for -- in the case you're describing, for the plan or for the state to come to an agreement, because the plan or the state knows that the deferral could be targeted and that CMS may actually use it, where they probably wouldn't in the case of a large deferral, which would put a much broader set of access issues into play, from my perspective.

CHAIR VERLON JOHNSON: All right. Thank you, Tim. Thank you, April.

Jenny, and then Dennis. We'll finish with Dennis.

COMMISSIONER JENNIFER GERSTORFF: Yeah. I have a couple of questions on Option 1. Are we aware of any situations where CMS has withheld full federal match on managed care capitation because of compliance issues, or is that something we would be looking into if we pursue Option 1?

CHRIS PARK: When we did our interviews with CMS, the staff we talked to who had been there for a few years had said they had never used that authority to withhold the match on the entire capitation payment. That doesn't mean it's never happened, but at least with the current staff that we interviewed, they had not used it. They essentially indicated that it was very unlikely to be used in most situations.

COMMISSIONER JENNIFER GERSTORFF: Okay. Thanks, Chris.

Then I would be interested in, if we pursue this option, which I don't love, but I have mixed feelings -- but if we do pursue this option, understand more about how a portion of the capitation would be quantified if they were going to withhold or defer payment. Capitation payments are usually set to be kind of a global managed

care budget, and so it can be difficult to identify components of that capitation. So all the different situations where they're monitoring compliance might create difficulties in quantifying that, and so who would be responsible for quantifying the portion of capitation that will be withheld or deferred and how that would be done?

CHAIR VERLON JOHNSON: Okay. Dennis.

COMMISSIONER DENNIS HEAPHY: Thank you.

I like 2 and 3 because I believe that they really support growing state capacity, and that's one of the things we really want to do at MACPAC is really help states develop the capacity to provide oversight and ensure access to services. And I think No. 1 is actually an overreach and undermines the opportunity of states to build their capacity.

So rather than moving in the direction of CMS stepping in, I think I'd rather see us focus more on what can be done to support states internally to build their capacity to provide the oversight so that there would be no need for CMS withholds or deferrals or any sort of intervention, so what can be done actually to support states in their capacity to do those things? Thanks.

CHAIR VERLON JOHNSON: All right. Thank you, Dennis. Nice way to close this out.

So thank you so much, Holly and Chris, for this. I think this has been a really helpful conversation. I can see there was a lot of great thought put into the comments made by the Commissioners.

We definitely had some significant discussion on Option 1 as we all heard, including concerns about what feasibility and the need for clear safeguards. Is it the right thing to do alongside additional leverage could actually be helpful? But at the same time, I think you all heard, too, some strong support for Options 2 and 3, maybe some modern tweaks really around improving data clarity and performance information and how that's used for oversight was really important.

So hopefully, this was really good feedback for you to take back. But I do want to pause and see, Holly and Chris, is there anything else you'd like to flag or any questions or anything else you need from the Commission.

HOLLY SALTRELLI: Very helpful. We appreciate the feedback. Thank you.

CHAIR VERLON JOHNSON: All right. Okay. Thank

you.

All right. So, with that, I think I'll turn it over to Bob, right?

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman.

We're going to discuss appropriate access to residential services for children and youth with behavioral health needs. This is a continuation of our work that we started in the last cycle. So we've got Joanna Gee and Sheila Shaheed joining us to walk us through and some draft policy options.

APPROPRIATE ACCESS TO RESIDENTIAL SERVICES FOR CHILDREN AND YOUTH WITH BEHAVIORAL HEALTH NEEDS: DRAFT POLICY OPTIONS

* SHEILA SHAHEED: Awesome. Thank you, Commissioners, and good morning.

So today staff will be presenting draft policy options for ensuring appropriate access to residential treatment for children in Medicaid.

Next slide, please.

So we will be going over some high-level background information, including federal requirements and

guidance, and a summary of key findings. And so as a reminder, this information can also be found in greater detail in our June 2025 chapter. So we will then consider draft policy options for consideration by Commissioners, and then we'll end with next steps.

Next slide.

So as the Commission has historically stressed, residential treatment is intended as a last resort. Federal laws are in place to ensure that children with Medicaid receive appropriate access to behavioral health services, and so the Americans with Disabilities Act of 1990 prohibits discrimination against individuals with disabilities, including Medicaid beneficiaries with serious mental illness, or SMI, and requires that these services be delivered in the most integrated setting possible.

And so under the U.S. Supreme Court's 1999 ruling in Olmstead v. L.C., states must provide treatment for individuals with disabilities, including SMI and serious emotional disturbance, or SED, in community-based settings if the individuals do not oppose such services and if such placement is appropriate and can be reasonably accommodated by the state.

However, residential treatment is available to provide intensive clinical treatment for youth with SED or co-occurring conditions such as substance use disorder, or SUD, who cannot be served in their communities.

Medicaid-enrolled children and youth typically access this intensive level of care in Psychiatric Residential Treatment Facilities (PRTFs), Qualified Residential Treatment Programs (QRTPs) for children in child welfare, or other settings that do not meet the requirements of a PRTF or QRTP.

Next slide.

And so as you all may recall, the EPSDT requirement mandates that states provide Medicaid beneficiaries ages 21 and younger access to any medically necessary Medicaid coverable treatment, including residential treatment, for physical or mental conditions.

And so the federal IMD exclusion prohibits payments to facilities greater than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, and these are commonly referred to as IMDs.

There are exceptions to the IMD exclusion,

including the optional psych under 21 benefit that allows states to cover services that are provided in PRTFs or in the psychiatric unit of a general hospital. Though this benefit is optional, under EPSDT, states are required to provide it if it is deemed medically necessary during an assessment.

Federal rules also describe requirements in the areas of accreditation, certification or assessment of need, and development of care plans.

Our June chapter covers these areas in greater detail, but I do want to note that care teams are required to certify that community resources are insufficient to meet the needs of the child and that their condition requires an inpatient level of care before being admitted to a PRTF.

Following admission, an interdisciplinary care team is required to develop an individualized plan of care that includes treatment objectives, therapies and activities, and post-discharge plans.

For a QRTP to receive Title IV-E payment on behalf of a child, the child must be assessed by a qualified individual that is not associated with the public

agency or the residential program within 30 days of placement, and that assessment must be validated by a court within 60 days of placement.

And so I'll now provide a brief summary of our key findings, and next slide, please.

Okay. So, as a reminder, all this information can also be found in our June 2025 chapter.

So, throughout our research, we found that there is a lack of easily attainable and specific information about the facilities that are serving Medicaid beneficiaries and that this difficulty finding information makes it difficult for families and providers to understand their treatment options. There are some federal sources that provide some facility information, but there are still gaps in information to help identify treatment.

For example, the Centers for Medicare & Medicaid Services (CMS) publishes on its website the names and locations of PRTFs that have had a health and safety survey, but it does not provide other information such as bed availability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains findtreatment.gov, which

allows users to search for behavioral health treatment facilities based on factors such as location and acceptance of Medicaid, but it does not provide information on bed availability. In addition, the Office of the Inspector General has raised some questions surrounding the accuracy and completeness of the site's information.

States have developed and do maintain online resources, including bed registries and searchable databases of facilities, to help identify residential treatment options. Differences in state approaches to creating and maintaining these databases makes it difficult to generalize and compare data across states.

In addition, each state maintains a list of licensed QRTPs, but no publicly available database or repository includes, for example, the number of beds in each facility or the number of children that are placed in out-of-state PRTFs. Despite these limitations, stakeholders have reported that registries have improved access to residential treatment services and reduced wait times.

Our work also found that there is limited data available to understand the use of residential treatment

services, including for non-PRTF facilities and out-of-state facilities. Federal regulations do not require that states collect and report information on the use of residential treatment settings other than PRTFs. An analysis of PRTFs only would provide key information but would likely be of limited generalizability.

PRTFs must submit annual attestation statements to each state Medicaid agency with which they have an established provider agreement. These statements include some information about out-of-state placements and PRTFs, but CMS neither posts nor validates this information.

CMS's 2022 and 2023 T-MSIS behavioral health data books provide different stratifications of data on beneficiaries receiving treatment for behavioral health separately for children and adults. However, much of the collected data, including the use of residential treatment care services, readmissions, and use of the emergency department post-discharge are not differentiated between children and adults.

State-initiated data collection efforts vary in regards to what data are collected, how they are collected, and definition of residential care settings that are used,

and thus are not comparable state to state.

Notably, one state in our study maintained a data dashboard that provides county-by-county information on the percentage of Medicaid-enrolled youth who received residential treatment. No other state interviewed routinely published such data.

Next slide, please.

So out-of-state placements may be necessary if an in-state facility lacks the capacity or expertise to address the behavioral health needs of youth that are referred for treatment or if they otherwise deny admission.

Our findings show that securing appropriate residential treatment options can be challenging for children with more complex needs, such as those with intellectual or developmental disabilities, or I/DD, SUD, sexualized behaviors, eating disorders, aggression, and more than one behavioral health diagnosis.

We also learned that some facilities may reserve beds for out-of-state beneficiaries, which provide higher payment rates than in-state beneficiaries. Some state Medicaid officials also reported that out-of-state placements can make it difficult for children to maintain

connections with their families and transition back to their respective states of residence.

At a national level, there is no single source on use of out-of-state residential care, which makes it difficult to get a complete picture about the circumstances surrounding out-of-state placement, including length of stay, outcomes, and post-discharge outcomes.

Next slide, please.

And so I'll be moving through this slide pretty quickly, but as a reminder, all the information on this slide can be found in greater detail in our June 2025 chapter.

Our chapter describes other findings, such as that both assessments and admissions are characterized as fragmented and variable by states. The chapter also emphasizes the importance of home- and community-based behavioral health services and that the lack of such services can affect access to residential treatment. The chapter notes that the well-documented prohibition of Medicaid payment for room and board also continues to pose a barrier to care, and finally, the chapter acknowledges the ongoing challenges posed by an insufficient behavioral

health workforce.

And so thank you all for listening so far, and I'll pass it over to Joanne to go over our draft policy options.

* JOANNE JEE: Thanks, Sheila. Hi, Commissioners.

We're going to start talking about our draft policy options for your consideration. We're going to talk about three main areas where we offer some options. We're going to go into detail, but this slide here on slide 10 is really just intended to orient you to what those options are.

The first is intended to address the lack of complete and up-to-date information on facility and beds therein and would have the Department of Health and Human Services (HHS) develop a centralized directory of facilities.

The second aims to increase the availability of data and reporting on the use of residential services and the users of those services, with a special focus on out-of-state facilities.

And then the objective of the last option is to provide greater clarity around federal expectations for

discharge planning to promote a smoother discharge from a facility, particularly out-of-state facilities, back to a child's community in their home state.

The first option for your consideration is to recommend that Congress require the Department of Health and Human Services, or HHS, to develop a directory of facilities and that that information be updated regularly and made publicly available. The directory should provide information, including but not limited to, things like treatment expertise, bed availability for both in- and out-of-state patients -- or, excuse me, beneficiaries, and other factors that would be important to consider, such as the accessibility of facilities for individuals who have disabilities.

In developing the directory, federal agencies, namely CMS and SAMHSA, or the Substance Abuse and Mental Health Services Administration, should leverage existing information collected to minimize burden on federal, state, and facilities -- federal and state governments and facilities, and that they engage stakeholders in this development effort.

So this kind of directory is needed because, as

Sheila mentioned, there is no single source of information for it, which makes it difficult for families, providers, and states to identify the resources when they need them.

There currently is no federal requirement that relates to CMS's role in facilitating access to this type of information for its beneficiaries. And although there is some information collected by federal agencies, those do not provide all the information needed to find placement -- to find a placement when it's needed.

For example, as Sheila mentioned, the PRTF attestation information that states and CMS collect provide some helpful information about facility location, but don't expound on what that facility's treatment expertise or bed availability might be.

SAMHSA's treatment.gov website describes several factors, like facility location and the insurances that are accepted, including Medicaid, and is searchable, but does not provide information on bed availability. And as Sheila mentioned, there have been some questions about some of the data that are included in that database.

So Option 2 would be directed at CMS and would recommend that it regularly report on the use of

residential treatment services by youth, and that reporting include non-PRTF facilities, as well as out-of-state providers.

The report should include data on the characteristics of those who use the services as well as the type of services that are being used.

In implementing this recommendation, CMS should leverage existing data collection and reporting mechanisms to the greatest extent possible.

And the policy option would also call on CMS to engage stakeholders in developing this report and any additional data collection efforts.

So, really, this recommendation would be intended to increase data availability on the use and users of residential treatment services, particularly children in this case, and out-of-state facility use. There's only very limited reporting available on these things currently, and having this data can provide a greater line of sight into whether there are aspects of this care or subsets of populations for whom residential care is not working as needed and might provide some ability for states to identify ways to focus any needed interventions. And as in

the first option, there are no federal rules requiring this kind of reporting from CMS.

And lastly, I just wanted to mention that there is precedent for congressional action addressing the need for information on the use of out-of-state providers. In authorizing the Section 1945A health homes for children with medically complex conditions, Congress required that states taking up the state plan option to report different measures on the use of out-of-state providers.

Option 3 is the last option that we will be presenting. It is also directed at CMS, and it recommends that the agency revise federal regulations to establish minimum requirements for discharge planning for youth who leave residential treatment facilities.

This would include information on coordinating and sharing information between out-of-state providers and the new providers that would be assuming responsibility for care.

Our work showed that discharge planning can be helpful for facilitating transitions from inpatient to other health settings. Importantly, this includes community-based settings. The federal PRTF rules currently

identify discharge planning as a required component of plans of care, but don't elaborate on what expectations or requirements for those discharge plans or planning process would be.

CMS has previously opined on the importance and the need of discharge planning in the context of other programs or other aspects of Medicaid. For example, the Section 1945A health homes for children with medical complexity guidance for that program mentions the need for discharge planning. And then the Medicare rules for hospital and psychiatric hospital discharge also are a little bit more expansive in their requirements for discharge planning.

Finally, discharge planning policies do exist at the state level or at least in some states, but those policies are tied to state licensure activities and not really to the Medicaid -- not to Medicaid requirements.

So, Commissioners, during the remainder of this session, Sheila and I are happy to answer any questions that you might have. But your feedback on the draft policy options and whether they are addressing the challenges that emerged through our work would be useful, as well as your

thoughts on any considerations that you would flag as we move towards refining these options.

So Sheila and I will take back your comments and feedback from the discussion to refine those policy options, and then we'll be back with you for further discussion of them in future meetings.

And I'll turn it back to Verlon -- or I'm sorry -- to Bob.

VICE CHAIR ROBERT DUNCAN: That's all right. Thank you, Joanne. Nice job, Joanne and Sheila. Appreciate the work. I think you really did a nice job of outlining where EPSDT does a wonderful job of identifying the needs, but we have barriers in place. And the policy options you put before us, I think, are a set of tools that could be used to help with the frustration that states, providers, and families, and patients find themselves in. So thank you for the great work that you've done on this.

So, with that, I'll open it up to my Commissioners for feedback and input. All right. We've got Adrienne, then John.

COMMISSIONER ADRIENNE McFADDEN: Well, thank you, Joanne and Sheila.

Just a quick comment, I would say. I really appreciate the draft policy options. I think that Policy Option No. 1 gives me slight pause only because of sort of life experience where it feels like intention and impact sometimes diverge when it comes to directories, and that's usually because of the execution failures of directories. For bed availability, this is one area where the directory would need to be maintained and updated quite regularly to ensure that it's accurate and sort of reflects what the true environment is out there for bed availability.

And so just wondering if we have any sort of perspective on how to sort of encourage joint ownership of making sure that data is updated regularly so that the states don't have to stand up significant sort of information exchanges and other things to ensure that the directory is effective.

JOANNE JEE: Adrienne, when you say joint ownership, could you just say a little bit more about what you mean there?

COMMISSIONER ADRIENNE McFADDEN: Yeah. What I mean by that is there's a little bit of accountability on the facilities part, right, to be able to feed data to the

state on a regular basis, probably I would assume daily, just to sort of reflect their bed availability. There would likely need to be some sort of incentive or requirement to those facilities to ensure that that's done, and then there's probably going to need to be some sort of oversight to ensure that the information conveyed is actually accurate, and so just trying to figure out, you know, without trying to solution for that, how we can create some guideposts to make sure that the directory would actually have the impact we intended.

JOANNE JEE: Okay. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Adrienne.

John, then Mike, then Jen, then Patti.

COMMISSIONER JOHN McCARTHY: I guess I was thinking of this one a little bit differently than Adrienne was talking about this one, because I thought, for one, it wouldn't be a data exchange of the PRTF to the state, and then the states to the Feds, that it would be the feds, you know, controlling the database on this one, so the PRTF would be reporting directly to the Feds on this. So I think that's, Joanne, one of those issues, like, we just have to think through as well.

My other issue that I have with No. 1, which is -- and I know the reason the recommendations are run the way they are is because we're limited to Medicaid, but one of the issues with PRTFs is not just Medicaid kids in there, but it's all kids that are in there. So I think this is one of those few examples, for me, at least, where I do think having a federal role in this would be helpful, because, to me, you really need an entity to be able to collect all this data from all the PRTFs to be able to then be able to look at and see where are beds available, what service levels, all of those things across the country, since so many Medicaid agencies require on out-of-state PRTFs to send kids, fortunately or unfortunately, in those circumstances.

So I actually do support No. 1. I think one of my questions would be, could we go further to say that, you know, they would be doing this for all kids and they're not, you know, commercial? There's kids who have commercial insurance also going to PRTFs and people who are private pay, so, you know, something like that that keeps track of those things.

You could tie that back to what was being said

before, Adrienne. You could tie that to, as a requirement for Medicaid participation, right, a PRTF would have to be willing to report this on a daily basis, you know, that type of a thing in doing it.

And so I also like the fact that you were bringing in the other agency like SAMHSA on this, because this isn't just a CMS issue. That's what I was trying to figure out, kind of where this fits within the, you know, overarching point of this, because, again, got kids who have commercial insurance that are in there also. So I do like No. 1.

I also like No. 2. I think you -- again, there's things that we probably need to work out in there. But, you know, it's important to have that information.

I guess on No. 3, I understand why it's in there, not as supportive on that one. I don't know how much of a change it really would bring about. It'd be quite a bit of work, but I just want to reiterate my support for No. 1 and No. 2.

VICE CHAIR ROBERT DUNCAN: Thank you, John.

On 2, you mentioned there's some things you could tweak or work out. For the staff's sake, anything

specifically you think?

COMMISSIONER JOHN McCARTHY: Just what -- and I have to go back and look what's in there, but it's, you know, what different data bits are -- and what different data are we collecting on these different pieces and how are we doing it, just from the standpoint of, you know, we got HIPAA regulations, things like that. How do we identify certain bits of information that we would need to be able to use? So, you know, I'll continue looking at that one and then get back to them.

VICE CHAIR ROBERT DUNCAN: Thanks, John. Appreciate that.

All right. Mike, Jenny, Patti, and then Heidi.

COMMISSIONER MICHAEL NARDONE: Thanks. Thanks for this. Thanks for this work.

I wanted to -- I just wanted to ask a couple of questions. So, on the first one, I was struggling a little bit with kind of -- this just seems like it would be an immense database that would have to be managed on a pretty regular basis to really be of use to actually make -- help parents find beds somewhere in another state. And I'm just wondering, are there any examples of the Feds pulling

together this type of resource? And I'm just wondering, like, it's a good to have. I'm just wondering the feasibility and what the investment would be.

And the other thing I was trying to -- so that was a big question I had about 1, just because, I mean, it seems like these -- if it was really going to be helpful to states and individuals -- and I was struggling with this a little bit -- it would almost seem to be better to have it on a regional basis, right? Because you're not wanting to send someone from Pennsylvania to California or California to Pennsylvania. I mean, you're wanting to keep the person close by and even if it can't be facilitated in state.

So I just was struggling with that a little bit, kind of like what -- I don't know. I don't know if you have any -- I don't know if you have any other examples of where we're doing this. I mean, I just know in state, it was always a challenge to make sure that, you know, just the provider directories are up to date, right, on like -- on services within the state. So I just questioned doing this at the federal level, not necessarily not supportive, but I'm just wondering about the feasibility. I don't know if you have any comments on that.

JOANNA JEE: Yes. So we did think about sort of the challenge that would be associated with option 1, and we did specifically talk about what is learned with keeping things like provider directors up to date. I'm not actually aware of any sort of national database or registry. The SAMHSA findtreatment.gov is sort of the closest that we got to. Perhaps other Commissioners might have some insight into that, and we can, of course, keep looking, and we're happy to do that.

I just wanted to comment that we thought about this on a national level initially, just to respond, Mike, to your comment about a regional basis, just because of what we had heard so much about, like the out-of-state placements. And, you know, I never really thought about if the out-of-state placements are happening really sort of more regionally, like on purpose, or not. We do know that kids are traveling rather far from home in some cases, out of necessity, because they're going to where the beds are. So that's an interesting idea.

COMMISSIONER MICHAEL NARDONE: Just not sure where it would be housed, right? It's not clear where they reasonably would be housed. That's what I was kind of

trying to think through.

JOANNA JEE: Sure. Sure. But because of the nature of the out-of-state placements, we thought that having one single place for the information would sort of, a centralized place would make it easier for people who are looking for the placement for a child or a youth.

COMMISSIONER MICHAEL NARDONE: It does speak to, though, the value of number 2, right, which is just some of the basic information around who is located out-of-state, who is being sent out-of-state, you know, where are the facilities. Just that basic information, I strongly support number 2, just because we don't even know what the population is that we're really talking about, right. And just some of that basic information would be really helpful to have.

And I guess the only other comment I would have would be on number 3. I believe this is part of the work, so I just wanted to specifically highlight it, is I don't have an issue with discharge planning. I think that's a great idea. The issue is are there placements for kids to be discharged to? And so, you know, developing some of those alternatives I think is something we'll be coming

back to. But I wonder, the placement, or at least I would hope that if we are writing a chapter around that, there would be a lot of discussion that we would be coming back to that issue, or that it's a big part of discharge planning, is having the capacity in-state to be able to transition these kids.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike. Jenny, then Patti, then Heidi, then April.

COMMISSIONER JENNIFER GERSTORFF: Thanks, Bob. On option 1 I had questions similar to the other Commissioners. I think it wasn't clear to me who would be responsible for reporting to the list, maintaining the updates, if that was on providers or on states, or if that's something that would be worked out in engaging with stakeholders to develop something there. So more on that would be helpful.

And then what kind of IT systems would be necessary to maintain this kind of registry. Having that real-time information seems like a big lift, gets expensive, and I think the value may be well worth it in improving access and treatment for children. But looking more into what it would take to create that kind of

registry would be helpful.

And then on option 2, I just wanted to clarify, when we're collecting utilization, would non-PRTFs include inpatient hospital settings or observation stays, where a residential treatment facility might be an appropriate method of treatment, but the access isn't there. And so kids are boarded in emergency departments or inpatient beds.

JOANNA JEE: Yeah, so the option does not specify all of the data elements, and I think part of the idea behind the option is to engage the stakeholders, a breadth of stakeholders, to identify sort of what pieces of data would be the most helpful, thinking about what data are currently available and how they can be brought to bear to the effort. So that's sort of the approach behind that option.

COMMISSIONER JENNIFER GERSTORFF: Thanks, Joanne.

VICE CHAIR ROBERT DUNCAN: All right. Patti.

COMMISSIONER PATTI KILLINGSWORTH: So many thoughts. Such an important topic and an area of the system much in need of improvement.

Kind of at an overarching level -- and I know

we're overreaching, but I just need to say it -- this is a delivery system issue. And I know that we're sort of carving out pieces of it to look at, but it's really hard to look at residential services without looking at the availability of appropriate community-based services. Sheila, one of the things that you pointed out, and it's in the chapter, this requirement that in order to be admitted to a PRTF you have to determine that community resources aren't sufficient. Well, are they not sufficient because of the child's needs or are they not sufficient because of lack of availability of the appropriate supports for the child, right? So that drives utilization, and I'm looking forward to getting to that piece because it's just hard to look at part of the system in isolation.

Like my fellow Commissioners, I think 1 and 2 are -- well, I think they're all good ideas. I do see the challenges in execution on number 1. I have a question about can HHS actually require reporting from facilities that for whom there are no federal conditions of participation. Sort of what's their authority lever to be able to force that reporting, and what's the mechanism for it, if there's not an interaction with the federal

government on a regular basis, which is something to think about there, while saying that I do think that the access to those basic data elements would really help to inform policy decisions going forward.

One of the things I'd like for us to think about, I know we were going to try to collect data on bed availability by available for in-state versus out-of-state. As a matter of policy, I don't think a facility should be allowed to hold beds for higher payment services, whether that's commercial payment or out-of-state payment. A bed is a bed. If you participate in the Medicaid program, availability is availability, and you shouldn't be able to discriminate against in-state Medicaid beneficiaries in order to attain higher payment for the services that you provide.

I want to talk about 3 just a little bit, because I think this is an area where there's policy, but it's so nonspecific that it's virtually useless. To engage in discharge planning can mean very, very little, and I say that as someone who has actually reviewed those discharge plans before. So I do think that greater specificity would be incredibly helpful in discharge plan requirements, and

I'll give you some specific examples.

Effective discharge planning that does not engage the family, whether that's family of origin or foster family or whomever, where that child would be returning to, it's useless. You have to have that family engaged in the process.

You have to identify a community provider, and while I understand that we may think that there aren't enough community providers available, you can't just kick a kid out of a setting because they no longer need that level of care without appropriate supports in place to be able to meet their needs going forward. It's so irresponsible on our part to just say, "Well, they don't need the level of care anymore." We've got to have a plan. It's got to be an effective plan that engages an identified community provider who will support that child upon return to community, and everybody is really working together to figure out how to make this transition successful for that child and successful for the family who will support them, hopefully, or if it's an alternative residential placement, everybody sort of needs to be at the table.

So there's a full disclosure of what the child's

needs really are and understanding of that and the ability to make sure that the appropriate supports are in place for that child before they ever leave. That would include the availability of sort of after-hours, if you will, support for whoever that family is that's supporting that kid. Who do I call when things go south, so that I'm not running right back to the emergency department again in order to meet my child's needs? There needs to be the availability of that crisis support, that stabilization support.

And then in that vein, when we think about useful data, I think one of the most useful pieces of data that we might be able to get would be ED utilization for behavioral health conditions and then particular extended stays, this ED boarding issue. When we see kids popping up all the time in the emergency department, and staying there for long periods of time, it tells us a lot about the access issues in our system that could help us to drive and inform better policy decisions.

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

VICE CHAIR ROBERT DUNCAN: Thank you, Patti. Heidi, then April.

COMMISSIONER HEIDI ALLEN: Thank you for these really great options, and I appreciate all the Commissioners who spoke before me.

Related to draft policy 1, I mean, I definitely hear what folks are saying about feasibility. But it seems to be like such a critical part of making smart choices about when and where to send people that without having this recommendation I think that we undermine a lot of our policy objectives.

And, you know, I'm always amazed that we have cars that can drive us without a driver. Like our capacity for technology is so great. You know, somebody can take a picture of you from a drone and put you in a database, and they can find you anywhere. And yet we can't figure out what the census is for these hospitals and who is where?

And I think that the problem extends also to long-term care facilities and not knowing how many beds are available there, and how many people are there. And these have significant broader issues in terms of climate change, environmental disasters, where you need to know where people are, and you need the state Medicaid agency to be able to engage in supporting moving people out of fire

zones. Like there's just so many reasons for us to insist that we have a census of where people are and where people can go. And I 100 percent agree with Patti that it should not be allowed to withhold beds for higher paying patients.

And with draft policy option number 3, I think that just somehow this has been in our materials and this has been in our reports, but the fact that so many people stay in out-of-state placement simply because the state says "we don't know how to take them back" is just completely unacceptable. And I would really suggest that we have some kind of penalty for keeping people in place longer than a certain period of time that seems reasonable to come up with a way for them to come home. It's cruel to have kids who have completed their treatment, sitting out-of-state, away from their family and their community simply because the state is like, "Well, we can't figure out a way to bring them home."

And so it's about more than discharge planning. It's about discharge execution. And I believe there should be consequences for failing to bring kids home in a timely way. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi.

April?

COMMISSIONER APRIL HARTMAN: Thank you, everybody, for that information and the comments of my fellow Commissioners. I don't have much to add. I think people have pretty much covered it.

One thing, though, that I did want to bring out on policy 2, there was some discussion about making sure that when data is collected what behavioral health conditions that facility treats. One thing I would also say is please, if you're going to list facilities and what they offer, include age range. I had an 8-year-old who was suicidal, and there was no place to send them because all of the residential places started at age 12. So even though it says youth doesn't mean that they cover everybody. So that age is going to be really important to know where we can send kids, not just based on their condition but their age, because there's so many that there are no options in those cases.

So that's the only thing that I would add. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, April. And I would like to highlight I appreciate both Patti and

Heidi's comments on the discharge component and the coordination that that takes, because I do think that's an incredible piece that we've got to work to solve. Also the idea of looking at those in the ED, because I think that's where you see that continuation of that. And April, I really appreciate that age component, because we personally run into that ourselves when trying to work and place children. So that is something that needs to be identified.

Dennis.

COMMISSIONER DENNIS HEAPHY: I wasn't going to say anything, but I really would thank you guys for the work you did on this, because there's such an urgency around it. I don't think we speak to that enough, that we really need to get this going. So I appreciate everything that you put forward, and I hope we can get these policy options going so that kids are getting the services they require, in-state or out-of-state, but just hopefully getting started. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis. So Joanne, Sheila, do you feel like you've got enough to go back and tweak? I heard some concerns and questions around

policy number 1, of how that is implemented, and fleshing out some of the others, 2 and 3. But any other things you need from us?

JOANNA JEE: No. You gave us a lot to think about. Really, really useful conversation today, so thanks.

VICE CHAIR ROBERT DUNCAN: Well, thank you. I appreciate the work. As Dennis highlighted, I think this is critical and urgent as we look across the country and the needs of our children and their families. So thank you very much.

And with that, I turn it back over to Madam Chairwoman, Verlon.

CHAIR VERLON JOHNSON: Thank you, Bob, and that was really a great discussion and some great information.

So, you know, next, we're going to move into a discussion on community engagement, and so this session is really going to focus on the implementation of community engagement requirements and then how we are thinking about the effects on coverage, access, administrative burden.

So with that, I'm going to turn it over to Janice and to Melinda

CONSIDERATIONS FOR IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS: PRINCIPLES AND POLICY OPTIONS

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

Today Melinda and I will present draft principles for implementing community engagement requirements, and then we'll discuss a policy option for monitoring and evaluation. This session builds on the Commission's work to date on this topic.

In September, we discussed the statutory community engagement requirement, and we facilitated an expert panel with Medicaid directors from the District of Columbia and Utah, an enrollment assister from Georgia, and a Medicaid systems expert who previously worked at the Centers for Medicare and Medicaid Services, or CMS.

In December, we presented considerations for implementing community engagement requirements based on our findings from stakeholder interviews, and we also facilitated a panel with representatives from CMS and the National Association of Medicaid Directors to discuss federal and state efforts to operationalize requirements.

Today's session will begin with an overview of the community engagement, or CE, requirements pursuant to the 2025 Budget Reconciliation Act. Then, we will introduce the draft principles for implementing CE requirements. Then, Melinda will go over the policy option for monitoring and evaluation, and then we'll conclude with next steps.

As defined in the law, the requirements apply to non-pregnant, non-dually eligible individuals ages 19 through 64 who are eligible for the adult expansion group, or a Section 1115 waiver providing minimum essential coverage.

There are certain exceptions to these requirements that fall into two categories. There are mandatory exceptions, such as beneficiaries who are pregnant or entitled to postpartum coverage, are medically frail, or have a dependent child under 14. And states also have the option of providing short-term hardship exceptions, such as when a beneficiary has an acute inpatient stay or they must travel long distances to receive care to treat a serious condition.

To satisfy the requirements to obtain or maintain

Medicaid eligibility, individuals must work or volunteer for at least 80 hours in a given month, or they must attend school at least half-time, or a combination of any of these activities.

States are required to establish these requirements by January 2027 unless they receive a good-faith effort exemption, and CMS must issue an interim final rule, or IFR, by June 1st, 2026.

Next, we'll cover the principles for implementing CE requirements.

The draft principles are an organizing tool that help highlight the high-level takeaways from our research, and they're intended to represent the Commission's priorities for implementing CE requirements. The draft principles also tie directly to the major considerations that emerged from stakeholder interviews, and they reflect input gathered from the Commissioners during recent public meetings.

We anticipate including the principles in the June report chapter on implementation considerations, and the chapter will include a detailed discussion of related considerations, which were presented in December.

The first principle that emerged from our research is that CMS should provide timely federal guidance and technical assistance to states. Stakeholders emphasized the importance of CMS engaging early and often with states to support implementation of CE requirements. Many expressed concerns that states would not be able to implement by the deadline if states don't receive guidance from CMS before the IFR is due.

They also noted that understanding which topics CMS will address in guidance, including which decisions they will leave to states, would help states plan and prioritize more effectively. Stakeholders also talked about technical assistance. States would benefit from scenario-based TA from CMS and opportunities to learn from other states as they implement CE requirements.

The second principle we identified is that CMS and states should ensure that eligible individuals can gain and maintain coverage. Stakeholders have highlighted opportunities for states to minimize beneficiary reporting burden and to reduce coverage loss by using ex parte processes.

States can also reduce beneficiary reporting

burden by modifying enrollment applications, for example, by adding questions related to exceptions, and by deploying new tools to collect needed information, such as using income verification as a service or developing user-friendly consumer portals for beneficiaries to upload needed documentation.

Another way to help beneficiaries gain and maintain coverage is by promoting beneficiary awareness. Stakeholders highlighted how states can raise awareness and help individuals navigate the requirements by coordinating with community partners, such as faith-based organizations, providers, and managed care organizations.

The third principle that emerged from our research is that CMS and states should prioritize efficiency when procuring, updating, and operating state information technology systems. Stakeholders noted that Medicaid IT system changes needed to implement CE requirements will likely be costly and time-intensive. For example, increased reliance on certain data sources such as The Work Number are likely to influence implementation costs.

Stakeholders expressed concerns that the short

implementation timeline limits states' abilities to automate processes and competitively procure systems vendors. Stakeholders suggested to mitigate some of these concerns that CMS support states in the procurement process, including by leveraging the Advanced Planning Document, or APD, process to establish vendor expectations and expected costs, and by streamlining the APD process to alleviate time and resource constraints.

The fourth and final principle is that CMS and states should use timely monitoring and evaluation data to inform policy and operations. Stakeholders emphasized the importance of monitoring to help identify effective practices and trends that suggest the need for policy or operational adjustments.

The Public Health Emergency, or PHE, unwinding provides an example of this when state reporting informs efforts to address issues that contributed to potentially avoidable disenrollment.

Stakeholders also highlighted the need to assess whether CE requirements are meeting the stated goals of improving health and increasing employment.

And with that, I will pass it to Melinda.

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

The stakeholders we interviewed, as well as Commissioners in our previous public meetings, have expressed interest in making sure that there's transparent monitoring and evaluation of CE requirements in Medicaid.

In this section, I'll present background on monitoring and evaluation, followed by a policy option for the Commission to consider including as a recommendation in the June report.

Monitoring can provide ongoing updates on implementation as well as data on process and outcome measures to help identify trends that may warrant policy or operational changes.

CMS uses state-reported data to support Medicaid program monitoring. States submit data to CMS through a variety of mechanisms, including the Medicaid and CHIP Eligibility and Enrollment Performance Indicators project, Medicaid and CHIP Eligibility and Processing Data submission, and the Transformed Medicaid Statistical Information System, known as T-MSIS.

Performance indicator data provide monthly

metrics on key Medicaid and CHIP eligibility and enrollment processes and include state reporting on specified topic areas, such as call center volume and application processing time.

Eligibility processing data are largely focused on renewals and help CMS monitor the renewal process through reporting on metrics related to application processing, renewals initiated, renewal outcomes, and Medicaid fair hearings. Through T-MSIS, states also submit monthly data on enrollment, utilization, and spending.

During the PHE unwinding, CMS began using the data submitted through these three systems to publish a monthly snapshot on eligibility and enrollment. CMS continues to publish that monthly snapshot, though it is no longer required to collect and make public certain data on eligibility determinations and redeterminations.

In addition to routine monitoring of state Medicaid operations, CMS monitors the implementation and operation of Section 1115 demonstrations through a variety of mechanisms, including quarterly and annual state reporting. The agency has made efforts to enhance the rigor of state monitoring reports, including through the

release in 2019 of a monitoring report template and associated metrics for CE and other eligibility and coverage demonstrations.

Evaluations help answer the question of whether a policy change achieved desired outcomes, such as improved health. In Medicaid, evaluations are most commonly conducted for policies implemented through 1115 demonstrations. States are required to conduct independent evaluations of their demonstrations and submit a series of evaluation-related deliverables to CMS.

CMS has taken steps in recent years to improve the quality of state-led evaluations, including with the release in 2019 of detailed guidance on evaluating CE and other eligibility and coverage demonstrations.

At times, CMS conducts federal evaluations of 1115 demonstrations, such as those for substance use disorder and serious mental illness.

The agency is using a meta-analytic approach that examines the experiences of multiple states to provide insight into the factors that affect implementation and outcomes.

CMS has published a series of rapid-cycle reports

for both demonstration types and plans to publish summative evaluation reports in the future.

Finally, Congress has, at times, directed the Secretary of the U.S. Department of Health and Human Services to evaluate new Medicaid policies and programs such as the Certified Community Behavioral Health Clinics demonstration and the health home state plan option.

Based on the evidence gathered in the course of our project work, we are presenting a policy option on monitoring and evaluation. The policy option reads as follows: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, CMS, to develop a transparent plan for monitoring and evaluating community engagement requirements in Medicaid that provides insight into how such policies affect eligibility and enrollment, health status, employment, and the attainment of other identified policy goals. CMS should identify new metrics for state reporting as needed and build upon existing data collection activities to minimize administrative burden. Additionally, CMS should ensure the timely publication of monitoring and evaluation results to inform policy and

operational decision-making.

Stakeholders have consistently emphasized the importance of monitoring changes in eligibility and enrollment following CE implementation. Monitoring is critical to help CMS and states identify trends in policy or operational adjustments that can mitigate coverage loss among eligible individuals. Monitoring can also assist in identifying effective practices that could be replicated in other states.

There are no statutory requirements for monitoring CE implementation. CMS plans to monitor, and as you'll recall at our last meeting, Caprice shared that there is ongoing consideration at CMS of potential new metrics for state reporting. With input from states, beneficiaries, and other stakeholders, CMS should develop and make public a monitoring plan that includes new, meaningful metrics for tracking changes in eligibility and enrollment following CE implementation.

Stakeholders stressed the importance of tracking metrics over time and stratifying data by certain characteristics, such as demographic characteristics and application type. In developing this plan, CMS should

consider building on existing reporting mechanisms to collect new data while minimizing state reporting burden. CMS should further ensure that state reporting is made available to the public on a monthly basis and consider providing context to help interpret potential state variations.

This table lists potential metrics for monitoring as suggested by stakeholders, which could inform the development of CMS's monitoring plan. The table shows relevant metrics and indicates whether they're currently collected and made public by CMS.

Some of the proposed metrics are already publicly available through performance indicator, eligibility processing, or T-MSIS data, whereas other metrics specific to CE would be newly reported by states and published by CMS.

In addition to monitoring, several stakeholders noted how evaluation is critical to understanding whether CE requirements are meeting the goals articulated by policymakers, including those of improving health outcomes and increasing employment and self-sufficiency. Policies that make participation in work and other CE activities a

condition of Medicaid eligibility are relatively new and have not been widely evaluated.

CMS has not indicated plans to conduct its own evaluation or set expectations for state-led evaluation efforts. States can choose to conduct their own evaluations, though it's unclear how many will do so, and state-led evaluations may be limited by competing priorities and other factors.

CMS has experience evaluating state policy changes and can draw upon that experience to assess whether CE requirements are resulting in better health outcomes and employment gains. CMS can also leverage timely access to certain data sources, such as T-MSIS and potential employment data from the Internal Revenue Service.

In developing an evaluation plan, CMS should consider past evaluation approaches, such as the meta-analytic approach used for evaluating certain 1115s.

In addition to carrying out and making public the results of such an evaluation, CMS should prioritize the development of rapid-cycle reports that provide timely, actionable insights that can support continuous improvement. These reports could, for example, document

key features of state approaches and consider their relationship to relevant process measures, such as rates of ex parte and procedural terminations.

As far as next steps, we welcome your feedback on the draft principles and policy option. Depending on your interest, we'll refine the principles and policy option and return in April to present them as part of the draft chapter for the June report.

For today's discussion, it would be helpful to hear your thoughts on the following questions. Do the principles presented reflect the Commission's priorities for CE requirement implementation? Are there outstanding questions about the policy option that we can answer? And are there other factors that we should consider when refining the principles, policy option, and rationale?

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

CHAIR VERLON JOHNSON: Thank you, Janice and Melinda. This was really helpful. I really appreciate the work you really put into this, especially in bringing us the set of draft principles, and the monitoring and evaluation policy option for our consideration is really

good.

As I turn to my fellow Commissioners, I do want to ask you to keep the questions that Melinda laid out in mind and think about what you heard. So one, do these principles reflect our priorities, particularly around coverage instability? Are we striking the right balance between accountability and administrative burden? And then also, what other information, as she said, do you want to know early on to understand how basic implementation is actually playing out?

So with that I see Tim Hill's hand is up first, so Tim, I'll turn to you.

COMMISSIONER TIMOTHY HILL: Holy cow, first. So this is great work and I appreciate it. The dialogue especially you guys have been having with outside experts and CMS and others I think is incredibly valuable.

My only comment is really about the recommendation so much the principles which I think are all spot on. But given your point about evaluations, one, costing money and financial resources, and two, that at least now we haven't seen out of HHS a commitment to doing a large-scale evaluation such as what they would do under

an 1115 demonstration, I wonder if the recommendation ought to be for a statutory change versus a recommendation to HHS, that they require something of CMS. I think a statutory change is more likely to drive action on the part of the department, so I would just offer that as a consideration.

CHAIR VERLON JOHNSON: Thank you, Tim. Mike.

COMMISSIONER MICHAEL NARDONE: Yeah, thank you for this. I thought that you captured in your recommendation I think a lot of the points that I would like to see, because I think the importance of evaluating and monitoring this is critical.

I guess a couple of things I just wanted to see maybe reflected in the recommendation, which is when we talk about transparency, I don't think there's anything in the recommendation language around actual input from other stakeholders. And I think so maybe transparency is a way of saying that, but transparency is just about, I think, having people see what the evaluation tool will be without having any input, and I think there could be value in that.

The other thing I would hope we're looking at, maybe not necessarily in the short term but in the longer

term evaluations, is kind of some analysis of the costs of this endeavor and the benefits. You know, that's some of the information that we've had around earlier experiments. I think understanding a little bit better what it costs to implement these various initiatives in relation to the number of people who find jobs, successfully engage in community experience, I think would be helpful from an analytical perspective.

CHAIR VERLON JOHNSON: Thank you, Mike. I appreciate that. Doug.

COMMISSIONER DOUG BROWN: Thank you. Thank you for the work here. I have a comment on the policy options, and maybe it's just me but I'm having trouble with the health status in the middle of the policy here. I'm not sure of the meaning and the context and what you're looking for CMS to report on the health status of the individuals in the expansion population that are required to do the work requirements here. Are you looking to track if they have diabetes, hypertension, obesity, and for some reason I get disenrolled and what the health outcomes for those patients might be if they didn't have Medicaid, but once they're out of the program you're not tracking them from a

HIPAA perspective anyway.

So I'm having trouble with that definition of health status and what you're trying to collect inside the policy. I'm not sure how to revise that. I'm not sure if other Commissioners would like to opine on that piece. But I'm struggling with the health status and what you're going to collect as part of this policy. Thanks.

MELINDA BECKER ROACH: Doug, can I just maybe jump in with a clarifying question? You were highlighting the policy option related to evaluating the effect of community engagement on health outcomes. Is that what you were reacting to?

COMMISSIONER DOUG BROWN: Yes. Or just the term "health status." Policies affecting eligibility and enrollment, health status, employment, and the attainment of other identified policy goals. It's the "health status" piece. I'm just not sure how you're tracking that, or what you're asking CMS to track before and during community engagement activities. And maybe it's just me. Maybe it's just the way I'm reading it.

MELINDA BECKER ROACH: No, that's helpful feedback. We can take that back and give it a little bit

of thought. I think we tend, in these instances, to be a little less prescriptive, but if there are sort of certain aspects of an individual's health or certain measures that the Commission thinks would be important to be able to sort of track, that's something that we could consider building into the rationale associated with the recommendation.

COMMISSIONER DOUG BROWN: Thank you.

CHAIR VERLON JOHNSON: Thank you. Jami, then Heidi, then Anne.

COMMISSIONER JAMI SNYDER: Yeah, I really agree with you, Doug. I had a question around that, as well, in terms of what we'd be tracking relative to health status.

The other item that I just wanted to mention, first of all, I'm supportive of all the principles in the policy option presented. But on principle number 1 that has to do with timely federal guidance and technical assistance, I think the thing that I'm most concerned about right now, today, is states' readiness to go live with community engagement requirements by the end of the year.

So I don't know that we have to articulate it in the principle, but I do think it would be helpful if CMS would supply states, and perhaps they're doing this

already, with a readiness checklist or a readiness assessment tool, so that states could, on an ongoing basis, really assess where their areas of risk are and what they need to prioritize in order to go live. That kind of assessment would also be helpful to CMS, right, too, in determining whether there are states that are really at risk of, you know, challenge or failure in going live, based on what they're seeing in the assessment.

CHAIR VERLON JOHNSON: Thanks, Jami. Heidi.

COMMISSIONER HEIDI ALLEN: Thank you. I'm so happy we're doing this. I'm fully in support of the principles. I wanted to second some comments made by previous Commissioners, such as the potential for statutory change, stakeholder engagement, Mike's comment on measuring cost. I'd also be interested in some measure of churn and time spent uninsured, and appeals. And some way to understand unintended disenrollment for non-affected enrollees, other than, you know, we have the total disenrollment, but it's hard to tell temporal changes from when there may be accidental spillover effects by confusion, that people hear that they need to be working and they don't understand that they're an excepted

category, that it doesn't apply to them, but then they fail to re-enroll.

And then the last thing, and I don't know if this is possible, but this feels like something that would be worthy of CMS issuing an RFP for research organizations to do a really thorough evaluation. You know, kind of what we would expect from a Section 1115 waiver, though not all states do partner with academic or research organizations. But this is such a big policy change that having an external organization that has access to all of the relevant, necessary data so those data use agreements are in place and the data is available, and qualified health services researchers who can use that to really do some important work on the impacts of this policy change.

CHAIR VERLON JOHNSON: Thank you, Heidi. Anne, and then Carolyn, and then John.

COMMISSIONER ANNE KARL: Yeah. Thank you so much for all of this work. It's really great work, and I think it's helpful to see these principles laid out.

On the metric specifically, I just wanted to underscore. I think that the community engagement metrics are really helpful, and I think the type of information

that is needed to really monitor the impact. So all of the things about trying to be granular about who is subject to community engagement, who gets an exception from that, who is assessed on an ex parte basis, who is found to be non-compliant because they don't meet the community engagement requirements, or just that they didn't submit evidence.

So I just think all of that granularity, and I understand that it's just going to be really important, and I understand that there's always a scariness about imposing too much burden on states with reporting. I just think that given the newness of this policy and the impact on beneficiaries that it becomes really important to have this level of detail. So I think that the policy option, as it's worded today, is helpful, but perhaps some more specificity that gets at some of the specific pieces would be helpful to include in any monitoring plan.

CHAIR VERLON JOHNSON: All right, great. Thank you so much, Anne. Carolyn, then John, and then April.

COMMISSIONER CAROLYN INGRAM: Yeah. Thank you again for putting this together. I think it's a great start. I think as we keep going my guess is there's going to be more things than are brought up today that we want to

make sure to look into.

A couple of things, and I'm not sure exactly whether it's metrics or for consideration or in the recommendation. First, we talked about the need for automating things, to make it easier for members. There are a lot of newer technologies out there that are not kind of the old eligibility systems that allow members to very quickly put in information. They draw from payroll stubs to help members populate the information, to apply for public assistance programs. But state systems aren't open to accepting. They don't have open API.

So something to, I guess, encourage or ask for more automated processes to make it easier on members. When we've been looking at programs and ways to help members and states, there are states still that require wet signatures on documents. And sometimes the beneficiary can't easily get to the office to do a wet signature. So coming up with another way to sign documents. I mean, you're talking about a very basic thing. There's one state agency, many of you might guess, but they call the house to verify the application, and if you're not there to pick up the phone during that time, you miss your opportunity in

line, you could then lose your eligibility.

So there's got to be better processes and automation to what we can put in place here to make it easier for clients.

The other thing is looking at self-attestation for things like volunteering. I know on this screen here we've got -- there's the ability for community service and those types of things. But having some flexibility around making it easier for people to do self-attestation is going to be important for this population.

And then lastly, I'll say we talked about, and I don't see in the recommendations, but looking at what these changes are actually going to do to the overall population for Medicaid and access to care. We know that folks are going to lose coverage because of this requirement and change for different reasons. The population that's going to be left in the pool are going to be those that are at higher risk, higher need, and cost more to states.

So I do understand there's a great savings that's anticipated with this change, but I anticipate that actually the overall cost of the program is not going to be that significant, because the folks that are left are those

that are at higher risk, higher need. And there's actually going to be a need to review rates to providers, rates to managed care companies and others, to make sure that they are appropriate, because you're not going to have as many people to spread the risk across.

And so something in our policy option recommendations that rates also be reviewed, in terms of two things. One is to providers and then also to managed care companies in the rate-setting process, to take into consideration the high risk needs and high cost populations that are going to be left there. So thank you.

CHAIR VERLON JOHNSON: Thank you, Carolyn. John.

COMMISSIONER JOHN MCCARTHY: I'm just going to hit on the fact that I think earlier those guys were talking about the measures. One of them was if people fall off track, if they're uninsured, and that would be data that CMS and the states don't have, right. So I think we just have to make sure that when we're proposing metrics, the ones that we have here now I think hit on the things that they can collect, but other things, you know, they don't have. So for instance, if a person comes off Medicaid, you know, what's the reason why, but then do they

have other health care insurance that's not something that's collected now. And that's been talked about a couple of times, that's something that if there's some way we could track, but I don't know that right now.

I think the other thing we need to be thinking about in these metrics, and CMS should be able to have this, is how many people that come off of Medicaid, because their income goes up, but then they end up on the exchange. So that would be an example of them having data, so we could at least see how many people are moving from Medicaid into the exchange. Thanks.

CHAIR VERLON JOHNSON: Thanks for bringing that up, John. April.

COMMISSIONER APRIL HARTMAN: Yeah, and John kind of just asked what I was going to asks. I would want to know in the metrics how many people were not eligible anymore because they became employed. I didn't see that as a metric. But just knowing, is it doing what we want it to do, which is increase employment.

And then I think it is important to look at are they uninsured or do they get other insurance? Because when you look at someone working 80 hours a month, as part-

time, 20 hours a week, a lot of place, I know in my area, have gone to $15 an hour as the minimum. And it's very easy to disqualify yourself for income reasons once you get a job if you're working more than part-time, but you may not qualify for the insurance of that company that often requires you to work 30, 32 hours a week in order to get that, because then you would make yourself ineligible because you made too much, but you don't have enough to qualify for insurance.

So I think we need to kind of keep that in mind, to watch and see do people become uninsured and if they got a job, what happens after that.

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

[Pause.]

CHAIR VERLON JOHNSON: I think, Dennis, you may be on mute still.

COMMISSIONER DENNIS HEAPHY: Sorry about that. I agree with a lot of the things that were said about internally tracking data, that I was looking at the impact on folks who are no longer eligible for Medicaid, don't get other insurance, and the impact on the overall cost to the

system.

I also understand, and I tried to go back and look at the document but I couldn't find it, and that's privacy protections in the collection of data, who has access to that data, and how is that data going to be used that is being collected, to ensure that people's rights are being recognized. Because under the ADA it's perception of disability and then self-disability. So I just wanted to make sure that people are not being discriminated against because of what's being tracked in their data. So how do you make sure that data is being really protected in how it's used. And maybe it's in there. I went back and I just couldn't find what I was looking for. Does that make sense? I don't know, Janice or Melinda.

MELINDA BECKER ROACH: It does make sense, Dennis. It is not something that I think we addressed in writing up the policy option and the rationale, but it's something we can take back and consider weaving in when we come back with the chapter.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Any other questions from Commissioners?

[No response.]

CHAIR VERLON JOHNSON: Any other thoughts?

[No response.]

CHAIR VERLON JOHNSON: All right. Well, I just want to say thank you all for such a great, very thoughtful discussion. I think we definitely heard some strong support for the principles, right, along with some thoughtful questions around evaluation, transparency, and implementation, for sure. I was taking notes. I know all of you were. We had things around automation, churn, appeals, more granular data was also key, as well. So hopefully, Janice and Melinda, this was some good feedback, as you all continue to work. Do you need anything else from us, though, before we close out?

MELINDA BECKER ROACH: I think we're all set. Thank you so much.

JANICE LLANOS-VELAZQUEZ: Thank you.

CHAIR VERLON JOHNSON: Okay, great. Thank you so much. Appreciate you all very much.

CHAIR VERLON JOHNSON: All right. So now we are going to actually turn to open the floor for public comment.

What we'd like to do is invite people in the

audience to raise your hand if you would like to offer a comment. Please make sure that you introduce yourself and the organization that you represent, and we also ask that you keep the comments to three minutes or less, if you can. We appreciate that.

So, with that, let's see who we have. So we have one. Tricia Brooks, the floor is yours.

PUBLIC COMMENT

* TRICIA BROOKS Well, of course, you know, I could not leave this meeting without saying something. Hi, everyone. It's nice to see your faces.

And I missed the first little bit of the presentation, and I don't know if disenrollment surveys were discussed. But I want to bring this to everyone's attention in terms of the timeliness of being able to get at some of the underlying reasons of what's going wrong, isn't necessarily going to come from our quantitative data. We might be able to spot what areas are a problem, but disenrollment surveys could be started in the month following the first month of disenrollment.

And you can ask things like; have you been connected with work? Are you uninsured? What was the

problem with you continuing kind of thing? And that is going to get us the most descriptive information in the first weeks and months to hone in on problems that need to be addressed.

So as long as CMS -- and we don't even know if CMS will publish new data, but even if they do with the three-month cadence that -- and the lag there, it's just going to be very hard for us to get on top of problems early on.

And if you think about it, Arkansas did publish data, and the number of people losing coverage, including children was frightening to people, and as a result, it was intervened and stopped. And so I think we really need to have that quick early look to figure out whether we need to pause and re-examine how things are going.

So thanks for the opportunity, and keep up the good work there at MACPAC.

CHAIR VERLON JOHNSON: Thank you so much, Tricia, and always great to hear from you.

Do we have any other comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. It looks like no,

but again, always thankful for the comments.

Oh, wait. Let's see. We may have one. Oh, Thomas McDaniels, the floor is yours for comment. Thomas?

THOMAS McDANIELS: Hello? Can you hear me?

CHAIR VERLON JOHNSON: We can hear you.

THOMAS McDANIELS: Oh, great. I'm with the HIV and Hepatitis Policy Institute, and on behalf of our director, I had comments.

We are asking MACPAC to have an explicit exemption for people with HIV. As you develop your principles and policy options, we are urging MACPAC to recommend an explicit exemption for all people living with HIV from the community engagement requirement as mandated by Public Law 11921. People with HIV are living with lifelong, serious, and complex medical condition and have special medical needs. They cannot stay healthy without continuous access to lifesaving HIV treatment. Any gap in treatment risks serious health consequences, including failure of viral suppression and the risk of onward transmission.

Longer treatment gaps are potentially disabling, allowing progression to AIDS and after which life

expectancy is limited.

The interpretation -- people with serious and complex medical conditions and special medical needs are statutorily exempt from community engagement requirement. However, absent federal guidance, states can define which population to qualify. This interpretation is consistent with longstanding federal precedents. For decades, Congress and the United States Department of Health and Human Services have considered HIV both symptomatic and asymptomatic as a serious life-threatening and potentially disabling condition.

We believe that all people living with HIV should be exempt from the community engagement because automatically, that is, they should not have to navigate cumbersome new procedures to document their status with each Medicaid recertification.

Since HIV is a lifetime condition that will not change over time, this assessment should only be once. Under statute, states are directed to maximize ex parte verification of eligibility in relation to the community engagement requirements. Automatic exemption through use of data already available to the Medicaid program, such as

diagnostic codes and claims data, minimizes the burden on the enrollee. It also reduces the administrative burden on states and on health care workforce, providing care to people with HIV.

Approximately, 40 percent of people living with HIV nationwide are enrolled in Medicaid, making humane and clinically sound implementation of the new community engagement requirement is of the highest importance to them and their clinical care teams and the communities.

We appreciate this opportunity to discuss these comments, and we have also submitted these in writing. Thank you.

CHAIR VERLON JOHNSON: Thank you so much, Thomas. We appreciate your remarks.

Are there any other questions or any other comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. So seeing none, thank you again for the comments we heard, and I do want to remind all of you that you can also submit your comments on our -- through our MACPAC website, but also want to thank you for your engagement now.

We are now going to take a break and go to lunch, and we'll return back here at 1:30 Eastern. So we'll see you then. Thank you.

* [Whereupon, at 12:30 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:30 p.m.]

VICE CHAIR ROBERT DUNCAN: All right. Good afternoon, everyone. Welcome back to the second half of the day. We're going to pick up where we left off in December with Ava and Linn talking about our children and youth with special health care needs transitioning to adult. And they are coming to us today with some, several policy options to discuss.

So with that I turn it over to Linn and Ava. Thank you.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS COVERAGE TRANSITIONS: POLICY OPTIONS

* AVA WILLIAMS: Good afternoon, Commissioners. Today's presentation will focus on challenges beneficiaries experience with the transition from child to adult Medicaid coverage and the challenges states experience with the redetermination process. We will also present potential policy options to address these challenges.

I will start with a summary of the state flexibilities related to the Medicaid redetermination process before highlighting some findings from our T-MSIS

analysis. I will also summarize state flexibilities related to the transition between Section 1915(c) HCBS waivers. Then I will present on the challenges states and beneficiaries experience with the transition from child to adult Medicaid coverage and between child only and adults of all ages waivers. Linn will finish up with the challenges before moving on to the potential policy options and finishing with next steps.

While there are federal requirements for redetermination, states have flexibility when it comes to Medicaid redetermination policies and processes as well as the ability to adopt optional eligibility pathways. For example, state Medicaid agencies can choose to partner with the Social Security Administration, also known as SSA, to use SSA's disability determination in Medicaid eligibility.

In 1634 states, beneficiaries enrolled in SSI are automatically enrolled in Medicaid, and SSI criteria states that beneficiaries enrolled in SSI can also be enrolled in Medicaid, but they need to submit a separate application. And in 209(b) states, beneficiaries enrolled in SSI need to apply to Medicaid separately because a state may have more restrictive disability criteria than SSA.

States are required to send beneficiaries a notice regarding their upcoming redetermination if they are unable to complete the redetermination using ex parte and need additional information from the beneficiary. But there is flexibility in when states will send a notice requesting additional information.

Lastly, there are mandatory eligibility pathways states must adopt. States can also choose to adopt optional eligibility pathways such as the expansion pathway, as well as extending childhood eligibility up to age 21, using a state plan option.

Along with stakeholder interviews, staff also conducted analysis of T-MSIS to examine children and youth with special health care needs transitions to adult Medicaid coverage. Our findings show that the majority, 82.4 percent, of children and youth with special health care needs enrolled in a disability-related pathway remain enrolled in Medicaid as an adult.

We found variations depending on the disability-related eligibility pathway the beneficiary was enrolled in as a child, beneficiary race and ethnicity, and beneficiary enrollment state. Additionally, we found that more

children and youth with special health care needs in expansion states remained continuously enrolled compared to those in non-expansion states. Among those in expansion states, 13 percent were continuously enrolled and 48 percent of those who churned enrolled in the expansion pathway.

This figure describes the percentage of children and youth with special health care needs who are continuously enrolled when transitioning to adult Medicaid coverage, based on our T-MSIS analysis of data from 2017 through 2019, by state. We found that among those enrolled in SSI-related pathways, 88.3 percent of those in expansion states remained continuously enrolled compared to 78.7 percent in non-expansion states.

Additionally, findings from our analysis of Medicaid covered youth using the American community survey indicates that a larger proportion of young adults, 19 to 25 years, with self-reported disability, without SSI, in expansion states, are enrolled in Medicaid than those in non-expansion states, and a lower percentage are uninsured compared to those in non-expansion states.

States also have flexibility when it comes to

designing and operationalizing their Section 1915(c) HCBS waivers. For example, states are required to have transition planning and age-limited waivers, and there is variation in the robustness of transition planning. Specifically, the level of case management used to support the beneficiary's transition from child to adult waivers and from child to adult Medicaid coverage can vary.

States can also have reserved capacity in waivers for beneficiaries transitioning from certain waivers with certain conditions.

Lastly, states have designed their corresponding child and adult waivers, minimum and maximum age limits to overlap, allowing beneficiaries to transition waivers without a gap.

Even with state policy flexibilities, many beneficiaries experience challenges with this transition and may lose coverage during this period, and in the next section I will go over some of these challenges.

When conducting redetermination, states must first attempt on an ex parte basis, meaning using all available information and not contact a beneficiary unless more information is needed. Many states begin the process

60 to 90 days in advance, and there is no requirement to notify beneficiaries that the redetermination is beginning. Advocates shared that without advance notice of the redetermination, beneficiaries and families may lack sufficient time to provide needed documentation, and the notices often lack clear and actual steps, in plain language, about what the beneficiary needs to submit.

SSA send a notice to an individual if their SSI is terminated, and in states where SSI enrollment confirms Medicaid enrollment, such as 1634 states, the SSA notice will have information about their Medicaid status. But there are no federal requirements for SSA and state Medicaid agencies to coordinate on SSA notice language, and the information related to Medicaid eligibility. Advocates shared that the notices from SSA often do not have accurate information about the beneficiary's Medicaid status, clear, actual steps about how to retain their Medicaid coverage. Additionally, state Medicaid agencies are not required to inform the beneficiary of changes in SSI eligibility unless the state needs additional information to complete the redetermination.

Current federal rules allow states to provide

case management services to support transitions of coverage using a number of authorities, such as 1915(c) HCBS waivers and targeted case management. However, national- and state-level advocates shared that beneficiaries and their families do not receive sufficient support, as with the transition from child to adult Medicaid coverage, as well as with navigating multiple other transitions they may experience.

* LINN JENNINGS: Thanks, Ava. Our next challenge is on navigating the eligibility transition, and there are a few key requirements in state flexibilities that can help ease the Medicaid redetermination process and reduce churn for children and youth with special health care needs.

Currently, states are required to provide 12 months of continuous eligibility for all children under age 19, and this policy decision was made in response to research that shows that continuous eligibility reduces rates of churn. State Medicaid programs also have a number of flexibilities, for example, choosing to be a 1634 SSI criteria, 209(b) state, and this affects the redetermination process for SSI-eligible individuals. So in 1634 and SSI criteria states, most SSI-eligible

beneficiaries are redetermined on an ex parte basis, because their Medicaid eligibility is based on SSI eligibility, and the state could confirm those with SSA. States also have the flexibility to extend child eligibility up to age 21.

And advocates shared that even with these flexibilities, the transition to adult Medicaid can be challenging for beneficiaries and their families. One of the reasons for this is that some of those who are being redetermined may have lost SSI, and so they need to provide the state with additional information to complete the redetermination process, and they may never have been through this process in previous years because their Medicaid eligibility was automatic.

Advocates also shared that, in general, beneficiaries and their families can feel overwhelmed by the redetermination at age 19, and so having advanced notice can be helpful so that the family and the child have time to prepare, especially if they are also navigating other benefit program transitions.

We also identified through our work that one of the challenges is with the availability of optional

Medicaid eligibility pathways. States can cover optional adult Medicaid eligibility pathways, and the state adoption of these pathways affects which are available for those who are transitioning to adult Medicaid.

In addition to these eligibility pathways, Medicaid beneficiaries can also enroll in state waiver programs, and in some cases waiver enrollment confers Medicaid eligibility through a state optional pathway, and this can allow individuals who wouldn't otherwise be qualified for Medicaid to enroll.

And from our work in research we identified that many individuals who had SSI as a child don't remain SSI eligible as adults, and so they have to enroll in another non-SSI pathway as an adult to remain Medicaid covered. And because these pathways can vary by state, this can affect the ability of these transition-age children and youth with special health care needs to remain Medicaid enrolled as adults.

Now we'll move on to our potential policy options that address these challenges. And we have this high-level figure to show how each of the policy options aligns with the presented challenges. Two of these challenges have

more than one policy option, and for those, each of these policy options was designed to address unique aspects of this challenge.

I do want to note that the fifth challenge related to the availability of state optional pathways is not included in this policy option figure, as state Medicaid programs already have the flexibility to choose to implement these optional pathways, including the adult expansion pathway.

So we've developed two policy options to address barriers related to advance notice of the transition to adult Medicaid coverage and providing additional time to complete the Medicaid redetermination. The first directs CMS to require states to send notice a minimum of 60 days in advance of a child with special health care needs aging out of child Medicaid eligibility. Most states begin this redetermination process 60 to 90 days in advance of the end of the eligibility period, but states are not required to notify beneficiaries of an upcoming redetermination, and in general, are only contacting them if information is needed to complete the redetermination.

This type of advanced notice is used in other

programs, so SSA is required to send a notice to children with SSI in advance of their age 18 redetermination, so beneficiaries and their families can prepare for this transition. And SSA sends an annual notice about this redetermination beginning at age 14. However, there is no analogous requirement for state Medicaid agencies to notify children and families in advance of aging out of child Medicaid eligibility.

The second policy option directs state Medicaid agencies to implement a 30-day minimum for children and youth with special health care needs when responding to requests for information to complete the Medicaid redetermination when they are aging out of child Medicaid. The 2024 CMS eligibility enrollment rule requires states to provide beneficiaries who are being redetermined due to a change in circumstance a minimum of 30 days, but the implementation of this requirement is paused until 2035 by the 2025 Budget Reconciliation Act moratorium on this final rule.

We consulted with legal experts and confirmed that states still have the authority to implement this option, but CMS is not permitted to enforce the

requirement.

Many children and youth with special health care needs who age out of child Medicaid disenroll or churn during this transition period, and our research shows that beneficiaries and families need advanced notice so that they are aware of the upcoming transition to adult Medicaid. And without this advanced notice, beneficiaries and families may not be aware of the upcoming redetermination as an adult and how that might differ from prior ones, and the steps they need to take to maintain coverage.

Beneficiaries may also need more time to complete the Medicaid redetermination as an adult, especially since it may overlap with other redetermination processes such as the age 18 SSI redetermination or as they are transitioning between child-only and adult 1915(c) HCBS waivers.

Advocates noted that sometimes beneficiaries also received their notice late, so it's too late to respond to or after the deadline, or don't receive their notice at all, and this can lead to a loss of coverage.

Our next policy option directs Congress to require state Medicaid agencies to coordinate with SSA to

review and update the SSA's Program Operations Manual System, or POMS, notice language for individuals enrolled in SSI-related Medicaid who lose SSI. We've consulted with legal experts, and they determined that HHS, and therefore CMS, has no authority to direct SSA activities, including the information written in these notices related to Medicaid eligibility, and therefore, a statutory change would be needed if we were to want to ensure that the coordination between agencies is enforceable.

Children and youth with special health care needs aging out of child Medicaid eligibility who lose SSI may not receive SSA notices with easily understood information or that provide consistently accurate information about the effect on Medicaid eligibility and the steps that the Medicaid beneficiary would need to take to maintain Medicaid coverage after losing SSI.

State Medicaid programs only notify these individuals of the change in SSI-related Medicaid eligibility if more information is needed to complete the redetermination. So it's important that the SSA notice include accurate information about potential changes to the individual's Medicaid coverage.

State Medicaid agencies should coordinate with SSA to update the SSA notice language to include information about how loss of SSI affects Medicaid eligibility in states where SSI eligibility confers Medicaid eligibility, so 1634 and SSI criteria. And this should include the beneficiary's Medicaid status during the Medicaid redetermination period, what the beneficiary should expect from the redetermination process, and how they will be contacted if the state Medicaid agency needs more information.

This next policy option directs CMS to issue guidance to states on existing Medicaid authorities for supporting transitions to adult Medicaid coverage, and this should include information on assigning children and youth with special health care needs a dedicated case manager or care coordinator to support the Medicaid redetermination process as they transition to adult Medicaid. And for waivers, it could also specify that states consider including transition planning procedures, and their 1915(c) HCBS waivers that are specifically related to supporting beneficiaries through that Medicaid redetermination process.

Finding from our stakeholder interviews indicate that children and youth with special health care needs transitioning to adult Medicaid coverage may need more support navigating this process. Existing federal rules provide state Medicaid agencies state planning waiver authority to provide case management, which can be used to support beneficiaries during this transition to adult coverage. However, stakeholders shared that the level of support can vary greatly between states and even within states. We heard from advocates that youth with dedicated case managers or care coordinators often receive more support during the transition to adult Medicaid coverage than those without this dedicated support. And, in general, beneficiaries enrolled in waivers have smoother transitions than beneficiaries who are not and do not have that dedicated case manager.

And we developed three policy options related to extending eligibility for children and youth with special health care needs to help mitigate gaps in coverage as they reach adulthood.

The first policy option directs state Medicaid agencies to implement the state option to extend child

eligibility up to age 21 for children and youth with special health care needs. Four states have implemented this state option, and in 2024 CMS E&E Rule, CMS clarified that states can extend coverage for individuals under age 21 who meet the criteria for non-MAGI eligibility groups, as well.

The second policy option directs CMS to issue guidance to states on implementing this state option.

The third policy option directs Congress to extend the 12-month continuous eligibility through age 19 rather than up to age 19, for children and youth with special health care needs. Currently, states are required to provide continuous eligibility for all children under age 19, and this requirement ends when the beneficiary turns 19. And this means that a beneficiary's final 12-month continuous eligibility period may be cut short if their 19th birthday occurs fewer than 12 months after their previous redetermination.

And just as a reminder, this 12-month CE requirement was in response to research that shows that continuous eligibility reduces rates of churn. And so an extension of the final 12-month period through age 19 could

reduce the number of Medicaid redeterminations that occur in the final year of child eligibility for children and youth with special health care needs and ensure that transition-aged children and youth with special health care needs are continuously enrolled for 12 months prior to their transition to adult Medicaid.

And research demonstrates that disenrollment from Medicaid is greatest for youth between ages 18 and 19, so when they are transitioning out of child Medicaid eligibility and may be experiencing multiple simultaneous or near simultaneous transitions. Our analysis of T-MSIS indicates a similar trend as we've seen in the literature, with disenrollment from Medicaid among young adults with disabilities. So depending on the disability pathway a beneficiary was enrolled in as a child, 14.9 to 27.6 percent disenroll when aging out of child Medicaid.

Based on our findings and findings in the literature, there is strong evidence that extending child Medicaid eligibility up to age 21 and delaying the transition to adult Medicaid may ease the coverage transition for beneficiaries and their families and reduce the risk of a gap or a loss of coverage.

Stakeholders shared that delaying the coverage transition by extending child eligibility up to age 21 would provide young adults with disabilities and families more time to complete multiple transitions that may be occurring during this period. Further, interviewed advocates in some states also raised the importance of extending eligibility up to age 21 to align with EPSDT requirement, which is available for most Medicaid-covered children and youth up to age 21.

We would appreciate your feedback on these policy options and rationale and which options you would like to advance for the June Report to Congress, and depending on feedback from the Commission, we will return in March to present draft recommendation language and then in April to present a draft chapter. For the discussion today we have included our questions on this slide, and I'll turn it back to the Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you very much, Linn. I appreciate the work and the numerous policy options that we can explore. So I ask Commissioners to think through some of the things we addressed. Are these policies hitting the mark? What else can we ask them to

clarify?

With that I'll take questions or input. All right, Sonja, you're up.

COMMISSIONER SONJA BJORK: Thank you. Okay. We've been working on this for a while now, and I see that you've come up with some great policy options. Is it too much to ask that we go forward with all of them, because they all hit different aspects of this really important work. And to me, they don't seem too much to ask. I think you've identified some really concrete steps that will be very helpful in a practical way for young people and their families.

So I'm an advocate of moving forward with all of them. I am conscious of resource limitations and those other concerns, but I feel like you've done so much work already to get us to this point. So that's my vote for today. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Sonja. I laugh because I told Kate that last week. I said, "I like all of them. Let's go." So anyway, I appreciate your feedback.

Any other comments or questions from the

Commissioners? Yes, April.

COMMISSIONER APRIL HARTMAN: Why would we not extend the continuous 12-month eligibility period through age 21 if we're also asking to extend eligibility to that time?

LINN JENNINGS: Thank you for that question. That's something we also kind of considered in trying to develop policy options to address this challenge. And yeah, as of right now we didn't feel like we really had the evidence to extend it to 21, and especially since child eligibility has not been extended, you know, the state option to extend to 21. So we didn't feel like we had the evidence to have a requirement that didn't align with the child eligibility. But we are definitely open to discussion on that and kind of further consideration of that policy option.

COMMISSIONER APRIL HARTMAN: Well, I'd just say most pediatricians will see kids through age 21. So making it consistent throughout that whole age range kind of makes sense from my point of view as something that would be helpful. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, April.

Then we have Doug, Dennis, and John.

COMMISSIONER DOUG BROWN: Thank you. I'm very much in favor of option 5 and 6 and moving the age to 21 where possible. I think consistency across the program up to age 21 -- and Linn, your comments about states already have the ability to do that, they don't. Whereas the recommendation from MACPAC go to recommend maybe to states and to Congress and to CMS to make that recommendation across.

Obviously, there's a financial impact that goes along with that. We probably need to understand what that financial impact may be. But I would certainly be in favor of going to age 21 across the board here, which would help us in a number of places. I mean, commercial, we can cover kids up to age 26 on parents' health insurance. We should be moving Medicaid up to age 21 to kind of get us at least to the point where these kids have kind of potentially gotten out of high school, gotten into secondary school, gotten into a trade program, started their first job, and then can look for insurance with a job at a point where perhaps they can afford the insurance to go with the jobs. That would be my recommendation.

VICE CHAIR ROBERT DUNCAN: Thank you, Doug.

Dennis, John, then Mike.

COMMISSIONER DENNIS HEAPHY: I was wondering. I didn't see in the report. What percentage of these folks are in school, are in school until they turn 22?

LINN JENNINGS: So we don't actually know that from our data, unfortunately, and from our T-MSIS analysis, I don't know. We might be able to look at some of that in our survey data, but from the T-MSIS analysis, that isn't something we were able to look at.

COMMISSIONER DENNIS HEAPHY: I just think it would be helpful, especially when you're looking for more evidence on a Policy Option 7, because it seems disruptive when folks are transitioning at age 22, when not extended to age -- everything's 21 at least, the minimum.

And then with Policy Option No. 2, I was wondering why 30 days and not 60 or 90. What was the rationale for that?

LINN JENNINGS: Yeah. So, for the Policy Option 2, we chose to recommend to states to just implement the state requirement that was put in place with the 2024 CMS E&E rule, and so it's just a minimum of 30 days. And I

think we chose to use that because the rule has strong evidence for allowing beneficiaries more time, while also minimizing the burden on states for having that extended -- like a more extended response time. But nothing -- states could choose to have a longer response time.

COMMISSIONER DENNIS HEAPHY: Right. No, I realize that. That's why I was asking about extending, because it's a burden for these families, and 30 days is not necessarily a long period of time, turnaround time for them to get everything they need in place.

But thank you. It's all great. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

John, then Mike.

COMMISSIONER JOHN McCARTHY: One of my concerns is in talking to states currently, you know, there's many states who are looking at budget issues, and they're talking about, you know, across-the-board 10 percent cuts to providers and other issues that are going on. So, at this time to be extending eligibility in states that could do it and have decided not to do it, I have an issue there.

I know our recommendations take a long time. So maybe things would be different by then. You know, maybe

if we were saying to extend it and there being a different FMAP tied to something like that, it would be something that I could support.

So those right now, I'm not necessarily in support of.

However, I want to go back to something Dennis was just talking about. So for Policy Options 1 and 2, I do support those. And to me, it's like moving those up even further, right? So, if for No. 1, instead of 60 days, that would be at least 90 days. Same thing with Policy Option 2, have it be at least 90 days.

Just, you know -- to me, it's almost do we even go further, like 120 days, so people know what's coming, because a lot of what I was reading, what we're having there is people being not caught off guard, but not quite understanding all that they need to do and the things that need to happen, so moving those times up.

And then also with Policy 3, I mean, there's another area there where if we could just get better working between those agencies -- and believe me, it was not something that I was very good at in the D.C. or Ohio. And so it's like, how could you get -- you know, and our

recommendation is good. I think that's one of those areas of do we just need to change this? Because when we move those ages from 18 to 21, we're still going to have this cliff that we see now unless we do some of what's in 1, 2, or 3.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, John.

Mike, Carolyn, and then Patti.

COMMISSIONER MICHAEL NARDONE: Yeah, I just had a couple of questions about some of the recommendations. So bear with me. I just want to ask.

On Policy Option 1, I don't understand the process, right? The state would give notice to the children's families 60 days in advance, but they might -- they might be determined eligible by SSA in that window between 60 and zero days of being redetermined? Is that correct? I'm just trying to figure out how the time periods line up. So that was just one question.

I mean, I guess it doesn't hurt for people to know that they're being redetermined, but they might not have to provide any information, right? You're kind of -- so the notice would have to be written to explain that they

might not have to do anything. Am I just understanding that correctly? I mean, I'm perfectly in line with the notice requirement, but I just want to understand that.

LINN JENNINGS: Yeah, thank you for that question. That was something we thought about quite a bit as well of not wanting to confuse beneficiaries that are getting notices and maybe don't have to act on it. And so if we were to move forward with this as a recommendation and developing the recommendation language, I think we would consider, like, limiting kind of how our population -- like, if you are SSI eligible and you're in a state where that confers Medicaid eligibility, the states shouldn't -- there's no need to send a notice, because as long as they're SSI eligible, they would continue to be eligible and really focusing on those who are in these categories that end at age 19.

So if you're in a Katie Beckett program or you're in some other non-SSI pathway, that those are the individuals who would most likely -- may need to provide additional information, and so those are some of the things we're considering as we're kind of drafting what some of this recommendation language would look like.

COMMISSIONER MICHAEL NARDONE: I was just trying to figure out how do you minimize the amount of confusion, right? And less notices can be better, right?

The second thing on Policy Option 3, did you consider -- so this -- I'm just trying to understand the recommendation here. I totally support this, right? Does there also need to -- does the requirement also need to extend to the federal CMCS agency and HHS? Because, I mean, I just wonder requiring the state Medicaid agencies to deal with SSA, it seems to me it also has to be at the federal level that the two entities are talking, or do you -- so maybe I would propose that that be considered when we're going to Policy Option 3, that there needs to be communication at the federal level, or else you're not likely to see that at the state and federal level.

And then on Policy Option 4, I just -- oh, not Policy Option 4. On the options that are for extending eligibility up to age 21, is the thought that it would just be CE, the children with special needs, or is it -- would states -- is the recommendation that all kids would be extended up to age 21? And if it is just children with special needs, are there some barriers there to -- given

that the definitions and state eligibility systems in terms of determining who those kids are, or would that have to be something that we would have to -- or states would have to work out?

LINN JENNINGS: Thank you. And that's a great question of kind of considering this population.

We had scoped it really to children and youth with special health care needs, just because that was the scope of our project, and using our kind of definition of this, who are SSI eligible or Beckett or eligible for an institutional level of care.

But also that is -- you know, as you're discussing this, if that -- it would be helpful to hear kind of like if that population makes sense, or if the evidence -- if you feel like the evidence kind of supports a broader population recommendation.

COMMISSIONER MICHAEL NARDONE: Well, I think, you know, maybe to John's point, the targeting is helpful, right? I guess my question was really, is it -- you know, is it how feasible it is to get consistency across all 50 states in the definition and then the eligibility categories? It was a question. I don't know. I'm not an

eligibility expert. I don't know the answer to that.

I would -- and I guess maybe to the question, it also kind of leads in, I guess, to my other question, which is around cost, right? And estimating the cost, which is, I assume something would not necessarily say we wouldn't support this, but it would be something to consider, right? But I'm wondering if you're thinking that since the EPSDT requirements would still be that you would have to provide services to 21, that the net cost might not be as large as one might otherwise expect, since you would have to still provide those services, regardless of their category. Is that right? I'm trying to understand this better. I'm not stating a position. I'm just trying to understand kind of the policies here, because there's a lot here. It's all good, but I'm just trying to understand it.

AVA WILLIAMS: I think I can give some context. Oh, sorry. I think I can give some context about the population. This is the same population that we used in our previous work, the transitions of care, and the Commission and staff did a lot of iterating on this population to make sure that we were expansive as possible, because we do understand that states and different

stakeholders may call or categorize the CYSHCN population in different ways. So, hopefully, that gives you some -- I guess I can't think of the word. Hopefully, that explains the population to you.

COMMISSIONER MICHAEL NARDONE: It's still a relatively small population, though, right? It went back. It's like 80,000 kids, right? That's what we're talking about.

LINN JENNINGS: Correct. Yeah.

COMMISSIONER MICHAEL NARDONE: And those kids would still get services. Those kids should theoretically still get services under EPSDT, even if they're switched to another category. I'm trying to suggest that the cost might not be that great to extend it to this population because of that federal requirement. That's where my head's going, and maybe I'm --

LINN JENNINGS: No. And I just wanted to note we will -- with any recommendations that we -- that the Commission chooses to move forward with, CBO does score them for us so that we have that context with the recommendations.

COMMISSIONER MICHAEL NARDONE: Thanks. Thank you

for putting up with all my questions.

VICE CHAIR ROBERT DUNCAN: No. Thank you, Mike. Great questions.

Carolyn, then Patty.

COMMISSIONER CAROLYN INGRAM: Thank you, and thanks to the team for putting this together and all of the options and how they address the challenges. I appreciate that.

I had one follow-up question. So if a person or a young person comes up on being 21, doesn't turn in information, and then falls off, there's an opportunity for them to get back on if they come back in and turn information in. Is that correct?

LINN JENNINGS: Correct. Yeah.

COMMISSIONER CAROLYN INGRAM: Okay. And is that usually 30 days, 60 days, 90 days? Because --

LINN JENNINGS: I will have to double-check. I want to say the reconsideration period was 90 days with the 2024 -- but I will double-check on that.

COMMISSIONER CAROLYN INGRAM: Okay. If we could just look -- I mean, 90 days, that sounds good, but if there isn't something that allows them to get back on and

get reinstated back to their date that they were kicked off, I think we should fit that into one of the policy recommendations, because what I'm concerned about is if people are on medications or in treatment, they get kicked off, but they have to continue those medications or treatment for some reason, how they go about getting coverage for that if they got kicked off, so inadvertently, again, because they didn't recognize something. So, if we could double-check how many days they have to get back on, and then are they reinstated back to the kicked off so that their claims and their bills and those types of things would be covered for their medications, their therapies, anything that they might need during that time period, that'd be great. And if not, if we could put that into the recommendations.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Linn, Ava, thank you for how you've laid this out. I think it's really easy for us to digest sort of how the challenges relate to the policy options.

And it's helpful for me to sort of think about these in two separate buckets, with 1 through 4 really being more about procedural things that can affect a child's ability to maintain eligibility, whether that's communication or process or time frames or whatever that is, and then the last three being more focused on are there actual eligibility pathways, right, for these kids to transition into.

It seems to me that the first four probably don't have a high degree of costs associated with them. There are changes and adjustments, and the intent is that kids who maintain eligibility will -- who qualify to maintain eligibility will, in fact, be able to complete the process seamlessly and stay on the program.

In the last three, I share some of the concerns that were voiced about just the budgetary concerns. While I think all of these are -- they're good public policy perspective of making sure that this population of particularly vulnerable children and youth have access to the benefits they need to maintain their health and ensure their greatest possible success as adults. We are sort of stepping into difficult territory right now when we are

asking states to expand eligibility in certain areas.

So I think we should -- one of the things I would like for us to do -- I remember when I went through the materials. There was some really good information about sort of the cost of churn, the fact that when these kids -- if they churn and they come back on the program, they tend to come back on with higher spend. And so hopefully, those are things that CBO is going to consider if they score this. But we should also, I think, dig deeper into it because if we can make the case that not only is there not a net sort of cost associated, we're actually paying more by allowing these kids to churn, right? And I think that's really worth looking at.

I do also think the whole 12 months of continuous eligibility through 19, it's just kind of kicking the can down the road, and truthfully, if you think about the eligibility pathways that these kids may transition into, if they leave SSI or Katie Beckett, it's in all likelihood perhaps a medically needy pathway, send down kind of a pathway where eligibility tends to be a little bit more frequent. And there's just a lot more process and burden to sort of deal with.

So if we're going to recommend continuous eligibility be increased from 18, I think it probably makes sense to push it all the way through 21 so that there's alignment and we're not seeing kids fall off just because of administrative burden associated with the frequency of eligibility redeterminations in a really fragile population.

But again, with eyes wide open, that some of those things have costs associated with them.

VICE CHAIR ROBERT DUNCAN: Thanks, Patti.

Dennis, then April.

COMMISSIONER DENNIS HEAPHY: I'm sorry. Could you remind me what percentage of folks lose their eligibility due to failure to complete paperwork for administrative reasons?

LINN JENNINGS: I'll have to look back at that. We don't have that in our T-MSIS analysis, but I know that there are some other data, I guess, more generally on procedural disenrollment. But unfortunately, those data quality are not -- were not good enough for us to use in our T-MSIS analysis. So we aren't able to know why they lost their coverage during that transition period.

COMMISSIONER DENNIS HEAPHY: I think based on just the previous statement regarding the cost of churn, like what's the overall cost of maintaining folks from 18 through 21 versus having folks be lost to the churn or some other reason and not maintain their status? I just don't get what's the overall increasing cost compared to the cost of maintaining folks in their current status. It seems to me that there would be cost savings, frankly, for continuity of care and other reasons.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

April?

COMMISSIONER APRIL HARTMAN: I just want to reiterate that we're taking care of these kids. We just -- it just requires some different documentation. Like, EPSDT says we take care of them until 21. We do. It's just we have to document differently because of the changes.

One thing to keep in mind that is a big issue for these families, especially the ones that have kids with special health care needs, is at 18, that child is considered an adult, no matter what their level of functioning is. And a lot of families are dealing with

having to go through legal things to get authority over making decisions for that child who is unable to do that for themselves and to have Medicaid -- become ineligible during that time adds another burden to these families that are struggling to understand how this child now became an adult. But they're still providing all the care for them, how to navigate that system so that their child is getting the care they need and they are able to support them, even though they're by age now an adult and supposed to be independent.

VICE CHAIR ROBERT DUNCAN: Thank you, April.

Any other comments, suggestions from the Commissioners?

[No response.]

VICE CHAIR ROBERT DUNCAN: Ava, Linn, did you get what you were looking for in the policies?

LINN JENNINGS: Yeah. Thank you.

VICE CHAIR ROBERT DUNCAN: I'd like to applaud you for a nice job of coming forth with these recommendations. I look forward to what you've got after the feedback today.

So, with that, I will turn it over to Madam

Chairwoman Verlon.

CHAIR VERLON JOHNSON: All right. Thank you, Bob. That was a great conversation. We appreciate it.

Okay. So next, we're going to turn our attention to the draft recommendation on Medicaid payment policies that support the HCBS workforce. As you'll hear, this work is really focused on the information states need to make some sound rate-setting decisions for sure.

And so I'm going to turn it over to Katherine and Chris. They're going to walk us through what they had as well as the draft recommendation, and then, Commissioners, we will have a great discussion around it.

So, Katherine and Chris, to you.

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

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

This session will return to 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. Today's presentation

includes a revised recommendation, as Verlon mentioned, for the Commission's consideration and for a vote tomorrow morning.

First, I'll provide a summary of the contents of our draft chapter on this subject for inclusion in our March 2026 report to Congress, including our study findings related to the HCBS rate-setting process and the required data inputs. After that, I'll review the revised recommendation, the rationale and implications, before turning it over to the Commission for discussion and feedback.

In this work, we began 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. Multiple phases of this work have been captured in the draft chapter and are reflected in the final version of the recommendation.

When the Commission last saw this material in September 2025, we presented a draft recommendation, and your feedback in that meeting has shaped the revised

recommendation accordingly.

With that, I'll review some overarching findings, the payment principles supported by those findings, and some additional findings that are specifically to our recommendation.

When we presented these over the course of the last two meeting cycles -- and these are captured in our chapter -- states have significant flexibility to design, operate and oversee their HCBS programs, and flexibility concomitantly to set payment rates consistent with Medicaid's statutory goals of economy, efficiency, access, and quality.

Because HCBS can be delivered through fee-for-service or managed care delivery systems and under multiple HCBS policy authorities, state payment models vary widely across states and even across programs within states.

We learned throughout the stages of our work that wages are a cornerstone of the underlying data states required to develop and maintain HCBS payment models and rates, and we also learned that specific, timely, and accurate wage data, while central to setting payment rates, are not always or uniformly available to states.

A couple other key points we surfaced that are described in the chapter. Once established, payment rates are generally updated over time. We learned states employ tools like rate studies, rebasing, and indexing in their HCBS payment models.

And finally, we did hear that HCBS payment rates do influence workforce participation. For example, we heard that within a state with different payment rates for direct care workers in two different programs, workers tended to leave the workforce in one program to move to the other where wages were higher.

With that in mind, our findings led us to three payment principles, which we shared in prior presentations but which I'll note here. 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 available, such as, as I mentioned, rate studies, indexing, or rebasing.

The findings that led us to these principles have underscored that robust wage data are the foundation for HCBS payment rates to promote an adequate workforce. These data need to be current, accurate, and granular enough for states to set payment rates for a diverse array of HCBS with a variety of worker classifications within them.

Currently, states use a number of data sources in establishing their HCBS payment rate and for updating them over time.

Our 2024 compendium of HCBS payment policies available on the MACPAC website revealed that the majority of states reported using wage data collected and reported by the U.S. Bureau of Labor Statistics, or BLS. And some states reported using other state-collected data like cost reports.

BLS data are widely used and offer both nationwide and state-specific data for hundreds of job classes identified by federally defined standard occupational classifications, or SOC codes, across labor markets, states, and settings. They are reported annually, and BLS data capture the entire labor force.

They are not specific to the delivery of Medicaid

services as a result, which means some job classes may combine a variety of HCBS worker types, and it means that BLS data capture those whose wages are paid by Medicaid and all others in those job types as well.

In the absence of Medicaid-specific BLS data, states may also leverage data such as cost indices, provider surveys, and cost reports. We've heard in interviews and in our technical expert panel that the latter can be administratively burdensome for providers, states, and other stakeholders, and have other limitations.

We also learned that market indices are not always specific to Medicaid or Medicaid services, and states may still lack access to neighboring states' Medicaid HCBS wage data if they rely on their own provider survey or cost report data.

The Access Rule promulgated a number of new requirements related to HCBS payment in the HCBS workforce. Reporting requirements include data on hourly HCBS total payment rates, and specific to this work, the proportion of HCBS payment rates that account for direct care worker, DCW, compensation. Compensation, as defined in regulation, includes but is not limited to worker wages.

The rule's broad definition of direct care workers creates the potential for confounded data that can conflate diverse worker wages, such as across nurses and other workers, such as direct support professionals, or DSPs. And to report under 42 CFR 441.311, states will collect and aggregate data on compensation across each service and different direct care worker categories.

States will report the aggregated compensation and payment ratio based on these data, but the underlying wages the data states need to set payment rates will not be reported or published.

Because there are related provisions in existing regulations that will likely require states to collect the same underlying data, the recommendation builds on those reporting requirements to include data elements that address the gaps we identified.

So, given that background, I'll turn to our revised 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 amend 42 CFR 441.311(e)(2) to require states to report 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 as determined by HHS. 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 upon planned or existing data collection activities or tools and publish data on the CMS website.

I would call Commissioners' attention to a couple key provisions from the draft language presented in September. We added the link to the existing access rule language of 441.311 to make clear the relationship between current policy in this recommendation and the expectation that those reporting mechanisms and frequencies be the basis for this reporting. As such, we removed the frequency specific to the recommendation as it's established in regulation, which for the related data collection is annually. We removed the specific descriptive statistics as well, leaving it to HHS to determine those in

the context of the larger reporting requirement.

So to cover our rationale, we found that wages 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. We heard from multiple stakeholders throughout our work that the lack of HCBS-specific wage data create challenges for states, and we heard specifically that granular service and job class data would help states build wage assumptions that reflect the nuances and operations of their own programs.

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

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 access rule reporting requirements and

42 CFR 441 will permit CMS and the states to identify opportunities to build on rather than duplicate other related data collection and reporting. These data would create a resource that states are looking for, while allowing them to main 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.

Finally, our implications. CBO has estimated 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, it could have the added effect of allowing states to sunset other data collection.

There is no expected direct impact to enrollees, but of course this recommendation is designed to promote a robust HCBS workforce and ultimately improved access to HCBS services.

There is no expected direct impact to health plans, although changes made in payment rates on the fee-for-service side may have effects for payments under managed care models.

Providers may see minimal and immediate direct impact, and by aligning the requirement with accessible reporting, we expect minimal marginal reporting requirement for providers.

This recommendation language is slated for a vote tomorrow morning. Commissioner feedback on the draft chapter is welcome, and during our discussion, I will flip back to the recommendation language again so we have it front and center.

With that, Verlon, I will turn it back over to you.

CHAIR VERLON JOHNSON: All right. Thank you so much, Katherine. That was very helpful.

All right. So, with that in mind, as Katherine indicated, this is open for -- we really want to hear your discussion and reflections, keeping in mind this vote is planned for tomorrow. So your feedback is going to be really important.

So with that, let me go ahead and open up the floor with the Commissioners. Anyone have any questions or thoughts?

Okay. There we go. Jami.

COMMISSIONER JAMI SNYDER: Katherine, I think I've asked this question before, so my apologies. I know the services that are detailed in the recommendation are personal care, home health aide, homemaker and habilitation, and I think that's because those services align with what's in federal regulation currently, right, in terms of HCBS services?

KATHERINE ROGERS: That's right.

COMMISSIONER JAMI SNYDER: Yeah. And I'm just wondering, you know, when I think about HCBS services, I also think about attendant care, and I wonder if attendant care -- because oftentimes personal care and attendant care are kind of used interchangeably, but I wonder if attendant care would be captured under personal care here. And I just say that because I know a lot of states offer both services. That was certainly the case in Arizona, and attendant care was, I think, the service that had higher utilization levels, but just a quick question there.

KATHERINE ROGERS: Yeah, I can take that back.

I think one thing that is true about HCBS is -- and this is, to my understanding, why we have the -- and now I'm going to draw a complete blank on the name for it,

but the classification, so that when states call similar services different things, that we can work out the difference that we're talking about. So I'll take a quick look when I'm offline and take a look at where those two things would line up in the data.

COMMISSIONER JAMI SNYDER: That'd be great. Thank you.

CHAIR VERLON JOHNSON: All right. Thanks, Jami.

Angelo?

COMMISSIONER ANGELO GIARDINO: Yeah. Thank you, Katherine. I just wanted to voice support for the recommendation. I think it's responsive to the body of work we've done and to what we've heard from the stakeholders in terms of what would help them. So I appreciate the work you did in crafting this.

CHAIR VERLON JOHNSON: Thanks, Angelo.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Thank you.

Katherine, I think the word you may have been looking for is "taxonomy," and like Jami, I would support really making sure that we don't lose important information just for the sake of not naming a service exactly the same

way that a state has elected to name it.

"Respite" is another one that came to my mind where the same classes, if you will, of workers tend to deliver those benefits.

I know we're using the word, I think, "habilitation" probably broadly to include residential habilitation where people are receiving in-person supports typically in a congregate living arrangement. But those, again, are the same qualifications and groups of workers who tend to be delivering those benefits, and we need to be able to get the data across all of those similarly situated workers in order to be able, I think, to make meaningful recommendations around policy on this particular topic.

I would also just encourage us to think about, are there any other nuances that we would want to recommend? We've recommended the licensed nurses. There may be other categories of expertise among those workers that could be relevant to a pay differential. There are people who have special training and certifications to support people with behavior support needs. Not suggesting that we include it, but saying that we should consider it. Are there other things that we should consider recommending

that could account for rate differentials that should be taken into consideration? But do believe that we need good data to be able to inform good policy.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti.

And so are you saying that you want us to think about changing that recommendation as written or putting it into the chapter? I'm just trying to get a sense of how we can cover that. You know what I mean?

COMMISSIONER PATTI KILLINGSWORTH: Yeah, that's a great question, especially given where we are in the process.

It's a little -- probably late in the game to try to change the recommendation and be able to vote on it. Maybe there could be some more general language which says something like -- and other variables which could account for differentials in the wages paid to staff or something like that.

CHAIR VERLON JOHNSON: Does that make sense, Katherine? Okay.

CHRIS PARK: Sorry. I just wanted to jump in because I was able to look up exactly, you know, the four

categories that are mentioned, are tied specifically to regulatory language and, you know, paragraphs within 440.180 that identify what services are included in home- and community-based waiver services. And they don't give specific definitions. They say paragraphs 2 through 4 and 6, which are homemaker services, home health aide services, personal care, and habilitation. But they're not like full definitions as to what those broad categories may cover.

COMMISSIONER PATTI KILLINGSWORTH: That's helpful, Chris.

So I would just say that in the chapter, if we can just make clear that, you know, we are aligning with the statutory language or the regulatory language, but we really want -- we want to make sure that we are collecting data on all similarly situated workers, right, in home- and community-based services, that we're not -- people aren't reading this so literally that they only report if it's one of these four services and not a service that is very much the same in nature but perhaps has a different name, like Jami's attendant care or like respite care, right, where it's really the same workers delivering the benefits. And if we don't collect information across all of those, we'll

be missing important pieces.

CHAIR VERLON JOHNSON: Thank you, Patti.

Dennis?

COMMISSIONER DENNIS HEAPHY: I'm just grateful. Thank you very much for putting it together. Thank you very much.

I support the recommendation, and I also agree with comments by Patti and others regarding concerns about the categories. And so I think in the chapter it would be really helpful to say that we are not -- these are not the -- we're not being prescriptive -- I would rephrase it. We are -- we realize that there are different understanding, terminology used in different states, and they'll be taken into consideration as we're moving forward in, you know, working with the department. I don't know. Something that ensures that there is an apples-to-apples comparison across states.

CHAIR VERLON JOHNSON: Yeah. Thank you, Dennis.

Mike?

COMMISSIONER MICHAEL NARDONE: I was just going to thank Katherine and Chris for kind of tying this back into the regulatory framework, because I think that gets at

some of the concerns that were raised about, you know, how much, you know, additional, you know, requirements might be placed on states by this new requirement. So I appreciate you kind of working that back into the regulatory framework.

And I guess to Patti's point, I think that maybe the language that, you know, you have around the other descriptive categories -- unfortunately, I'm -- on the descriptive statistics might be something that gives you some flexibility in the language to kind of add additional nuances to this after further consideration, because I didn't -- my question was what the descriptive statistics would be. But I think that in listening to some of the other comments, that those might be the type of things that would fit into descriptive statistics.

CHAIR VERLON JOHNSON: Got it. Thanks, Mike.

Any other thoughts, questions?

[No response.]

CHAIR VERLON JOHNSON: All right. So something -- we got some helpful suggestions around ways to strengthen the chapter, some clarification. Sounds like there's some general support, though, in the direction of the draft

recommendation.

But I will check with Katherine and Chris if there are things that they need to draw out or have questions before ending their session. So anything else from your perspective?

KATHERINE ROGERS: I don't think so, Verlon. Thank you. This feedback was very helpful to us.

CHAIR VERLON JOHNSON: Great. Thanks again for all your work on this. We appreciate it.

All right. So with that we'll move on to our next agenda item, which is our Public Comment period, followed by a short break. So we'll go ahead and open the floor for comments. We do invite all of you in the audience to raise your hand if you would like to offer comments. Please make sure to introduce yourself and the organization you represent. And as always, we do ask that you keep your comment to three minutes.

So with that, I don't see any comments yet. There we go. Camille Dobson, the floor is yours.

PUBLIC COMMENT

* CAMILLE DOBSON: Good afternoon, Chairman, Chairwoman Johnson, and the rest of the Commissioners.

Camille Dobson, Deputy Executive Director at Advancing States. As you probably know by now, we represent the aging and disability directors that deliver home and community-based services to older adults and people with physical disabilities.

I want to take a moment to comment on the HCBS payment rate recommendation. As you can imagine, I'm not a fan of it. I think states are already struggling to figure out how to get accurate data for the requirements that are currently in regulation for the access rule. We have been spending some time working with the states that currently have their providers self-report data through the State of the Workforce Survey, and peeling out these individual categories of service is very complicated. And adding another layer that would require the states to peel out the underlying wage data, that build up those rates, you know, I'll be honest with you, I'm not sure if the juice is worth the squeeze. Many of those services do not use -- not routinely, but generally do not use clinical staff like licensed nurses to deliver those services.

And so while I appreciate the attempt at transparency and better rate setting, and I don't think any

state would disagree they could do a better job in lots of cases in that process, I'm just not sure that this level of detail would add enough value for the additional work it would require states to do. Thank you.

CHAIR VERLON JOHNSON: Thank you, Camille. I always appreciate your comments.

Anyone else have any comments? Okay, Chelsea, the floor is yours.

DR. CHELSEA FOSSE: Great. Thank you so much. Hi, everybody. This is Chelsea Fosse. I'm a dentist, and I lead the Research and Policy Center at the American Academy of Pediatric Dentistry, or AAPD.

When I was practicing clinical dentistry, I worked with adults with intellectual and developmental disabilities, and core to our mission at AAPD is the care of people with disabilities and with special health care needs throughout the lifespan.

So it has been so inspirational and so refreshing to see your conversations and hear your report on transitions issues. It is such a complex, massive problem, and thank you for taking it on. It's been awesome to see the developments you've made, the recommendations in the

June report, the further discussion today.

So I just wanted to thank you all for being forward thinking. I know all of us working in this space know that sometimes a lot of it feels a little bit like too late, but you all are confronting the massive challenges of figuring out the systems issues here. So thank you. We are trying to do our small part on the dental front, in terms of making the system work better for those who are transitioning from pediatric to adult care.

Thank you again. I appreciate all your considerations and thoughtful discussions and hard work.

CHAIR VERLON JOHNSON: Thank you so much, Chelsea. We appreciate your comments.

Any other comments?

[No response.]

CHAIR VERLON JOHNSON: All right. So just a reminder that if you have additional comments later you can definitely feel free to submit that through our MACPAC website.

And now we are at a break until 3:15 Eastern time, so we'll see you back then. Thank you.

* [Recess.]

VICE CHAIR ROBERT DUNCAN: Good afternoon, and welcome back. We are going to get started again dealing with behavioral health. We are going to look at a draft chapter from Anu and Janice for us to check the tone and material in the chapter for potentially our March report.

So with that I'll turn it over to Anu and Janice to walk us through.

BEHAVIORAL HEALTH IN MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

* JANICE LLANOS-VELAZQUEZ: Thank you. Good afternoon, Commissioners. Today, Anu and I will be providing a brief descriptive overview of utilization and spending among enrollees with behavioral health conditions in Medicaid and CHIP. We will highlight key findings from our analysis, which are included in the draft chapter for the March Report to Congress.

Today's session will begin with some background on behavioral health and Medicaid and describe the methodology for this analysis. Then we'll describe some selected characteristics of enrollees with behavioral health conditions, review their use and spending, and then we'll focus on two specific populations: children and

youth, and non-dually eligible and non-elderly adults. Finally, we'll conclude with key takeaways from our analysis and our next steps.

Behavioral health is an umbrella term that includes mental health conditions such as anxiety, mood, and personality disorders, and substance use disorders, or SUD, such as opioid use disorders and other drug use disorders. Co-occurring disorders refer to the presence of both a mental health condition and an SUD. For this analysis we also included enrollees with intellectual or developmental disabilities, or I/DD. Because many individuals with I/DD conditions require behavioral health supports, and research is limited in this area, we identified a need to study their behavioral health service utilization.

Throughout our presentation today, when we refer to enrollees with behavioral health conditions we are referring to enrollees with either a mental health or an SUD condition, or both, regardless of the presence of an I/DD diagnosis. Enrollees with I/DD are explicitly included when we discuss the I/DD population and those with co-occurring mental health and I/DD conditions.

Enrollees with an SUD only include enrollees ages 13 and older.

In our analysis we found that in calendar year 2023, nearly 27 million, or 27.6 percent of Medicaid and M-CHIP enrollees had a behavioral health condition, and they accounted for almost $370 billion, or 57.5 percent, in total service-related spending. About 23 million, or 23.1 percent of enrollees had a mental health condition, and 10.3 million, or about 10 percent, had an SUD condition. They accounted for $326 billion and $160.3 billion in total service-related spending, respectively.

In our analysis, we look at behavioral health services, but there is no federal standardized definition for behavioral health services, and state definitions and coverage of these services vary widely. Under federal law, Medicaid requires states to cover certain behavioral health services while allowing states discretion to cover additional optional services. Mandatory behavioral health services include inpatient and outpatient hospital services, services delivered through a federally qualified health center, or FQHC, and physician services. Optional services that states might choose to cover can include case

management, clinic visits, and prescription drugs.

For enrollees under 21, states are required to cover medically necessary behavioral health services through the early and periodic screening, diagnostic, and treatment, or EPSDT, benefit.

Medicaid enrollees receive behavioral health services in a number of care settings, including inpatient, emergency department, outpatient, residential, and community-based settings.

To measure use and spending among enrollees with behavioral health conditions, we analyzed 2023 data from the Transformed Medicaid Statistical Information System, or T-MSIS, for Medicaid and M-CHIP enrollees. Enrollees in separate CHIP are excluded from this analysis. We looked at enrollment, service use, and spending in 2023. We used a two-year look-back period solely for the purposes of identifying behavioral health conditions.

Because there is no standard definition of behavioral health service, we defined behavioral health services as any claim or encounter with a primary or secondary behavioral health-related diagnosis code. Among these identified behavioral health services we further

classified them by selected care settings, including inpatient, outpatient, community mental health clinics, psychiatric residential treatment facilities, SUD residential facilities, and anything that didn't fit within those categories was classified as "other." We also identified drugs used to treat behavioral health conditions and classified them into drug groups.

The tables and figures on spending throughout our presentation represent total service-related spending, meaning that they exclude capitation and supplemental payments, and represent spending associated with fee-for-service and managed care encounter claims. Because behavioral health services can be covered through fee-for-service or managed care and these coverage arrangements can differ, we classified fee-for-service or managed care spending based on the claim type, regardless of an individual's enrollment in an MCO [managed care organization].

Because enrollees can have multiple conditions, enrollees and their associated spending can appear in more than one condition category and are not considered mutually exclusive.

In our analysis, we exclude dually eligible enrollees from select utilization measures. Because Medicare is the primary payer for many behavioral health services for this population, Medicaid data may not capture all the services received, which could result in incomplete utilization records.

Throughout our presentation, dually eligible enrollees are included in the initial section describing enrollee characteristics and where we highlight total service-related spending. And in figures related to behavioral health services, care settings, and prescription drugs, we exclude dually eligible enrollees, and they are also excluded from the sections that focus on children and youth and non-elderly adults. And please refer to each table or figure notes for details on the population included.

We will begin by looking at who Medicaid enrollees with behavioral health conditions are by focusing on selected demographic and program characteristics, and we'll first take a look at eligibility groups. We recognize that this is a very data-dense slide, so don't worry. You don't need to read every number. I'm going to

try to guide you and let you know where to draw your eyes as I highlight a couple of the key findings.

Along the x-axis are the different enrollee populations with the leftmost bar representing all Medicaid and M-CHIP enrollees and each subsequent bar representing enrollees within specific behavioral health or IDD condition categories.

The colored sections within each bar represent the share of enrollees in each eligibility group. The numbers along the bar indicate the total number of enrollees in each group. In 2023, 97.6 million individuals were enrolled in Medicaid or M-CHIP, 26.9 million of which had a behavioral health condition.

First, we'll focus on the light blue section near the bottom of the bar, which represent the blind or disabled eligible group. Among all Medicaid enrollees, we see that 8.3 percent fall into this category. That share increases to 16.1 percent among enrollees with a behavioral health condition. That's shown in that second bar. And this rises sharply to 42.1 percent among those with co-occurring mental health and I/DD conditions. That's shown on the last bar on the right.

Next, taking a look at the dark green sections, which represent non-M-CHIP children, these enrollees make up 35.2 percent of the overall Medicaid population, again looking at the leftmost bar. As we move to enrollees with behavioral health or mental health conditions, the second and third bar, we see that the share of children drops to around 20 percent. In contrast, looking at enrollees with an I/DD condition, the second-to-last bar, half of this population are in a non-M-CHIP child eligibility group.

Finally, we will focus on the light green sections that represent the new adult group. Looking at the left hand bar, 26.7 percent of all Medicaid enrollees fall into this category. This share increases to over 30 percent among enrollees with a behavioral health condition, and rises further to 46 percent among enrollees with a substance use disorder, the very middle bar.

Now we'll take a look at the distribution of race and ethnicity. This is a similar structure to the previous slide. The colored sections here represent the share of enrollees in each racial or ethnic group.

Starting with the leftmost bar, non-Hispanic white enrollees, showed in the dark blue at the bottom,

make up almost 40 percent of all Medicaid enrollees. Their share increases to over 50 percent across most behavioral health and mental health condition groups, with one exception. Among enrollees with I/DD conditions, the second-to-last bar, they make up about 44 percent.

In contrast, enrollees who identify as Asian or Pacific Islander, that's shown in gray in that small section, they make up about 5.7 percent of the overall Medicaid population. But they represent a smaller share of enrollees with behavioral health conditions, dropping to less than 3 percent.

For other racial and ethnic groups, the distribution across condition categories generally mirrors the overall Medicaid population.

And I will now pass it to Anu.

* ANUPAMA WARRIER: Thanks, Janice. We will now take a look at use and spending for enrollees with behavioral health conditions.

In this graph, across the x-axis we have the condition category and the total service-related spending by each condition category. The lighter portion of each bar represents the spending through fee-for-service, and

the darker part of the bar represents the spending through managed care.

In 2023, Medicaid enrollees generated $642.3 billion in service-related spending, over half of which was through managed care. Enrollees with behavioral health conditions accounted for over half of the total service-related spending, with the same proportion through managed care. Across the other condition categories, we observed that over half of spending is through managed care, with the exception of spending on enrollees with I/DD conditions, where the inverse occurs and most spending is through fee-for-service.

This graph highlights total service-related spending per enrollee by selected mental health conditions. Across the x-axis we have the selected conditions and the number of enrollees with each condition.

Among enrollees with any mental health condition, their spending amounted to over $14,000 per enrollee. We see that spending per enrollee was highest among those with serious mental illness, or SMI, at over $24,000. SMI can include conditions like schizophrenia and bipolar disorder. Among enrollees with conduct disorders, which can include

conditions like oppositional defiant disorder, spending per enrollee was $23,000.

Looking at per-enrollee spending among enrollees with co-occurring I/DD and mental health conditions, we observed that per-enrollee spending is much higher, at over $34,000 per enrollee, compared to enrollees with mental health conditions on the previous slide. And spending per-enrollee more than doubles for enrollees with SMI and I/DD, compared to the previous slide where we looked at just SMI.

These figures highlight use and spending among enrollees with behavioral health conditions that used a behavioral health service in 2023, and what type of care setting they were in when they received that service. Because enrollees can receive services in multiple settings, the percentage of users by care setting is not mutually exclusive and will sum to more than 100 percent. However, because a claim can only be classified for one care setting, spending by care setting is mutually exclusive and will sum to 100 percent.

In 2023, there were 16.1 million behavioral health service users, and they generated around $80 billion in spending on behavioral health services. On the bar

graph on the left, we see that most enrollees, or 64 percent, received care in an outpatient setting, and that 30 percent received care in an inpatient setting. On the donut chart on the right, we see that outpatient care comprised about a third of total behavioral health spending, and that inpatient care comprised 27.6 percent.

These figures highlight prescription drug use and spending among enrollees with behavioral health conditions who use medications to treat those conditions. Similar to the previous slide, users are not mutually exclusive but spending is, and in 2023, there were 14.3 million enrollees that used prescription drugs, and generated $15.5 billion in drug spending. In the bar graph we see that antidepressants were the most commonly used prescription drug, with 63 percent of users, and in the donut chart, antipsychotic and antimanic agents made up over 40 percent of total spending on behavioral health drugs.

In this section we'll focus just on children and youth enrolled in Medicaid and M-CHIP. We will be describing the prevalence of behavioral health by selected characteristics. Here we look at prevalence overall and then by the enrollees' eligibility pathway.

Of the nearly 44 million children and youth enrolled in Medicaid or M-CHIP, 17.4 percent had a behavioral health condition in 2023. When we looked at rates by eligibility group, we see that children and youth belonging to the blind or disabled eligibility group and the total foster care group had the highest rates of behavioral health prevalence. Of the nearly 1 million children and youth in current or former foster care (or total foster care) half had a behavioral health condition in 2023.

When looking at rates by race and ethnicity, non-Hispanic white children and youth had the highest prevalence of behavioral health conditions in 2023, while children and youth who identified as non-Hispanic Asian and Pacific Islanders had the lowest prevalence at around 7 percent.

By geographic location, a larger share of children and youth living in rural areas had a behavioral health condition compared to their counterparts in urban areas.

In 2023, children and youth with a behavioral health condition spent $54.3 billion on all services.

Nearly half of that amount, or $26.5 billion, was spent on behavioral health services.

When we look at per-enrollee spending, we see that total spending per-enrollee was highest for children and youth with co-occurring mental health and I/DD conditions, while behavioral health spending per-enrollee was highest for those with co-occurring mental health and SUD conditions.

On this slide we describe behavioral health utilization among the 7.6 million children and youth with behavioral health conditions and how utilization varies across the age distribution, which you can see on the x-axis. Nearly three-fourths of children and youth with a behavioral health condition used at least one behavioral health service in 2023, and behavioral health utilization was highest for children under age 13 and lowest for enrollees between ages 18 and 20. Around 38 percent of 18- to 20-year-olds with behavioral health conditions did not use a behavioral health service in 2023.

These figures highlight prescription drug use and spending among children and youth with behavioral health conditions who use medications to treat those conditions.

And again, similar to the earlier slides, users are not mutually exclusive but drug spending is. So in 2023, 3.5 million children and youth with a behavioral health condition used behavioral health drugs, and this accounted for $3.3 billion in spending. The majority, or 59 percent, of users used drugs to treat attention deficit and hyperactivity disorder, or ADHD, and as you can see in the donut chart on the right, this also represented the majority, or three-fourths, of behavioral health drug spending for this group. Close to half also used antidepressants, which represented only 4 percent of spending.

And now I'll switch over to findings about our next population of interest, non-dually eligible adult enrollees between ages 21 and 64.

Similar to the previous section, we will begin with describing prevalence overall and then by eligibility group, race and ethnicity, and geographic location.

Over one-third of the 42.3 million adults in this age group had a behavioral health condition in 2023. Behavioral health conditions were most prevalent in the blind or disabled eligibility group, at 60.4 percent.

Here we see that non-Hispanic American Indian and Alaska Native and non-Hispanic white adults had the highest prevalence of behavioral health conditions, both around 45 percent.

When looking at geographic location, a larger share of adult enrollees residing in rural areas had a behavioral health condition, compared to one-third of enrollees living in urban areas.

In 2023, non-elderly adults with behavioral health conditions spent $197 billion on all services. Over a quarter of that amount, or $53.2 billion, was spent on behavioral health services. Total spending per-enrollee and behavioral health spending per-enrollee was highest for adults with I/DDs and co-occurring mental health and I/DD conditions, while per-enrollee spending was more similar for mental health, SUD, and co-occurring mental health and SUD conditions.

Here we describe behavioral health utilization among the 15 million non-elderly adults with behavioral health conditions and how their utilization varies by eligibility group. Sixty-nine percent of adults with a behavioral health condition used at least one behavioral

health service. Behavioral health utilization was highest for adults in the blind or disabled eligibility group, and lowest for adults in the former foster care group. Enrollees belonging to the Other health group had the lowest rate of utilizing five behavioral health services or more, at 33.8 percent.

Next, we will discuss some key takeaways from our analysis and then conclude with next steps.

In 2023, we found that more than a quarter of Medicaid and M-CHIP enrollees had a behavioral health condition. Their spending accounted for over half of total service-related spending among all enrollees.

Over 16 million non-dually eligible enrollees with behavioral health conditions used behavioral health services, which accounted for nearly $80 billion in spending. Around 14 million used behavioral health drugs, which accounted for $15.5 billion in spending.

More than 60 percent of behavioral health users received care in outpatient settings, and this represented one-third of total behavioral health service spending.

Looking at behavioral health drug use, a majority of these enrollees used antidepressants, but

antidepressants accounted for a relatively low share of drug-related spending.

When we look just at children and youth, we found that around 17 percent had a behavioral health condition in 2023, and their behavioral health spending accounted for almost half of their overall service-related spending. Children under age 13 were more likely to use behavioral health services compared to older age groups. Behavioral health spending per user was highest for children and youth with co-occurring mental health and SUD conditions.

Looking at non-dually eligible and non-elderly adults, 36 percent had a behavioral health condition, and their behavioral health spending represented over a quarter of their overall service-related spending. Adults in a blind or disabled eligibility group had the highest prevalence of behavioral health conditions and were more likely to use behavioral health services. And finally, we found that behavioral health spending per user was highest for adults with co-occurring mental health and I/DD conditions.

Our next steps on this project are as follows:

First, we welcome Commissioner feedback on the

behavioral health data we have presented today.

Second, this data was used to compile a draft chapter for the March Report to Congress, which we submitted for Commissioner review in the meeting materials.

And finally, we would be interested in hearing about any areas of particular interest for future work related to behavioral health use and spending.

Thank you. With that I will turn it back to you, Bob.

VICE CHAIR ROBERT DUNCAN: Thank you, Anu, and thank you, Janice, for the great work in the draft chapter. And look to Commissioners, I've got Patti and April. So I'd love to hear your feedback, guys.

COMMISSIONER PATTI KILLINGSWORTH: Thank you, Bob.

Really interesting information. I have one question and then a thought about next steps and where we may want to dig deeper.

So when you talk about the definition of behavioral health services, I think you said it was it is defined by having a mental health diagnosis on the claim or encounter as a primary or secondary diagnosis. Is that

correct?

JANICE LLANOS-VELAZQUEZ: Yes, that's correct.

COMMISSIONER PATTI KILLINGSWORTH: And so there wasn't -- just so I understand, there's not -- there wasn't a linking, if you will, of people who might have that diagnosis on one type of behavioral health service claim, but for example, maybe on a different claim, didn't have that, that primary or secondary diagnosis. That service wouldn't be counted. Is that correct?

JANICE LLANOS-VELAZQUEZ: Yes, that's correct.

COMMISSIONER PATTI KILLINGSWORTH: And here, this sort of gets to my concern. So one, in the key takeaways, I do think there's more to be said about people with intellectual and developmental disabilities, both as it relates to children and as it relates to non-dual, non-elderly adults. I think just the sheer differential in per-enrollee spending is so significantly higher, that that bears calling out in the data.

Another thing I think bears calling out in the chapter and really informs some future work that's really important is just acknowledging that there's a significant portion of people with intellectual and developmental

disabilities who utilize behavioral health services without a behavioral health diagnosis, right? A significant portion of them, in fact. And we know that. We know there are many reasons for that. It's a lack of -- it's a lack of expertise among people who are making these diagnoses. It's attributing way too much to their intellectual and developmental disability and not really recognizing those behavioral health conditions. It's a lot of things, but we know it's a factor.

And so when we exclude what we know to be behavioral health-type services, because that diagnosis is missing, we in all likelihood are excluding a number of people with I/DD who utilize behavioral health services as well as behavioral health expense. And even with that acknowledgment, we can see clearly from the data, they represent a very disproportionate level of spending compared to other utilizers of services.

So I do think it's an area that we need to dig into more deeply, maybe even think about another run at the data in ways that could account for some of what we know is overshadowing in the diagnoses and missing both people and claims that are legitimately behavioral health services and

behavioral health needs but may lack a proper diagnosis.

I also think we'd see it significantly affect anti-psychotic use if we were to pull all of that information in.

JANICE LLANOS-VELAZQUEZ: Thank you, Patti, for that comment.

And I just wanted to note that, yes, the behavioral health portion of spending wouldn't necessarily be categorized as behavioral health spending if they don't have the diagnosis code, but we do look at total spending. So we are seeing part of that picture, but that's a really good point about future work to maybe differentiate that a little more clearly for the I/DD population. So thanks for flagging.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

April.

COMMISSIONER APRIL HARTMAN: Thank you for this work. Excellent data to have.

One question that I have is, do you look at all -- or have you looked at who is providing the care? And the reason I ask is because there's a big movement to do integrated behavioral health with primary care. And I'm

wondering, especially with the portion of services that are being offered in -- you know, that are being done in the outpatient setting, is this with psychiatrists, psychologists, primary care, who -- what is the provider type that is providing these services?

JANICE LLANOS-VELAZQUEZ: That isn't something we looked at for this specific analysis, but it is something we could consider for future analyses.

COMMISSIONER APRIL HARTMAN: Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, April.

Dennis.

COMMISSIONER DENNIS HEAPHY: Thank you, and thanks for the great work.

I actually wanted to follow up on April's comment and question and say it would really be helpful to understand the breakdown and the types of services that people are using between inpatient, outpatient, community-based services, what types of community-based services are actually being provided, and looking at those services almost like the way we do HCBS services and institutional services. Like, how can we better understand the cost curve and expenditures for this population of people, and

are there other recommendations that can be made to states on how they might bend the cost curve by investing more in community-based services to reduce institutional service and care?

VICE CHAIR ROBERT DUNCAN: Heidi.

COMMISSIONER HEIDI ALLEN: Hi. This is really cool, and I'm really excited about this.

And like Dennis and April, I'm really curious about just what we think of as therapy, which I think is being categorized in here as outpatient.

We know a lot about medications and prescriptions, but those are only, you know, one lane of evidence-based treatment, and I see a lot of people here with diagnoses of anxiety disorders, depressive disorders, adjustment disorders. And those are things that evidence-based practices are also in place for therapy protocols, and yet, I don't understand. You know, it's hard to differentiate, you know, if a person has a major depressive disorder, can they get access to not just an SSRI, but can they see a therapist? And are therapists participating in the Medicaid program?

And as a social work professor often trying to

convince social work students who are going to go into mental health that they should serve the Medicaid population, there's always this question of, you know, well, how much does Medicaid pay a therapist? And it's just impossible to find out. I've spent hours looking online to try to figure out the difference between what an insurance company or what would be considered self-pay or a private insurance company and Medicaid pays, because I think it's actually in some places, not that big of a differential, because states have recognized the need to incentivize the workforce. But there's just no transparency whatsoever.

And when we're thinking about the highest cost services, which are emergency departments, inpatient hospitalizations, substance use treatment disorders, and we don't really know where, you know, evidence-based treatments that are happening that could prevent those, other than medications which are, you know, which have modest efficacy, but sometimes comparable efficacy to behavioral treatments -- and I think that sometimes the literature suggests that the most successful approaches are when they are combined.

And so just -- I would appreciate being able to dig down a little bit more into what we think of as therapy and therapy that's provided by, you know, not just psychologists, but social workers, licensed mental health clinicians, and see if we can see what on average kind of what that's costing, you know, or what like states are doing, how much they're paying.

I know that's something really difficult, you know, because we don't have access to managed care contracts, but even in fee-for-service, I think that would be super useful.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Heidi.

John.

COMMISSIONER MICHAEL NARDONE: I guess, Bob, what is the question here? Because I've heard a couple of my fellow Commissioners speak, and they're asking to go deeper. Is the question you have to us, is the chapter, as it is, good and that it can be published, and that we'll continue to do work from here? Or is it, hey, we shouldn't publish this chapter, as it is, until you've done this other work?

JANICE LLANOS-VELAZQUEZ: It's the former.

VICE CHAIR ROBERT DUNCAN: I was going to say it's my understanding, this is the chapter, the content, the expectation.

COMMISSIONER JOHN McCARTHY: Okay. So from that standpoint, then, I think you guys done, you know, like amazing job as always on, you know, difficult data to deal with and pulling things out and kind of going back to what Patti was saying. So Patti's question was the question that I also had. So she always -- you know, she's quicker to me on the draw on these things. So it's, you know, how are you calculating it, and what are you pulling?

This seems to be an excellent first run. I really don't have any other changes from there, then.

Having said that, I think going into the future, some of the other issues that have been raised, I think, are things that we can start digging into. But for where it's at now, I think that the chapter is pretty good.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thanks, John.

EXECUTIVE DIRECTOR KATE MASSEY: Janice or Anu, can you flip to the Commissioner questions, just so that

folks have a reference. It was a good call out that John raised.

VICE CHAIR ROBERT DUNCAN: All right. Dennis, do you have another question?

COMMISSIONER DENNIS HEAPHY: Yeah. It's basically saying, like, I support the chapter, everything in terms of framing it as a first run at this, and understanding that there are a lot of other considerations, looking at certified peer specialists, whether it be -- or recovery coaches or, like, what other what other services are available to folks out in the community that states are using to support folks with mental health and substance use disorder. So I think this is, like, the first run to it, but I think it's important to say that more will be done after that, if that's helpful.

VICE CHAIR ROBERT DUNCAN: Thanks, Dennis.

Jami, then Patti.

COMMISSIONER JAMI SNYDER: Yeah, fantastic work. I'm thrilled that this is going to be a chapter in the upcoming publication.

I think the area where I'm kind of most interested -- and Patti spoke to it, but just wanted to

reiterate -- is the per-enrollee spending across the general population versus the I/DD population. I think there's definitely room for additional exploration there and would love for us to kind of dig in and try to identify, you know, what some of those factors are that contribute to the increased spending.

VICE CHAIR ROBERT DUNCAN: Thanks, Jami.

Patti.

COMMISSIONER PATTI KILLINGSWORTH: Sorry for a second bite at the apple, but just want to clarify kind of between the comments that I made, what's sort of relevant for this chapter and then what's sort of relevant for the future work.

I really would like to see us call out when we explain the methodology for identifying behavioral health spending, the fact that it would therefore not include, right, potential spending on what otherwise might be characterized as behavioral health services, if that specific diagnostic code is not there, and maybe even taking it a step further.

I do think we need to call out specifically how that relates to the I/DD population because there's enough

evidence to show that we often miss the actual formal behavioral health diagnosis, even though behavioral health utilization can be very high, by the way, not just among children and youth with I/DD, but certainly among children, youth, and adults with I/DD.

And then, yes, I think we should think about how we might, in a second data run, dig deeper to try to overcome some of those shortcomings in the data and be able to identify that spending. I think it would be fascinating to look at utilization of services that are generally by virtue of diagnosis deemed to be behavioral health services, but were not in this analysis, because that diagnostic code was missing. I think we're going to find there's a lot of -- and I say that from personal experience, and so I do think there's implications for the current chapter, just in terms of being transparent and then sort of laying out a need for exploration further in subsequent work.

VICE CHAIR ROBERT DUNCAN: Thanks, Patti.

Jenny.

COMMISSIONER JENNIFER GERSTORFF: I was surprised to see that the prevalence of beneficiaries in rural areas

utilizing behavioral health services was higher than in urban areas. A lot of times when we're identifying conditions using claims data, we'll have bias in identifying them because of access issues and people not being treated because of access, and I would expect there to be more access in urban areas. So it was an interesting comparison, and if there's anything that in the future we can look at for settings of care by those different urban versus rural and kind of breaking that down to understand what's driving that.

VICE CHAIR ROBERT DUNCAN: Thank you, Jenny.

Anyone else? Patti.

COMMISSIONER PATTI KILLINGSWORTH: So related to that, there was a pretty high utilization or expenditures for telehealth services, and so that might be an interesting part of that analysis is just understanding if the use of telehealth has increased access to behavioral health services in those rural areas. I don't know if the data would bear that out or not, but it's certainly a potential, I think.

VICE CHAIR ROBERT DUNCAN: Thanks, Patti.

Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: No.

Janice, I think you got a lot of feedback both on the draft chapter. Do you feel like you have what you need to refine the content so that we have it in the March report?

JANICE LLANOS-VELAZQUEZ: Yes, we do. Thank you very much. The feedback was helpful.

ANUPAMA WARRIER: Thank you.

VICE CHAIR ROBERT DUNCAN: And do you feel like you got the feedback that there's more to be had in this work?

JANICE LLANOS-VELAZQUEZ: Yes, for sure.

ANUPAMA WARRIER: Definitely.

CHAIR VERLON JOHNSON: Okay. Thank you.

I'd like to thank our Commissioners and thank Anu and Janice for the great work on pulling this together. Thank you.

With that, Madam Chairwoman, it's all yours.

CHAIR VERLON JOHNSON: All right. Thank you. That was really great.

All right. We're going to close the day with a

very important discussion on justice-involved youth and transition back to the community, and, you know, this work is, from our perspective, intentionally focused on youth, right? And the considerations here are meaningfully different, I think, from the work we've done before around involved adults, justice-involved adults.

You know, I love our Commissioners. I've learned so much about youth, the youth and the importance of how we think about their health care and particularly the Medicaid space. I've learned that youth are still developing. We know they're often connected to multiple systems at once, and so the transition back to the community has long-term implications in a way that's distinct from adult re-entry, for sure.

So this session is really about us understanding how Medicaid can support their continuity of care for youth at this very critical moment, you know, so what early implementation looks like and has shown us so far.

So, JoAnn, I am very excited to hear what you have to tell us today. So I'll turn it over to you.

MEDICAID FOR JUSTICE-INVOLVED-YOUTH TRANSITIONS TO THE COMMUNITY

* JOANN MARTINEZ-SHRIVER: That's great. Thank you so much, Verlon.

So good afternoon, Commissioners. Last September, I reintroduced background information on Medicaid for justice-involved youth, you know, as a refresher and to lay the groundwork for our findings on this topic. So I've returned to present the draft chapter that will appear in the March report to Congress.

So for this session, I'll start with an introduction. Then I will describe some population characteristics of youth involved in the justice system and how the federal Medicaid policy is related to incarcerated individuals. Then I will discuss findings related to state implementation of Medicaid coverage suspensions and pre- and post-release services, coordination efforts between Medicaid and juvenile justice, and complexities of reaching and serving this population. Then I will conclude with next steps.

The transition from incarceration to the community is a critical time for justice-involved youth, who I will refer to as "JIY" or "youth." JIY are defined as young people who have had contact with the criminal

justice system, such as through arrest, incarceration, or probation.

Oh, sorry. Can you hear me okay, or is it not loud enough? Can you hear me okay?

Okay. So JIY are defined as young people who have had contact with the criminal justice system, such as through arrest, incarceration, or probation, so not just youth who are placed in correctional facilities, but also touch the system in some capacity.

While Medicaid has historically paid for very few services for incarcerated individuals, except when an inmate is admitted for inpatient care for over 24 hours, recent federal policy has shifted to allow states more flexibility to provide Medicaid services to JIY, which can help improve transitions for youth re-entering the community.

With this shift, states are busy implementing new requirements while addressing challenges that have come up. We learned about these efforts, as well as the characteristics of JIY and policies affecting them through a policy scan, a literature review, and interviews with stakeholders such as Medicaid and juvenile justice

officials in five states.

Since the interviews were conducted in 2024, we had the opportunity to reach back out to the Medicaid programs again for current information on their implementation efforts, which I'm speaking to today.

And then lastly, by way of an introduction, it's important to mention that even though the requirement to implement services for youth became effective a year ago, so January 2025, it's still pretty early in their implementation efforts, and time is needed to see how these changes will play out for youth.

Now I'll touch on some background information on demographics and unmet need very briefly, since this was covered pretty well in September.

So nationally, there were just over 29,000 youth in correctional facilities across the country, based on a single-day count in 2023. From this number, JIY are largely male and are 15 years old and above. Youth of color, low income, and LGBTQ+ youth are overrepresented in the juvenile justice system. And JIY have significant physical and behavioral health needs compared to peers who are not incarcerated.

In terms of physical health, the unmet need ranges from basic routine care to chronic conditions that are either untreated or undertreated, and in terms of behavioral health, research also points to significant need.

Multiple studies estimate that about 70 percent of JIY have a mental health condition, and a Bureau of Justice Statistics survey found that 60 percent of youth during a 10-year period in facilities may have had a substance use disorder.

In terms of federal Medicaid policy, the SUPPORT Act and the Consolidated Appropriations Act, I'll refer to as "CAA," 2023, in part, ushered a shift in longstanding Medicaid policy on coverage and services for JIY. First, the SUPPORT Act prohibits states from terminating Medicaid eligibility for eligible youth who become incarcerated. Rather, states should suspend coverage during confinement so that it can be more easily reinstated upon release.

The SUPPORT Act also directed the Department of Health and Human Services (HHS) through the Centers for Medicare & Medicaid Services (CMS) to issue guidance on opportunities for states to provide pre-release Medicaid

services to incarcerated adults and youth through a reentry Section 1115 demonstration waiver.

Then the CAA 2023 required that states provide certain services specifically to JIY. Under this statute, states must provide certain screenings and diagnostic services to eligible youth 30 days prior to release, as well as targeted case management 30 days prior to release and for at least 30 days after release.

Now we'll turn to some state efforts to implement these requirements.

For suspending Medicaid coverage during incarceration per the SUPPORT Act, some states reported that past state initiatives inform their efforts on this front. For example, one state reported that the Medicaid agency had been suspending coverage for many years as part of a health program for inmates that they developed in 2014.

To effectuate a suspension, states also reported using automated or manual suspension processes or both. For example, another state reported that while most of their suspension processes are automated, meaning that an electronic file will be automatically transmitted from one

system to another, some manual intervention is needed when there are special circumstances, like when a youth is transferred to another facility rather than being released. Such a circumstance would require a manual intervention to maintain the Medicaid suspension because they're still incarcerated.

States reported some challenges with their suspension efforts, like navigating different adult and juvenile justice systems within the state. For example, officials reported that different authorizing environments for adult and juvenile corrections in their state have made it challenging to navigate, like both systems, to enable new youth suspensions.

States also noted difficulty reinstating Medicaid coverage after suspension when JIY are released because of unpredictable release dates and also difficulty engaging some correctional facilities in suspension processes, particularly at the local level.

In terms of the CAA 2023, states reported working with CMS to implement services for JIY, and as expected, such efforts reflect states' unique circumstances and needs. For example, one state received approval to

implement pre- and post-relief services incrementally as part of the state's Section 1115 reentry demonstration.

States also reported leveraging managed care, particularly to provide targeted case management as required.

Some of the challenges that states reported in their efforts to implement pre- and post-release services include enrolling correctional providers as Medicaid providers and establishing billing processes. One state, for example, cited a significant learning curve on the correctional side, and not just for billing Medicaid, but just billing in general, like any insurance, because it's not what their correctional providers are accustomed to in the state.

And the states we interviewed are working to address such challenges by, for example, developing detailed guides for facilities, and in one state, retaining a third-party administrator to provide technical assistance for correctional providers.

Turning to coordination, even though the SUPPORT Act and CAA are requirements for Medicaid programs, state officials noted that coordination with correctional

agencies is essential for their compliance. As such, building new relationships has been critical.

Some states had existing Medicaid-corrections relationships, like I said, based on past state initiatives, and so they feel a little ahead of the curve in establishing those connections, while others are starting anew. Whether these relationships are old or new, states reported that they benefit from recurring touchpoints to answer questions and provide support for these new roles.

So, interviewees were enthusiastic about developing relationships across agencies, but it can be a little tricky. As I noted earlier, related to suspension processes, some of the states we spoke with cited the difficulty of engaging local correctional facilities to share information or develop partnerships.

And certainly, sharing information on JIY status is an important part of coordinating, but states noted barriers to data sharing, such as the technical complexity of consolidating data from multiple sources, the use of paper medical records in correctional facilities, and resources to update eligibility systems or develop

infrastructure for billing.

With the new requirements and services being put in place, state officials that we interviewed noted some of the complexities of serving this vulnerable population, which can affect their access to care. For example, correctional facilities face challenges recruiting and retaining staff, which can lead to long wait times for services and limited ability to transport youth to community-based appointments.

JIY also have co-occurring conditions and significant behavioral health needs that are complex to treat and often translate to high health care and medication costs, and once returning to the community, JIY face some challenges finding Medicaid-enrolled providers, as well as adolescent specialists or providers that offer trauma-informed care.

Also, because a lot of JIY are involved in both the juvenile justice and child welfare systems, they often have placement changes, and that can delay access and create fragmented care.

And then, lastly, while the involvement of a youth's family for reentry planning is really important,

parents may be unwilling or unable to engage in their child's care, which can affect medical decision-making and the support needed to successfully transition.

So despite these complexities, several stakeholders we interviewed were optimistic about these opportunities to support JIY transitions, with the hope that they could change a path of further justice system involvement.

So now I will turn to next steps. So I welcome any feedback the Commissioners have on the chapter. I am very interested in your thoughts on tone and whether any clarification is needed, and I'm also happy to respond to questions.

And I turn it back to the Chairwoman. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you, JoAnn. I really appreciate your work on this chapter.

So with that, I will turn it over to the Commission for discussion and their reflections. If we can go back one slide, just so we know the type of feedback that would be helpful for JoAnn, I think would be great, and again, around tone, clarification, and just highlighting the right area.

So with that, Commissioners? Okay. You all pop up at one time. I love it. All right. So we'll go to Anne, then Angelo, then Mike.

COMMISSIONER ANNE KARL: Hi there. Thank you so much for this. I just think this is such an important area to be highlighting. So I just -- when you are asking whether it's highlighting the key findings, I think it does a great job.

As we know, this is such a vulnerable population, and I think when Congress makes new requirements that deal with the intersection between two different systems, everybody understands like, oh, this is a great idea. And this is a point of coordination where there often are failures, and I think what this chapter does a really good job of is just acknowledging how difficult it is to actually coordinate across two systems.

I have not had a front-row seat. Maybe I've had like a mezzanine seat, watching as states have actually gone through and tried to implement this. And I think that point about things like billing, provider enrollment, it's almost every turn, there's a new challenge that comes up. And you have people working across organizations that don't

necessarily have a long shared history across those different agencies within a state. So I just think the chapter does a nice job of lifting that up and making it clear that there's been really painstaking work that's been done.

And again, I don't think that we've crossed the finish line yet, but I think it just speaks to the challenges with working with this population and hopefully encourages people to double down and continue to push forward. So thank you.

CHAIR VERLON JOHNSON: Great.

I'll hand it over to Angelo.

COMMISSIONER ANGELO GIARDINO: Yeah. Again, I'm appreciative for all the work as well. I think the chapter really does strike the right tone. It's very informational. It gives us some baseline information from which to understand what I hope is the evaluation for the waivers related to this population so that we can understand them better as that data rolls out. So I think you've done a really great job. You've balanced a lot, and I think it's really informative.

JOANN MARTINEZ-SHRIVER: Thank you so much.

CHAIR VERLON JOHNSON: Thank you, Angelo.

Mike?

COMMISSIONER MICHAEL NARDONE: Thank you. Thank you, JoAnn. This is really helpful, and I think it strikes the right tone. As Anne said, I think the complexities of this work, it does do a good job, I think, of explaining and helping understand the complexities of this work.

The one thing I was looking back on the chapter, one of the things that I appreciated was that you also involve the voice of people with lived experience. I think you mentioned that in the chapter, and I was wondering, the one thing, what I didn't see is I was wondering if there's anything else from that perspective that you could maybe add to the chapter, because I think there was only maybe one or two references to that, although I thought it was really an important add-on that you were actually -- that the focus group incorporated a lot of different stakeholders. Did you incorporate those voices? Am I remembering correctly?

JOANN MARTINEZ-SHRIVER: I think that the focus group, I think that was for the adult work.

COMMISSIONER MICHAEL NARDONE: Okay.

JOANN MARTINEZ-SHRIVER: But the work focused on youth also did speak to people with lived experience. So I'm happy to take that back and see if there's room for incorporation.

COMMISSIONER MICHAEL NARDONE: I think there was only one place where it was mentioned. And so I was like, geez, I wish there was a little bit more from that, to the extent that that could help inform the writing.

The other thing I wanted to -- and I don't know if it's in the context of this or in this chapter or maybe if this work continues, but I'm curious about the role that managed care has in this. I would imagine that managed care would help in terms of -- you raised some of the issues around criminal justice facilities becoming providers. It would seem to me that if, with respect to implementing the CAA 2023 requirements, that the managed care organizations would be the ones who actually did the targeted case management, as well as the diagnostic testing and those sorts. So the basic service requirements of that, I wonder that might bring -- that might deal with some issues.

It might raise some other complexities. So I

know that we've -- in other contexts, we're looking at managed care for kids with special needs, and I wonder if there's some kind of overlap there in terms of some of the work with respect to managed care.

JOANN MARTINEZ-SHRIVER: Okay. Thank you.

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

Adrienne.

COMMISSIONER ADRIENNE McFADDEN: JoAnn, I'd like to just add my voice to the fact that this was really well done, and I think it struck the right tone. And I don't think you really missed anything.

I will just raise an interesting population that I think has even more complications and risk is the justice-involved youth that are incarcerated in adult facilities, whose processes may not sort of be the same as a juvenile-focused facility. And there may be some sort of -- they will have to deter off of their normal processes. And so that may add to the complexity of making sure that we're transitioning the justice-involved youth that were in adult facilities in a way that's meaningful.

JOANN MARTINEZ-SHRIVER: Great. Thank you.

CHAIR VERLON JOHNSON: Yeah. Thank you. That was a good point.

Dennis?

COMMISSIONER DENNIS HEAPHY: Thank you. This is really great.

I think, though, for me, what would be helpful is to somewhere mention the disproportionate percentage of folks with disabilities in this population and the impact of the system on these folks, I think folks with mental health diagnoses or other diagnoses.

JOANN MARTINEZ-SHRIVER: Thank you.

COMMISSIONER DENNIS HEAPHY: Well, thank you.

CHAIR VERLON JOHNSON: Thanks, Dennis.

Carolyn?

COMMISSIONER CAROLYN INGRAM: Thanks, and thank you for going through all of the information you put together. I just wanted to point to a couple of resources that might be helpful, and I'll go through and look for them and see if I can find them.

But the Center for Healthcare Strategies used to run a program where they actually worked with states to implement some of these changes and had some findings about

that. I'm not sure if you interviewed or talked or spoke with them, but that might be helpful to go back and look at their writings in that area.

And then just want to reiterate Mike's point about looking at what managed care does. I think what I found, at least from running one health plan who has done this work, is there are some really good models out there of sample language that managed care companies can enter into kind of a joint powers agreement back with correctional facilities, just around things like sharing data or having staff go into facilities and help as somebody is doing discharge planning to make sure that they get their prescriptions, make sure they are set up for their first appointments and things like that, that are probably helpful and I think would be interesting to add to this because some of this is obviously run through, as Mike pointed out, managed care companies.

So I'll leave it at that. Happy to talk offline, though, to point you in the direction if you're looking for some of that information, but would be a good add. Thank you.

JOANN MARTINEZ-SHRIVER: Thank you.

CHAIR VERLON JOHNSON: Thanks, Carolyn.

Patti.

COMMISSIONER PATTI KILLINGSWORTH: Hey, JoAnn, great work and very comprehensive.

In terms of tone, I think the only thing for me that's missing is that I kind of come away from the chapter thinking, okay, these barriers and challenges are formidable. So what? Right? So what do we do about it? And what I don't have a sense of -- and maybe it's too early, because I know this is really about sort of level setting and providing an overview, but just a sense of where do we go from here, what are the next steps, what are the things that we need to look at, where do we see the potential opportunities, because there are so many barriers and challenges?

If you tell me it's too early to sort of think about giving some sense of next steps, I respect that. But that would be my thought, is I would like to walk away feeling like there are paths that we can take to come to meaningful recommendations that can make things better.

JOANN MARTINEZ-SHRIVER: Okay, I do think because of that, some of the message I got from states was

that they were really early. It was really new in their implementation. So that makes me think that we need a little bit of time to see how it plays out. But I definitely take your point for wanting to know what's ahead. Thank you.

COMMISSIONER PATTI KILLINGSWORTH: And maybe that's just sort of in the wrap-up, reiterating that, right, that a big part of what we need to do is let some of these recent policy changes sort of play out the work that states are doing, come back and assess the impact that that's having.

I guess I wanted something at the end that felt a little bit more next-step focused, if that makes sense.

JOANN MARTINEZ-SHRIVER: Yes, thank you.

CHAIR VERLON JOHNSON: All right. Thank you.

Carolyn, did you have another comment?

COMMISSIONER CAROLYN INGRAM: I did not. Thank you.

CHAIR VERLON JOHNSON: Okay. All right. Thank you.

You probably did. You just have to hold on, see if that's okay.

COMMISSIONER CAROLYN INGRAM: Yeah, I just get excited about that hand-raising activity. Thank you.

CHAIR VERLON JOHNSON: Yeah, I appreciate it.

Just a reminder, though, JoAnn, that she has a wealth of knowledge, though, that she offered.

So anyone else have any thoughts or feedback?

[No response.]

CHAIR VERLON JOHNSON: No?

All right. Okay. So again, I mean, thank you, JoAnn and Commissioners, for your thoughts. I think you can tell that we all appreciated your insights that you shared today with us, JoAnn, and I hope the conversation and some of the feedback was helpful, too, as you finish developing the chapter.

So do you need anything else from us, though? I guess that's always our question.

JOANN MARTINEZ-SHRIVER: No, that's good so far. Thank you.

CHAIR VERLON JOHNSON: All right. Okay. Well, thank you so much. We appreciate it.

All right. That was our last agenda item, so we are actually now going to move to our final public comment

period. As always, as we open up the floor, for public comment we do invite you to raise your hand if you would like to offer a comment. Please make sure you introduce yourself and the organization that you represent, and we ask that you keep your comments to three minutes or less.

So with that, let's see if we have any comments. We have one. Oh, Rob. Please take the floor

PUBLIC COMMENT

* ROBERT NELB: Hi, everyone. Good afternoon. My name is Rob Nelb, and I'm the Director of Policy at America's Essential Hospitals. I'm really glad to be with you all today.

As you may know, our association represents those hospitals that serve a safety net role, who are the leading providers for Medicaid and the uninsured.

I just wanted to join you today to make sure you are aware of some new bipartisan legislation that we just introduced in Congress earlier this month, the Reinforcing Essential Health Systems for Communities Act, H.R. 7145. The legislation proposes a set of practical and evidence-based measures for finding safety net providers, based on the care that they provide to Medicaid and uninsured

patients. It builds on decades of consensus about defining safety net providers, include work the Commission has done identifying deemed DSH hospitals and the important role that they play in our communities.

And I just think it's really important right now, given all the cuts to the safety nets that are happening as a result of the One Big Beautiful Bill Act. According to our analysis of that bill, for example, it's projected to add over $443 billion in hospital uncompensated care over 10 years, and it's going to disproportionately harm the safety net. You know, essential hospitals account for about 5 percent of hospitals nationwide, and they are going to bear about 25 percent of those added uncompensated care costs.

The bottom line is that we think the designation is a really important tool for policymakers to be able to target the limited resources that are available to the safety net providers that need them most. In the past, with provider relief funds, or even the rural fund, it has been really challenging when policymakers don't have a designation they can use to help target funding.

This legislation includes a few tweaks from prior

years that give policymakers some additional tools, including an index that could be used to scale support as needed. And in addition, it also includes a task for MACPAC, so that's why I wanted to flag it with you all, a call for MACPAC to add to its agenda research looking into payment policies that could help use this designation to provide targeted support to essential health systems, to help ensure the access to the services that they provide.

I appreciate the Commission's work today on managed care oversight between states and plans, but I think there is more that the Commission can do to really examine payments between health plans and providers. Directed payments have been a really important tool that many states have been using to hold plans accountable for paying providers adequately. But as those payments get cut, I remind you to look into some alternative tools.

You know, we've been concerned about other changes on the horizon, such as eliminating separate payment terms and other accountability mechanisms that give some transparency to how that funding is going.

So anyway, it's great to join you today. I look forward to staying in touch on this issue. And just thank

you all for your work and I hope we can be a resource as you move forward.

CHAIR VERLON JOHNSON: All right. Thank you so much, Rob. Good to hear your voice, and we appreciate the information.

Anyone else have any comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. Well, seeing none, I just want to remind you that if you do have a comment later you can always send it through our MACPAC website.

With that our meeting is adjourned for today. We do invite you to join us tomorrow at 9:30 a.m. Eastern, for day two. And in the meantime, we hope you all have a great evening, and stay warm. Take care. Thank you.

* [Whereupon, at 4:23 p.m. the meeting was recessed, to reconvene on Friday, January 30, 2026, at 9:30 a.m.]

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PUBLIC SESSION

REMOTE
VIA Zoom

Friday, January 30, 2026
9:45 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

[9:45 a.m.]

CHAIR VERLON JOHNSON: Good morning, everyone, and welcome back to our second and final day of the MACPAC January meeting.

I do want to thank you all for your engagement yesterday and to say thank you because we did cover a lot of ground for sure, and today we're going to continue with a lot of different conversations around also some amazing, interesting things, and we'll also close out with a public comment as well.

So, if you recall yesterday, we talked about HCBS payments, and we discussed a draft recommendation during that time. And we're now going to return to that vote.

Before I do, I want to note that MACPAC's conflict of interest rules does apply. Our policies of course are posted on the MACPAC website, so you can refer there anytime.

Now, as required by statute, Commissioners represent a wide range of backgrounds and bring diverse perspectives as well as reportable interests to their service. Our conflict of interest policy is designed to

ensure that any financial or other interest that could rise to the level of a potential conflicts are disclosed and appropriately reviewed in connection with the vote.

Commissioners are required to report relevant interests at the time of candidacy and annually thereafter. These disclosures, which are publicly available, form the basis for determining whether a potential conflict exists for a potential vote.

In advance of this voting meeting today, the Conflict of Interest Committee, which I appoint as Chair and which reflects a mix of Commissioners, reviewed the reportable interest on file and any other relevant information.

So, before we proceed, I'll briefly clarify what constitutes a conflict of interest under MACPAC policy. It is a reportable interest that rises to the level of a potential conflict only if it would be particularly, directly, predictably, and significantly affected by the outcome of a vote or specific recommendation. Generalized interests do not meet that standard at all.

On January 13, 2026, the MACPAC Conflict of Interest Committee met by conference call and reviewed

Commissioner's reportable interests under that standard that I just mentioned. The committee determined that no Commissioner has a potential or actual conflict of interest related to the recommendation under consideration today. The members of the Conflict of Interest Committee were Bob Duncan, who serves as the Vice Chair of the Commission and the chair of the committee, Sonja Bjork, Doug Brown, Jennifer Gerstorff, Angelo Giardino, Tim Hill, and Adrienne McFadden.

So now I will turn to Katherine Rogers to walk us through the HCBS payment recommendation, who will then turn it over to our Executive Director, Kate Massey, to facilitate the vote.

So, Katherine, over to you.

VOTE ON RECOMMENDATIONS FOR THE MARCH REPORT TO CONGRESS

* KATHERINE ROGERS: Thank you, Verlon.

Our recommendation reads: The Secretary of the Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to amend 42 CFR 441.311(e)(2) to require states to report 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 as determined by HHS. 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 upon planned or existing data collection activities or tools and publish data on the CMS website.

EXECUTIVE DIRECTOR KATE MASSEY: Great. Thank you, Katherine.

Okay. So we'll conduct a Commissioner vote at this time, and just remember that I'm looking for a vote of yes, no, or abstain.

Heidi Allen?

COMMISSIONER HEIDI ALLEN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

COMMISSIONER SONJA BJORK: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

COMMISSIONER DOUG BROWN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

VICE CHAIR ROBERT DUNCAN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Jenny Gerstorff?

COMMISSIONER JENNIFER GERSTORFF: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

COMMISSIONER ANGELO GIARDINO: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

COMMISSIONER APRIL HARTMAN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

COMMISSIONER DENNIS HEAPHY: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?

COMMISSIONER TIMOTHY HILL: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?

COMMISSIONER CAROLYN INGRAM: No.

EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?

COMMISSIONER ANNE KARL: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Patti Killingsworth?

COMMISSIONER PATTI KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

COMMISSIONER JOHN McCARTHY: No.

EXECUTIVE DIRECTOR KATE MASSEY: Adrienne McFadden? Adrienne McFadden?

VICE CHAIR ROBERT DUNCAN: She's on, but her

voice isn't coming through.

EXECUTIVE DIRECTOR KATE MASSEY: Okay. I'll circle back. Thanks, Bob.

Mike Nardone?

COMMISSIONER MICHAEL NARDONE: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

COMMISSIONER JAMI SNYDER: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Did we get Adrienne's audio worked out?

COMMISSIONER ADRIENNE McFADDEN: Can you hear me now, Kate?

EXECUTIVE DIRECTOR KATE MASSEY: Yes, I can hear you.

COMMISSIONER ADRIENNE McFADDEN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: That's a yes vote, Adrienne?

COMMISSIONER ADRIENNE McFADDEN: That's correct, yes.

EXECUTIVE DIRECTOR KATE MASSEY: Great.

And then, Verlon Johnson?

CHAIR VERLON JOHNSON: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Okay. So that's

15 in favor and 2 against.

Verlon, I'll turn it back to you.

CHAIR VERLON JOHNSON: All right. Thank you.

[Pause.]

CHAIR VERLON JOHNSON: All right. Are we moving on to the next agenda item? Okay, there we go. All right. Thanks.

CHAIR VERLON JOHNSON: Oh, Katherine, I saw you still there. I forgot that you were doing this one, as well. Okay.

Our first session today looks at automation in Medicaid prior authorization. This work examines how tools like algorithms and artificial intelligence are currently being used in prior authorization processes and what that really means for things like access, oversight, and transparency. Patrick Jones and Katherine Rogers will walk us through the findings, including where automation is being used today as well as where there may be gaps in policy or oversight. So I will turn it over to both of you. Thanks.

AUTOMATION IN MEDICAID PRIOR AUTHORIZATION (PA):

INTERVIEW FINDINGS

* PATRICK JONES: Thank you. This morning Katherine and I will present findings from MACPAC's research on automation in Medicaid prior authorization. In today's presentation we will provide an overview of the work we have conducted, present background information on both Medicaid prior authorization and automation, and share findings from our research.

Last year, MACPAC began a research project investigating how states, managed care organizations, and providers incorporate technology, including artificial intelligence or AI, to automate parts of the Medicaid prior authorization process. We will refer to prior authorization as PA throughout this presentation.

This project defines automation as the use of technological tools, such as algorithms and AI, to supplement workplace human action or decision-making. We conducted the study to develop a deeper understanding of how automation is being used in the Medicaid PA process. We also sought to identify existing federal and state policy levers to govern its use and to identify where additional policy levers are needed.

MACPAC contracted with Mathematica to conduct this study. Mathematica completed a literature review on automation in Medicaid PA, reviewed state and federal policies impacting the use of automation, and conducted a series of interviews with state Medicaid agency staff, federal government representatives, Medicaid MCOs, IT vendors, and provider and beneficiary advocates.

I will now turn to Katherine to present background information on PA and automation gathered during the literature and federal policy review phases of this project.

* KATHERINE ROGERS: Thanks, Patrick. As Patrick mentioned, I'll take us through an overview of the PA process in Medicaid and some additional background on what we learned from our policy scan and literature review.

Prior authorization, or PA, is a process often with multiple steps and parties involved by which a payer authorizes a provider in advance of the provision of a health care service, device, or medication. Generally speaking, the process originates with the provider's determination of the medical necessity of a certain treatment and ends with an authorization decision from the

payer. Denials of a service, which could be whole or in part, must be appealable by the beneficiary.

This slide depicts actually a simplified representation of the overall process, and just to note that this graphic is available in significantly more detail in an August 2024 issue brief available on the MACPAC website.

From a federal standpoint, Medicaid programs have the authority to impose PA processes as a utilization management, or UM, control, and generally determine which services require PA. There are certain services that are most commonly subject to PA. States in their oversight of Medicaid MCOs, or managed care organizations, may also require certain services be covered by MCOs without requiring a PA. For example, barring health plans from requiring a PA for medications for opioid use disorder, emergency services, or transportation to a hospital.

State-by-state requirements for PA understandably vary between fee-for-service and managed care programs and plans.

Federal and state oversight of Medicaid PA includes standards for timeline, notice, appeals, and

reporting. Medicaid payers must expedite requests related to needed urgent medical care. They may not require PA for early and periodic screening, diagnostic, and treatment, or EPSDT, services, and states may impose additional limits on PA policies implemented by Medicaid MCOs through their state Medicaid managed care contracts.

CMS provides oversight directly to state fee-for-service practices in UM and reviews and approves managed care contract plans with states. Through these contracts, CMS and states can ensure health plan compliance with the PA standards set forth in federal Medicaid managed care regulations and 42 CFR 438, for timeliness, clinical oversight reporting, and more. States can also leverage the external quality review, or EQR, process to provide detailed oversight of PA practices by Medicaid MCOs. And lastly, the interoperability rule that was finalized by CMS in 2024 also imposes additional requirements on fee-for-service that are new, as well as amending some managed care plans' requirements related to PA.

Now we'll turn to some context on the use of automation in the PA process.

First, we'd like to define a couple of things.

Overall, I would just reiterate that this project focuses on those uses that replace or supplant human decision-making, and that is the focus of the definitions here.

Algorithm is a term often included in discussions of automation and AI. When we use this term, we're talking about a set of programmed rules that achieve a certain function or purpose. In more advanced machine learning models, algorithms may be ever more complex and refined using artificial intelligence or AI. To draw a distinction, not all algorithms are AI, but AI relies on algorithms to do its work.

An AI model can serve essentially as a trained version of an algorithm that can adapt to new situations and improve over time, based on its data input.

AI is defined in federal statute, which is the definition we paraphrase here. This refers to machine-based systems that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments.

In the interest of time I won't spend much more time on predictive and generative AI, but these definitions are here for your reference. Both have applications within

the PA use cases we'll talk about in our findings. In particular, AI models are increasingly leaning on large language models, or LLMs, that use exceptionally large volumes of data, including free text, to model and understand natural language processing, and AI models may offer potential benefit in digesting, using, and learning from unstructured data. These may include large natural language data sources like books, websites, and importantly for us, clinical notes. But also data that are simply structured differently or different kinds of data in the same source, such as numeric data, photos, visit notes, all frequently part of a patient's clinical record.

In our initial policy scans and literature review we found a variety of applications of automation in the prior authorization process. These were confirmed through our interviews. Payers and providers may apply automation tools to nearly all steps of the PA process, including submitting requests, filling forms, verifying process compliance, formatting data, and making PA decisions.

Our literature review surfaced benefits and risks of automation in the Medicaid PA process also. These were underscored by our interviewees, as well. Providers often

report that PA processes occupy a significant portion of staff time, and that AI offers significant benefits in reducing them. One case study found that AI adoption reduced the time to draft a PA request letter for orthopedic surgery from 1 to 2 hours to 10 minutes. And in the same way automation can improve the efficiency of payer processing of PA requests. Research has found that automation tools can lead to PA decisions reporting in more appropriate, cost effective care.

Our work surfaced risks, as well. Automation can reduce transparency into the PA decision-making process, because vendors or developers may hold exclusive rights to the algorithms in AI and do not disclose decision criteria or logic. It may also mean limited transparency into how it is balancing appropriate clinical reviews with cost containment. And automation tools may use data or decision pathways that lock in existing biases, such as demographic disparities in existing health care data.

The existing policy framework offers means by which CMS and the states effectively oversee fee-for-service and managed care utilization management systems, PA policy, and operations. These policies do not explicitly

prescribe or prohibit the use of automation tools in Medicaid PA, nor do they impose specific mandates or minimum standards related to its use. Federal regulations at 42 CFR 438 do specify that within Medicaid managed care any PA decision must be made by an individual with appropriate expertise in the enrollee's medical, behavioral health, or long-term service and support needs.

In response to public comment on a prior proposed Medicaid managed care rule, CMS acknowledged the possibility of automation in authorization decisions, but this regulatory language has not changed to date.

Outside of the Medicaid program, CMS has issued guidance regarding automation for PA in Medicare Advantage plans. Guidance on the 2024 Medicare Part C and D final rule included information regarding how and when algorithms or software tools may be used in PA. And that guidance states that automation tools should not replace patient-specific medical evaluations and that they cannot deny coverage based only on population-driven predictions.

Outside of the existing policy framework there has been emergency policy action in automation generally. For example, the Trump administration's AI strategy has

emphasized reducing administrative burden for private sector AI development, innovation, and implementation, issuing two relevant executive orders within about the last year. One required executive agencies to create action plans to achieve that executive order's goals within about six months. A second identified variation in state AI laws as a barrier to policy promoting U.S. global dominance in AI, and directed the Secretary of Commerce to identify onerous such laws and restrict access to broadband funds to states with these laws.

And with that context, we'll turn to our interview findings.

Consistent with our literature review, we found states and MCOs are using automation in a number of ways. In our interviews, all states and MCO respondents reported some form of automation within their PA process, which included uses for synthesizing volumes of information, extracting data from electronic health records, categorizing requests for authorization, determining whether services required PA, automating authorization approvals, and referring PA requests for clinical review.

States and MCOs commonly reported relying on

vendor solutions that check incoming PA requests against programmed rules-based criteria, such as clinical coverage criteria, completeness of documentation, and known approval rules such as PA requirements or limits.

Overall, our interviews found MCOs using automation more than in fee-for-service programs in the states we spoke with, and stakeholders repeatedly emphasized the use of human-in-the-loop policies, or including clinical reviewers in the process for decision-making when PAs could not be automatically approved.

We heard that payers and others use automation as a tool to get to yes faster and to expedite burdensome or laborious parts of the lengthy administrative process. Another common theme was the application of AI or other tools to extract, analyze, or synthesize diverse, complex, or large data sources to reduce manual and time-consuming human processes.

The existing policy framework grants states enough authority to oversee Medicaid UM and PA processes. Beyond that, there is no explicit federal policy specifically requiring the collection of information or documentation about automation use in either fee-for-

service or managed care. We heard from interviewees this means governments have limited insight into automation adoption and use. Interviewees stated more information would be helpful, but did not uniformly offer examples of what disclosure would be most useful.

We learned that payers have surfaced information about automation through routine oversight channels, such as procurement processes, site visits, and existing reporting requirements, but these have typically resulted from voluntary disclosures. No state reported mandating reporting on or about automation for its MCOs, for example.

These existing policies do not directly set minimum standards, prescriptions, or prohibitions on the adoption or use of automation tools, so long as their use comports with existing standards for operation and oversight of UM in Medicaid. Federal Medicaid managed care regulations and states' regulations and managed care contracts offer CMS and the states mechanisms to provide oversight to the PA process, and similarly do not directly prescribe or prohibit certain approaches to the use or adoption of automation.

CMS's process for review and approval of managed

care contracts between MCOs and states relies on the regulatory requirement set forth in 42 CFR 438, and changes to that review process may require changes to that regulation.

And most recently, the interoperability rule offers an important step in federal guidance on states' and MCOs' application of PA processes.

With that I will turn it back over to Patrick to continue the review of our findings.

PATRICK JONES: Thank you, Katherine. As of December 2025, seven states have passed laws regulating the use of automation in PA. This map shows states that have passed such laws. Automation is not defined uniformly across these state laws, leading to variation in what automation tools are impacted by these pieces of legislation. Laws in California, Illinois, and Texas apply to an umbrella of automation tools that include both AI and algorithms. By contrast, laws in Arizona, Maryland, and Nebraska only apply to AI.

State laws share some common features. Six of the seven states -- Arizona, California, Illinois, Maryland, Nebraska, and Texas -- passed laws requiring a

human-in-the-loop for PA denials. These laws bar automation tools from denying PA requests on their own, and require a qualified human to make PA denials. However, these laws do not bar automation tools from approving PA requests.

State laws vary in other respects. For example, California, Maryland, and Illinois require automation tools' decision criteria to follow accepted clinical standards and bar automation tools from discriminating against members of protected classes.

Stakeholders raised concerns that automated PA processes present potential risks to Medicaid beneficiaries, states, providers, and health plans. Multiple stakeholders warned that automation tools may increase prior authorization denial rates for Medicaid beneficiaries due to aggressive cost containment strategies and data limitations.

One beneficiary advocate warned that MCOs may dial up or dial down approval and denial rates to contain costs at the expense of beneficiaries' clinical needs. This concern echoes findings from a literature review which identified several cases in which health plans allegedly

used automation tools to increase PA denial rates.

Multiple stakeholders also raised concerns about the appropriateness of the data used to train AI models. Medicaid beneficiaries differ from the general population in key factors related to health needs and service utilization. They are lower income with a higher incidence of chronic disease, and utilize certain services such as behavioral health or long-term services and supports more frequently. Thus, AI models trained on data that does not reflect the Medicaid population's attributes, such as data from commercial health plans, may be biased and make incorrect PA decisions when applied to the Medicaid population

Provider and beneficiary representatives also raised concerns that automation may reduce transparency into the fairness and accuracy of PA decisions. These stakeholders identified the black box nature of AI models and intellectual property protections as potential barriers to transparency.

In addition to this, MCOs and providers stated that the resources and expertise required to implement automation may create a divide between well-resourced

health care systems that can adopt and effectively govern automation tools and less-resourced systems that may be unable to do so.

In interviews, MCOs, IT vendors, and states reported that they are aware of some of these risks and have taken counter measures, such as requiring a human-in-the-loop for all denials. However, as one beneficiary advocate noted, human-in-the-loop requirements alone do not guarantee a thorough and fair review of PA requests.

Finally, we found that limited federal guidance on automation in Medicaid PA may be slowing the adoption of automation tools. States, MCOs, providers, and IT vendors are currently implementing automation with little federal regulation or guidance. One MCO stated there is a vacuum in federal guidance specific to automation that contrasts with the extensive guidance that CMS and other regulators have issued in other areas related to PA.

Stakeholders reported that the absence of federal guidance makes many states and MCOs reluctant to implement automation systems that may be superseded by federal action and require costly reworks in the future.

States have implemented their own laws and

policies, but stakeholders warned that variation between states creates a fragmented regulatory environment that limits the development of automation. For example, one provider representative stated that too much variation in state approaches can create a regulation soup that is difficult for providers and MCOs to navigate.

Stakeholders representing states, MCOs, providers, and IT vendors spoke in support of federal action on automation in PA. States expressed support for federal regulations, guidance, and technical assistance. For example, one state representative proposed that the federal government set a floor of regulations that the states can iterate on. MCOs, providers, and vendors expressed a need for regularly updated, standardized rules and guidance on testing, implementation, and safety that apply across states and patient populations.

However, some states and MCOs expressed concerns about federal intervention. One state warned against the federal government taking a one-size-fits-all approach that overlooks variations in state size, resources, and Medicaid policies. Additionally, an MCO stated that federal regulations may limit its ability to innovate on new

automation tools that help them meet PA turnaround requirements.

Key takeaways. Literature and stakeholder interviews reveal that actors across the health care sector are integrating automation into the PA process. However, its use in Medicaid remains nascent and not well documented.

Variable adoption, timely implementation, and documentation limit our understanding of these tools, their effectiveness, appropriateness, and fairness in the context of Medicaid PA.

When applied to PA, automation offers opportunities to optimize appropriate care, reduce administrative burden, and improve efficiency. However, many stakeholders have significant concerns about automation in PA creating barriers to care and reducing transparency. Given the limited information available, it is difficult to assess the scope and impact of these potential risks and benefits.

Current federal and state oversight and regulation of automated PA processes in Medicaid is limited and inconsistent. This reduces visibility into how

automation impacts Medicaid and creates barriers to its adoption. Many stakeholders expressed support for federal action that creates clarity and consistency in this policy area.

Staff expect to present a chapter on automation in Medicaid PA for the June 2026 Report to Congress. At this session, we ask Commissioners to share their reactions to these findings. In particular, we ask you to consider the following:

Our research found that states and the federal government have limited insight into the use of automation in Medicaid PA. Should states and the federal government collect information regarding the use of PA automation? If so, what information should be collected, and why?

Next, many state laws require a human-in-the-loop for all PA denials, and all MCOs we spoke to stated that they have human-in-the-loop policies. Should the federal government make human-in-the-loop policies a standard requirement?

And finally, stakeholders from multiple groups expressed support for federal regulation of automation in Medicaid PA. Is there a role for federal regulation or

guidance at this time, and how should federal guidance and regulation balance the risks and benefits of automation?

This concludes our presentation of findings from our research on automation in the Medicaid prior authorization process. I will now turn to the Chairwoman to facilitate the Commissioner discussion.

CHAIR VERLON JOHNSON: Thank you so much, Patrick and Katherine. This was definitely very timely and good information.

It is striking how limited visibility there is today into how automation is actually being used in Medicaid prior authorization, particularly managed care, and I know that my fellow Commissioners will have a lot to say around this. So I'm going to turn it over to the Commission for their discussion and reflections on this one, for sure.

So, with that, okay, John McCarthy, you're up first.

COMMISSIONER JOHN McCARTHY: Hi. This question is for Patrick.

I think the third question you had on there was, you know, should we collect data -- or no. Should federal

government make a standard of human-in-the-loop? I think one of the things you haven't proposed here for us to talk about is to align Medicaid requirements with Medicare requirements. Have we looked into that?

PATRICK JONES: Yes, that is an option we have considered. So we have looked at that.

COMMISSIONER JOHN McCARTHY: Okay. I mean, I think to me, that's one of those areas where, you know, trying to align those two would make it easier on vendors and easier on people, and so I think that's something that we should, you know, take a look at. Not saying that that's the way to go, but, you know, what is Medicare doing so we could take a look at aligning with that?

Thank you.

CHAIR VERLON JOHNSON: Thanks, John.

Angelo?

COMMISSIONER ANGELO GIARDINO: Yeah, I just wanted to really comment that I was really impressed by the depth of the analysis here and the balance that you struck in describing this new technology that clearly has both benefits and concerns. And I thought that was really helpful.

As a former Medicaid managed care medical director, the idea of increasing the speed to getting to yes is great, because so much of our time goes to collecting the information we need, and to spend time on requests that are completely in line with the standards that we've shared with the providers and the community in order to, you know, to go from 21 days to 14 days to 7 days to a few hours, that's wonderful. So I would love to preserve that idea of getting to yes faster so that patients can get the services they need quickly and providers can deliver that care.

I do like the idea in this phase of our development, the human-in-the-loop concept, because when you're going to deny service, that's where you really need to have expertise that's clear, transparent. And, you know, we haven't gotten to the point that we've engineered the physician or the nurse practitioner out of the care. So I like that human-in-the-loop.

So my suggestion would be -- and what would be helpful for me is perhaps to have some guiding principles to this work, because this is so rapidly developing that I think there's going to be new findings, new technologies,

new literature. But if we had our guidelines or our guiding principles, for example, anything in this use of technology that gets us to yes faster, that would be a guiding principle for me. That's great.

When care is being denied, making sure that it's being done in a fair and transparent manner that is open to being scrutinized and appealed, you know, I just wonder if you couldn't help us with some guiding principles.

But my conclusion is that you all have done a really great work at explaining an evolving area of practice, and I felt like I really learned a lot by reading the materials and listening to you. So thank you.

CHAIR VERLON JOHNSON: Thank you, Angelo.

Carolyn.

COMMISSIONER CAROLYN INGRAM: Thank you, and thanks for getting this work out. It's going to be complicated, but it's definitely something we should be diving into and looking at.

I wanted to go back to your definitions in that section. We talk about -- and I think it's in the documents on page 5, but I can't remember which slide it is on -- about simple algorithms being part of AI, and I

wanted to make sure it's clear when we're putting information together that a simple algorithm that is really a decision tree is not AI, it's not machine learning.

So algorithms have been used for a really long time, both in Medicaid managed care but also in fee-for-service, where you have rules that are applied. So, if a person, for example, has a diagnosis of X, they then get medication Y, or if a person has been defined to be having certain services they need in the community, based on activities of daily living, they get so many hours. It's a decision tree. So it's not automated learning. It's not AI.

I understand in the documents that we talked about how algorithms are used as a base for AI, but I think in our findings and in our literature and throughout the document, we need to be really clear that simple algorithms are not AI. Those are not rules that are put in place to deny care. So it's not using a machine to make those decisions. It's a decision tree.

So I appreciate whoever did the work on putting this together about making sure that we had a more thorough expansion of definitions, but I think we need to be really

clear. Those algorithms and those decision trees have been around for a really long time, and so I guess I would ask to go back and take a look at that and see if there's a better way to define it, make it more clear. If you're talking about algorithms that are using machine learning in some way, to make sure that we're setting that in there. It has a lot of implications for what might come down the line in terms of what we recommend if we group everything together. So I'd ask that we take a more careful look at that and be clearer in our definitions and what we mean.

All right. Thank you.

CHAIR VERLON JOHNSON: Thanks, Carolyn.

KATHERINE ROGERS: Thanks, Carolyn.

Verlon, can I just jump in really quickly?

We did hear about this in our interviews, because I think a lot of folks have the same reaction. Number one, there's been forms of automation in place in utilization management and lots of other places for a long time relying on algorithms.

We define automation very broadly, because when we're talking about automation that replaces human decision-making within the utilization management or PA

space, they are carrying out certain functions.

But, Carolyn, I take your point very much that they are doing so in different ways. For example, one comment -- if folks recall, we had a panel discussion on this last spring, and one of our panelists called out the difference in the scale of how quickly decisions can be made using, for example, a decision tree that plots you through different branches versus when a machine is doing that through an AI model. So we're very conscious of the distinction.

We did cover the waterfront to make sure we were understanding both, but we will continue to keep this top of mind and ensure that in our work we continue to capture the differentiation there.

CHAIR VERLON JOHNSON: Thank you. Thank you, Carolyn. Thank you, Katherine.

Doug?

COMMISSIONER DOUG BROWN: Thank you.

Very good work here. To Angelo's point, I think we have to consider guardrails on our recommendations that we want to move forward with, have to use caution here because we don't want to be too restrictive or prescriptive

based on the rapidly evolving AI marketplace, right? The technology continues to evolve at a very quick pace, and the AI is getting better and better and better at doing this. There are obviously concerns that folks have well-articulated here.

I think back to the time where I was in a PA call center when I started my career. The human-in-the-loop piece, every interaction I had was a denial that could not be authorized through the system as it came through, because there were decision trees in the system. So the time that gets to me, the human-in-the-loop, you're looking at the data and then you're reviewing the data, and some of those decisions were very quick.

It was pharmacy. So if the state had selected and said we have three preferred drugs and you wanted one and you hadn't tried something else on the formulary, the request was, why can't you try something else? Is there a therapeutic reason why you can't try that one first? If the physician agreed that they could try something else, the case was closed, and you moved on to the next case. Other times, there was a therapeutic reason, you do the override, and you would pass it along.

So I don't think human-in-the-loop is necessarily a negative piece here or safety. It's part of the process that's been in place for a long time from doing prior authorizations.

I also think we should look at things like auditing by third parties of denials in these programs. So states can set up or the federal government could set up a program where, on the backside, you're auditing and doing some auditing of those denials to ensure that the AI is working correctly, that bias is not part of the model.

From a bias standpoint, I mean, there's 70- to 90 million patients in Medicaid on the dataset that's out there in T-MSIS. You can pull in and use that as a background for the AI to kind of look at and think about what that the whole population that's in Medicaid gets from disease states to drugs to help weed out some of the bias that could be looked at, as long as that data is made available to the companies that are doing the AI and bringing that forward.

The last thing I want to make a comment on is CMS has the ability to certify programs. They certify MMIS systems before the FMAP and federal matching funds are put

down. We could make a recommendation here that CMS should certify these AI systems as they get put in or prior authorization or other systems here, or that they have certified and then states could use them, right? They could get some national certification here. So there's a couple of different ways we could go.

Great work, lots of discussions here, and lots of good questions to ask. I just don't want us to be too restrictive or prescriptive in what we come up with here. I think the market is changing very rapidly here.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Doug.

Heidi.

COMMISSIONER HEIDI ALLEN: Thank you so much for this work. I'm really excited about MACPAC's ability to look at this issue, and I also found the materials to be super helpful.

I have a number of comments that I hope we will consider for future conversations.

First, I fully do recommend the idea that MACPAC would put principles similar to those that have been created for the Medicare program. I hope that when we

think about humans-in-the-loop for denials, that we put a meaningful definition behind that, because I think some research using commercial claims have found that that human-in-the-loop is so quick as to be meaningless, that people are making decisions in less than 30 seconds, things like that.

I'm interested in the difference between working with vendors between fee-for-service and managed care and how vendors are advertising their services to each.

I think it's really important that the information that's communicated to consumers from an automated denial using AI is very clear and specific as to what was the actual, not just for medical necessity reasons, but really clear so that it's actionable on the part of the client to appeal. I think particularly because the difference between algorithms and AI is that AI is informed by a lot of information, and it's decision-making on its own. So there isn't necessarily a decision tree that you can then point to to say what happened.

Then I guess the last thing -- or last two things is, one, we need to acknowledge errors in the medical records and really think about how those are addressed,

because they could have such a profound impact on people if AI is drawing from records from a variety of sources and then making decisions when, in fact, those sources may not be accurate.

I also feel the same thing about bias. You could put all of T-MSIS data into these algorithms, and you could draw conclusions about people in rural areas, about African Americans, about LatinX populations, and you could say, based on all of this data, we have found less success in these approaches when it's not a medical reason why they're less successful. There's systemic issues, systemic barriers.

I think it's important to have an ethics committee that is looking specifically at bias and how it might play out in the algorithms that are developed using data from Medicaid. I think that that's important for all health insurance companies, but I think particularly for the Medicaid population.

Thank you. I'm very excited about this work.

CHAIR VERLON JOHNSON: Thank you, Heidi. I completely agree with you on that one. I mean, having access to data is very important, but that data quality

matters just as much. Automation tools are only as reliable as the data they're built on. We need to really understand that.

In Medicaid, we know that data can reflect historical patterns and access, of course, diagnosis and service use, as you pointed out.

So I just want to say that it doesn't make automation inappropriate, but it does underscore the importance of why we need to think about monitoring and oversight, as you all have all indicated. So I'm loving your comments.

So, with that, let me turn it to Dennis.

COMMISSIONER DENNIS HEAPHY: Thank you.

I agree with what Heidi was saying and with Verlon, and I sit here and I think this state has five different MCOs, and each MCO has its own AI that it's using to automate the decision-making process. What criteria is each plan using? Are they using the same criteria? What is the oversight that's taking place to ensure that the goals and the efficiency are the same? Is it to improve equity and health outcomes, or is it just to increase the speed of the automation?

So I just have overall concerns about the lack of oversight that's taking place now, and I'd love to see more information about how states are providing oversight of MCOs in their state, with the service system as well, to ensure that there's, like, what are the outcomes of those, of the -- what are the outcomes of the automated systems that are being used. Are they seeing greater equity and access to services? Are they seeing people getting authorization of -- or to say the modified authorization of services? So, if someone asks for service A, but they get a modified service, which is B, is that increasing? And do beneficiaries have the right, the ability to actually implement a robust appeal with all the information that they need to do so? Because the proprietary protections create a barrier to access to actually do that.

So I would much rather see -- and I'd love to hear if there's anything out there -- about open source AI, rather than the use of proprietary information, because this is something that really is supposed to be -- this is a government program, and it seems that a government program should be as transparent as possible, and that proprietary practices stand in the way of that, and that we

might look at, we might look at other models, such as open platforms.

Thanks.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Mike, you're up next.

COMMISSIONER MICHAEL NARDONE: Yes. Thank you, and thanks for this information.

I don't claim to be an expert on AI and in the Medicaid program, and so this has really been a good education for me.

I wanted to go back to something that John said earlier, because I think it was an important point, that that's where I was going too, which is that I think it would be helpful to the extent that, you know, Medicaid wants to develop some policies around this, that it kind of -- that it be consistent with where Medicare is going. And I don't know if that means some level of joint advice or, you know, Medicare setting the benchmarks upon which maybe Medicaid builds off of, given the unique nature of the population. But I was kind of going in a similar place that John was, and I wanted to just reinforce that.

I did want to ask a question about the Medicare

regulations, and specifically -- or the Medicare guidance. I wanted to ask, are there -- I did not see in the guidance that human-in-the-loop systems were required or basically recommended in the Medicare guidance. It seemed like you're very careful about how you phrase that, and I'm wondering if there was a human-in-the-loop discussion in that guidance from Medicare.

KATHERINE ROGERS: I can answer briefly, and we can take this back to take an additional look.

The guidance does not use that phrase. It does say that decisions must be based on patient-specific medical evaluations and underscores the need for specific clinical decision-making that is not based solely on machine-based, population-driven predictions.

So we'll take another look at that language, but it doesn't use that exact same phrasing.

COMMISSIONER MICHAEL NARDONE: Okay, thanks.

And then I guess I was also kind of following a similar line of thinking with Dennis, which was on slide 16, you know, you mentioned that states and federal government have limited insight into MCOs use of automation and that there's no federal requirement obligating states

to collect information from MCOs. But I was wondering in operational practice when you were talking to state stakeholders with MCO contracts, did they mention that they -- even though it's not a federal requirement, that they do have some insights or some information on the automation tools that are used by their managed care companies?

I'm thinking that this might be something that most states do try to at least understand how the states -- how the MCOs would be implementing their PA processes.

KATHERINE ROGERS: So states absolutely have insight into and oversight mechanisms for the PA process and utilization management more broadly, and so to the extent that they are -- for example, we heard from interviewees that through site visits or through procurement actions, this information was disclosed.

We did not hear about specific requirements, for example, in a procurement, in an RFP, for example, to specifically address and produce information to a level of detail specific to this one application.

I think that states are exercising their authority to oversee managed care plans, use of utilization management functions in general and PA specifically, and so

as part of that, we didn't hear that there's specific new action requiring disclosure documentation or reporting specifically as well, so like reporting on the performance of a tool that's been implemented within the PA process.

COMMISSIONER MICHAEL NARDONE: That might be something that there could be a federal requirement around that. That's one of the ways we could go here, some transparency around that.

Okay. And then just the final, did you encounter -- you know, just kind of in my past experience with PA processes, there always was -- you know, in order to make a denial -- and again, I'm with -- I'm very, very much in tune with others who've said, you know, it's great if we can use this tool for speeding up approvals, but, you know, we're a little concerned about denials, and is there any human involvement?

And I'm just kind of maybe with Doug along the lines that human involvement in the PA process was like standard when there was a denial, and I guess I would like to preserve that, unless there's more information that would convince me otherwise. But I don't think so.

So anyways, I'll stop there. Thank you.

CHAIR VERLON JOHNSON: Thank you.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Clearly, we were all very interested in this, and thank you again, Katherine and Patrick, for a really comprehensive overview. It's incredibly helpful.

It is an area that is both emerging and evolving quickly and has great promise as well as great risk. So I want to just reiterate a few comments that other Commissioners have made and then add a few to that, and when I say reiterate, it's really to add my support for those comments.

I do think that the absence of policy on this issue is concerning, when you think about sort of the risk that is there, again, great promise, but also great risk. So it probably is an area that we should lean into, recognizing that we do want to proceed sort of cautiously, as Doug said, with guardrails and not be too quick to make recommendations that might limit the development of things that could be very beneficial to improving access for enrollees and for reducing administrative burden.

I liked the idea -- and actually, was going to

recommend the same -- that Angelo put forth around guiding principles. It's kind of become a way that we do things at MACPAC, and I think because this is an emerging area, having guiding principles could be very beneficial.

I do think that we should think about kind of things that are always guiding principles for us, one of which is around transparency. Here, there's probably a careful balance because of the proprietary nature of some of these tools, but ultimately, it's important that states are aware when tools are being utilized. Maybe that could become part of policies and procedures that health plans disclose when they're employing those kinds of tools. But states need to be aware.

Importantly, as Heidi raised, a beneficiary and a provider requesting prior authorization on behalf of a beneficiary need to understand the specific reason that a service has been denied or denied in part, right? That needs to be clear. You can't take action to demonstrate medical necessity if you don't understand the rationale behind a clinical decision. Without sort of revealing all of the secret sauce that is part of a particular solution, that piece of the communication has to be clear.

I think we also tend to have sort of fundamental principles around oversight and accountability sort of at all levels, and so I would think that there might be a way that we would build that in, again, being cautious to not sort of over-engineer any recommendations around setting policy in ways that might limit really helpful evolution of these tools over time.

The human-in-the-loop piece, which I think is important, I think does need, as Heidi pointed out, greater definition, and I think that may be a simple tweak to the managed care regulations, which already require that an individual is involved in making denial decisions. Maybe that needs to be a little bit more prescriptive in terms of what that means, right, that it really does require an individualized review of the medical needs of the beneficiary by that qualified clinician, that it's not just sort of a rubber stamp to something that AI has already generated on their behalf. So, maybe that's an opportunity as well.

Then in terms of ways that we could have additional oversight, perhaps through the EQRO process, which already reviews prior authorization, and UM programs,

that a piece of what they should be looking at is how health plans are employing these various tools in those processes and making sure that they're not in any way restricting access to services and are kind of meeting the goals that have been laid out for those programs.

I certainly look forward to continuing this focus and hope that we can be helpful in striking the right balance between the tremendous efficiencies that can be brought to bear while minimizing risks to our beneficiaries.

CHAIR VERLON JOHNSON: Thank you, Patti.

Jami, then April, then Dennis.

COMMISSIONER JAMI SNYDER: Yeah, I was just going to kind of reiterate the comments from John and Mike around choosing Medicare as sort of a benchmark, and one of the things that I was thinking of as we move forward in our inquiry and investigation around AI and its utility is following the CMS Innovation Center's new model, the WISeR model. I think there are six states that are participating, but the real focus of that model is looking at how a technology like AI can streamline the review process for certain services.

So I would just want to take advantage of some of the work that CMS is already doing and talking with them and the states, the participating states.

It kicked off at the beginning of this month. So, clearly, we don't know a lot at this point, but I think it would be helpful to stay connected to that effort as well.

CHAIR VERLON JOHNSON: Thank you, Jami.

April?

COMMISSIONER APRIL HARTMAN: I'm speaking from the provider perspective, and I can tell you the PA process gets very painful.

The first question asks what information should be collected. I'd see data all the time on the number of PAs that are denied and then how many of those are overturned and that kind of thing. But one piece of data that I think is missing might be how many denials are even contested, because it has gotten to the point that the administrative burden of trying to appeal a denial is such that it's almost not worth it. If there is a medication I want to prescribe and I have to get a PA and I try and it's denied initially, I can call, that I'm going to get a

human-in-the-loop. It's probably someone who has a high school diploma. It's not someone with a level of expertise that's greater than mine, and so they're going to say, oh, I'm going to take this to my manager. Then I'm going to talk to their manager, maybe, in a day or so, and then they're going to say, oh, you need a peer-to-peer review. So then I talked to a physician who has an equal or greater level of knowledge than me and can answer or approve that. So it's so cumbersome that if something's denied, I'm almost just going to just prescribe something else, just without even trying it.

One piece of information that I would like to see is how many denials are actually contested, not just how many are overturned, because I think when you just look at which ones are overturned, it gives you an inaccurate count of what's happening. That's one thing.

I think that, again, the human-in-the-loop piece, having better definitions of who that should be and what level of expertise should be required for that is important, because like Heidi said, right now, I don't think it makes a difference, because if you get somebody, yes, it's a person, but they don't have the expertise to

really make that decision without elevating it a couple levels, so being very intentional about that piece of it. I'm actually a really big fan of AI. I think it's great.

But on the third point here, you asked the question of how should our federal guidance and regulation balance the risk and benefits of automation, and I have to kind of back off from PAs to say it feels like automation has been used with PAs for a long time. This doesn't feel like something new. So I think what we're talking about is just how to regulate it, not if it should be used, because it's being used.

What concerns me and what I hope that there's more talk on automation in general is that there are organizations using automation in different ways that impact care. One thing that has been a really hot topic with some of the managed care organizations that I'm involved with has been the use of automation to do prepayment audits, meaning that they will downcode the level of service based on an automated audit of the claim, not the medical record, anything like that, but of the claim itself. They say, oh, you can always appeal it, but that appeal takes a while.

The last thing I wanted to bring up is when you go through the PA appeal process, it is ultimately up to the beneficiary to appeal this with the insurer. Most of the patients that we work with in Medicaid don't have the health literacy to be able to do that, and we can help them. But again, the administrative burden on the member or on the provider makes it extremely difficult.

So those are the points that I wanted to bring up. Thank you.

CHAIR VERLON JOHNSON: Thank you, April.

Dennis, then Adrienne.

COMMISSIONER DENNIS HEAPHY: Thank you.

I just wanted to -- we've been focusing on the federal piece of this, and I hope we don't support anything at the federal level that would impinge the ability of states to innovate interventions to improve and protect the rights of beneficiaries as they are on the ground experiencing the direct impact of AI in their states. So I do hope we continue to support the right of states to develop their own interventions to support effective use of AI that really is in the interest of beneficiaries and taxpayers.

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

Adrienne, Anne, and then we'll close out with Carolyn.

COMMISSIONER ADRIENNE McFADDEN: So for once, I feel like I timed my hand right, and so I think my comments actually play off of April's and Dennis's comments.

So I was going to say, again, just to reinforce, automation is not new. I think we've heard that many times.

But with April's experience with the status quo PA, it gives me some additional optimism around AI, and I think I've said in other meetings around this topic that I am a supreme optimist around AI just because of my background and experience and work experience.

But anytime we can create better and more simplified experiences for physicians, clinicians, and other providers by getting them approvals faster and, in some cases, even real-time approvals, is a huge win because it reduces wait time and accessing care for their patients, which is also a win for the patients. So I want to make sure that whatever we do as a body does not sort of stifle

that.

Also, I think I'm going to probably state the obvious, and hopefully, this is not controversial, but responsible AI is not problematic. I think it's those exceptions when AI is used irresponsibly that seem to cause a trepidation. I felt like I kind of got that theme from sort of the information with the interviews, et cetera.

All of the organizations I work with, whether they are managed care companies, health tech companies, or others, have had some form of a local responsible AI governance body when using AI. Perhaps that's an area that we can sort of look at as MACPAC to focus in on maybe optimizing guiding principles for those bodies so that we don't stifle responsible innovation, because I do really think that innovation is important for Medicaid going forward.

CHAIR VERLON JOHNSON: Thank you.

Anne?

COMMISSIONER ANNE KARL: Yeah, I think it's great. It's really exciting to see MACPAC doing such rigorous work on technology that's new instead of sort of being -- you know, instead of waiting for it all to play

out and then identifying problems. I think being on the front end, I think, is really great. So I just want to commend the team for the work on it. I think it's really detailed and great.

I'm with Adrienne and several others, that I think there's huge promise with AI, but I do think that there also are some challenges.

I think one thing that would be helpful, because I think several things get sort of squished together when we're having these types of conversations, is to be really clear about what the AI is doing in the prior auth process. Is it just applying clinical guidelines against the medical record where it's sort of saying, look, we have these established clinical guidelines that if you have these conditions, we think that this treatment is medically effective for that, and therefore, it's sort of scanning the medical record in a much more efficient way to assess whether someone actually has the conditions that would merit the treatment? Or is the AI actually generating the clinical guidelines, where the AI is like reviewing medical evidence and saying, oh, we think that this would be effective for this person or this set of conditions?

I think in the former, that really just feels like administrative streamlining and gives, I think, raises fewer concerns. The latter -- and again, I'm not saying that these are insurmountable concerns, but I just want to acknowledge it's like a different set of issues that you're thinking about. The latter, where the AI is actually establishing the clinical guidelines, to me, that raises questions about the ability of enrollees to effectively appeal the decision because the AI, it's often such a black box. That's just kind of the nature of machine learning. There are questions about the quality and representativeness of any training data that it's using, all of the questions of inherent bias related to that, et cetera. So I think it just gets a lot harder if the AI is actually building the clinical guidelines as opposed to merely applying them.

So I would just encourage in future work on this, that we're sort of being clear about that, those distinctions, and just being specific about that, because I do think it's sort of separate issues.

Then I think related to that is we talk a lot about patient-specific reviews, and that comes up anytime

that we're talking about prior authorization, not just specific to automation and the prior authorization process. So I think that's something that people are familiar with, but I find there's a lot of confusion around what that really means. What is the patient-specific review about? Again, is it a more granular assessment of does this person's medical condition meet the criteria we've already established, or is it something more about should the criteria be different for this person or something like that? Those are two really different pieces, and I just think there's a lot of confusion in Medicaid generally about how that works. So I just think that's important to distinguish as well.

CHAIR VERLON JOHNSON: Thank you so much, Anne.

And the, Carolyn?

COMMISSIONER CAROLYN INGRAM: All right. I'll go fast because I know we're running out of time. A couple of things after all of the feedback from everybody.

I do think it makes sense for us to look at Medicare, although what I'm finding in my quick scan is there's not a lot there, and that just recently articles came out, actually today while we were talking, that

providers are pretty upset with some of the WISeR implementations. So it might be a good way for us to learn quickly.

But to reiterate some of my fellow colleagues or Commissioners' comments, this is moving with rapid pace. So looking if we can do some principles quickly might be good, because otherwise, by the time we meet next, things are going to be way ahead of where we are. So maybe looking and leading on those principles might be the best thing to do.

Thank you.

CHAIR VERLON JOHNSON: That's great. Great summary right there. Appreciate it.

So I think this has been a really great conversation for sure. I think we heard some really thoughtful perspectives on both the benefits of automation AI and importance of transparency and safeguards. I think you all spelled it out pretty well.

I'm looking at Patrick. I'm looking at Katherine. You had asked us some key questions. I know we talked about visibility and how it's used. We talked about human-in-the-loop, what that means, other safeguards, and

some potential federal guidance. Is there anything else, though, that will be helpful for you all as you walk away from this conversation and continue down the path of this work?

KATHERINE ROGERS: I think this is a lot of really helpful feedback, and I think we have what we need for right now. Thank you.

CHAIR VERLON JOHNSON: All right. Awesome. Well, thank you all again. I thought that was a great conversation.

So Carolyn said that we were running out of time. We actually ran out of time, but I wanted to make sure we continued this conversation, because it was so fruitful, for sure.

But now we're going to actually turn to the Program of All-Inclusive Care for the Elderly, or PACE. We've had this conversation before, and this work is going to look at the role of state Medicaid agencies in overseeing the PACE program, including how oversight responsibilities are structured and exercised in practice.

With that I'm going to turn it over to Brian and Michelle to walk us through a little bit more of what they

learned and have us engage in a conversation. So Brian and Michelle, the floor is yours.

EXPLORING THE ROLE OF STATE MEDICAID AGENCY IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE): PROGRAM AGREEMENT AND WAIVER FINDINGS

* MICHELLE CONWAY: Thank you, and good morning, Commissioners. Today we'll be providing an update on the second phase of our work on the Program of All-Inclusive Care for the Elderly, or PACE. This work explores the role of the state Medicaid agency in PACE, in particular.

We'll start with an overview of the purpose and methodology of this work, then provide some background on PACE. We'll then provide key takeaways from our review of three different types of documents that important in oversight of PACE -- the required three-way program agreement among the PACE organization, the state, and the Centers for Medicare and Medicaid Services, or CMS; the optional two-way program agreements between a state and a PACE organization; and waiver requests from PACE organizations submitted through Section 903 of the Benefits Improvement and Protection Act of 2000, or BIPA. And finally we'll discuss next steps for this work.

As a reminder, the last time we presented on PACE was in April 2025, when we presented a draft chapter included in the June 2025 Report to Congress. We presented findings on the statutory and regulatory framework governing the program as well as key elements of the PACE model. During that work, stakeholder interviews and Commission feedback raised questions about transparency in the PACE model, particularly around shared federal and state oversight responsibilities, and state officials expressed differing views on the role of the state Medicaid agency.

Two types of documents also came up repeatedly during interviews: two-way program agreements signed between state administering agencies and PACE organizations, and waiver request documents submitted by PACE organizations to CMS, known as the BIPA 903 waivers, as I mentioned on the previous slide.

Building on these findings, a second phase of our PACE work explores how state Medicaid agencies fulfill their oversight responsibilities. For this work, we contracted with the Center for Health Care Strategies to conduct a document review of three types of documents used

in PACE oversight, again, the publicly available template language for the required three-way program agreement among CMS, states, and PACE organizations; the optional two-way program agreements between state administering agencies and PACE organizations, submitted by 16 states and the District of Columbia; and finally, the BIPA 903 waiver requests submitted to CMS by PACE organizations in nine different states.

In total, we reviewed 65 distinct documents between August and December of 2025.

I'll provide some background on PACE more generally since it has been a little while since we have given a presentation on PACE.

PACE is a provider-led, home and community-based care model that offers fully integrated care designed to delay, if not prevent, nursing facility and hospital use for older adults with complex care needs. To be eligible for PACE, individuals must be age 55 or older, meet the nursing facility level of care requirement, live within the service area of a PACE organization, and be able to live safely in the community at the time of enrollment.

As of November 2025, 74,000 dually eligible older

adults were enrolled in 198 PACE programs across 33 states and the District of Columbia. That number represents the 80 percent of PACE participants that are dually eligible.

PACE organizations rely on interdisciplinary teams of providers and must offer all Medicare and Medicaid covered services without benefit limitations on the amount, duration, or scope of services provided. PACE organizations must operate a PACE center, but care may also be delivered in participants' homes and alternative community settings, as needed.

As a Medicaid and Medicare program, PACE oversight spans multiple divisions and offices within CMS. Our previous interviews with federal officials revealed that the Center for Medicare holds primary responsibility for PACE oversight, but coordinates monitoring activities across CMS.

Federal oversight includes audits of PACE organizations as well as review of required quality data that PACE organizations submit quarterly through the CMS Health Plan Management System, or HPMS. And interviews also confirmed that there are relatively few domains in which state Medicaid agencies have the primary oversight

responsibility.

As a fully integrated care model, PACE organizations receive capitated payments from both Medicare and Medicaid. Payments do not vary with changes in a participant's health status but are intended to reflect the higher level of frailty among the PACE population. States generally base Medicaid capitation rates on a blend of nursing facility and community-based care costs for older adults in the area to account for participant frailty. Medicaid rates must be less than the amount that would otherwise have been paid, or AWOP, for a comparable population meeting the nursing facility level of care criteria but not enrolled in PACE. And separate Medicaid rates are established for dually eligible and Medicaid-only PACE participants.

Next, we'll discuss key takeaways from our review of the three-way program agreement.

PACE organizations operate under a three-way program agreement, among the PACE organization, CMS, and the state administering agency. The three-way program agreement is divided into seven articles with language that is standardized across states, as well as related

appendices that include information specific to the state and the PACE organization. These articles include sections on eligibility, enrollment, and disenrollment; appeals and grievances; quality assessment and performance improvement; and data collection and reporting requirements.

While these sections of the three-way program agreement are standardized across states and PACE organizations, CMS allows states to include two types of optional content in the three-way program agreement. First, an agreement may include additional state-specific requirements for individuals to qualify as PACE eligible. And second, states may include additional state-specific terms and conditions, agreed upon by the parties, if the terms and conditions are consistent with federal law and regulation.

In the three-way program agreement, CMS sets out several state rules and requirements for administering and overseeing PACE programs. These include setting processes and criteria around enrollment and disenrollment, reviewing PACE marketing materials, setting licensure requirements for PACE organizations, and monitor PACE program compliance.

Within monitoring there are several state-specific responsibilities, including conducting readiness reviews, monitoring during the PACE organization's trial period, which refers to the first three years of the organization's operations, conducting ongoing program monitoring, conducting monitoring of corrective action plans, or CAPs, and monitoring of level of care redeterminations. For some of these monitoring activities, such as trial period and ongoing monitoring and monitoring of CAPs, states work in conjunction with CMS. But for other activities such as conducting readiness reviews and monitoring level of care redeterminations, states are solely responsible and CMS does not have a role.

I will now turn it over to Brian who will discuss our findings around the two-way program agreements.

* BRIAN O'GARA: Thanks, Michelle, and good morning, Commissioners. Happy Friday.

In addition to the required three-way program agreements, many states also operate two-way program agreements between the state administering agency and the PACE organization. This is a snapshot. Among the 33 states and the District of Columbia that currently operate PACE

programs, 16 states and the District of Columbia reported using two-way program agreements, highlighted here in the dark blue. Three states -- Delaware, Oklahoma, and Texas -- indicated that they are in the process of developing two-way program agreements. And the remaining states, shown in light blue, are states that operate PACE programs but do not use two-way program agreements.

And just to note, for today's discussion we heard from officials in Missouri that they previously relied on a two-way program agreement, but have since codified their PACE requirements into state statute. So we will be including findings from Missouri as part of today's discussion.

The two-way program agreements that we reviewed included both agreement templates with boilerplate language as well as actual contracts signed by PACE organizations. These documents varied widely in length from 4 pages in New Mexico's two-way program agreement, to 298 pages in Washington State.

Overall, we found that states generally use these two-way program agreements to supplement the existing federal PACE oversight framework by adding more detailed

requirements. This leads to wide variation between states. But we found that the additional state requirements most often appear in areas already identified in the three-way program agreement, which Michelle just detailed and which we'll discuss in more detail now.

During the trial period, CMS and the state are required under federal regulations to conduct comprehensive overviews of PACE organizations. However, we found that in practice only three states addressed trial period monitoring requirements in their two-way program agreements. After the trial period, federal regulations in the three-way program agreement offer limited clarity on states' roles in ongoing monitoring, noting that the state, in cooperation with CMS, will conduct reviews, as appropriate.

All of the two-way program agreements that we reviewed, with the exception of Virginia's, include provisions around ongoing monitoring, but these are generally broad, such as record retention periods and state access to facilities and records for review.

When deficiencies are identified, federal regulations require that PACE organizations implement

corrective action plans, with CMS and states retaining discretion about how they monitor the effectiveness of those plans. We found that nine states include additional provisions around corrective action plans, five outlined enforcement actions of CAPs are inadequate, two defined time frames for developing CAPs, and three states took a more active role in monitoring. For example, Wisconsin's two-way program agreement allows them to take intensive oversight actions, including placing state officials or designated representatives at the PACE organization, to provide technical assistance and oversee corrective actions.

Separately, federal regulations assign states primary responsibility for conducting annual level-of-care redeterminations for PACE enrollees. Regulations allow states to waive these redeterminations if they determine that an enrollee's condition is unlikely to improve or change. However, we found that only one state waives this annual redetermination for specific conditions, Tennessee, and they list conditions such as Alzheimer's, related dementias, and congestive heart failure in their two-way program agreement.

Fourteen states use two-way program agreements to require that PACE organizations submit a range of data, including measures already reported to CMS through HPMS, and additional state-specific data. The quality-related reports that PACE organizations most commonly submit to states that also overlap with HPMS submissions include grievances and appeals reports in seven states, enrollment reports in six states, disenrollment reports in five states, and incident reports in four states.

PACE organizations are required to submit quarterly financial statements to CMS during the trial period and annual certified statements that are after. We found that nine states require additional financial reporting in the two-way program agreements, ranging from monthly to quarterly reporting.

CMS also requires that PACE organizations maintain quality improvement programs, but regulations do not clearly specify whether or how quality data must be reported to CMS or to states. We found that eight states include provisions in their two-way program agreements requiring quality-related reports.

Since 2013, CMS has required PACE organizations

to submit Medicare encounter data for services that generate provider claims, and more recently to submit chart review records to capture diagnoses from PACE center services that do not generate claims. We found that seven states require PACE organizations to submit encounter data to the state, but five of these two-way program agreements do not specify the scope of the encounter data. California and North Dakota, however, do more clearly define encounter data requirements. California requires PACE organizations to report all Medicaid-covered services for which they are financially liable, while North Dakota specifies reporting for all services delivered to Medicaid enrollees, including denied claims when Medicare pays.

We found that 12 states impose additional reporting requirements beyond what is currently required by CMS. The most common among these are service utilization reports, and fraud and abuse reports in five states, statistical data in four states, and provider listings in three states.

While most two-way program agreements we reviewed focused on further tailoring existing oversight responsibilities, we found seven states used these

agreements to further define the state's role in some area of administering PACE, most often through reviewed PACE marketing materials or support beneficiary education of the PACE model. We found few instances where states used these two-way program agreements to assign new roles to the state. Michigan is the only state that gives their state administering agency a role in the clinical operations of PACE organizations, requiring state approval of nursing aide training curricula and materials.

Next, we'll move on to the third type of document we reviewed, the BIPA 903 waivers. As mentioned previously, PACE organizations are allowed to request waivers of certain regulatory provisions under Medicare and Medicaid. In PACE's authorizing statute, Congress outlines five core elements of the model that may not be waived, however, and those are listed here.

CMS has standardized instructions for PACE organizations that wish to submit waiver requests. The PACE organization will draft the waiver request and submit it to the state. If the state does not approve the request, CMS automatically denies the waiver. If the state approves the request, the state then forwards it to CMS,

along with any other comments or concerns the state may have. And CMS makes determinations on these waiver submissions within 90 days of receiving a request, and then notifies the PACE organization of its decision.

We reviewed a total of 47 waiver requests from 32 PACE organizations across 9 states. We found that nearly all of the waiver requests really related to two primary issues. Most of the waiver requests we reviewed requested the waiving of regulations around in-person enrollee assessments and reassessments. So during the COVID-19 public health emergency, CMS issued guidance permitting the use of remote technology to conduct assessments and reassessments. We found that many PACE organizations have continued to request that these be conducted via remote technology after the public health emergency has ended. And the majority of submissions also requested waivers of in-person assessments for service determinations.

The other major area was lots of PACE organizations we reviewed requested waiving requirements that a master's level social worker be a part of the interdisciplinary team. Seventeen waivers requested this specifically, and nearly all of these requests focused on

the current shortage of master's level social workers and proposed, instead, substituting other professionals such as licensed clinical professional counselors or bachelor's level social workers.

It is important to note for today's discussion that not all of the waiver requests we reviewed have complete information. Some lacked information on state or federal approval or denial.

And now we will end with some next steps.

Michelle and I will be back in March to share findings from stakeholder interviews on the role of the state Medicaid agency in oversight for PACE. We welcome any Commissioner feedback or questions about the findings that we have shared today in the memo. And we also have two specific sets of discussion questions included here.

And with that I will turn it back to the Chair.

CHAIR VERLON JOHNSON: Thank you, Brian and Michelle. Very helpful. I love the update.

So let's keep on this slide here so the Commissioners can look and see what we are trying to accomplish here. With that, let me open it up for the Commissioners for their questions and thoughts.

All right. Patti.

COMMISSIONER PATTI KILLINGSWORTH: Brian and Michelle, thank you for this information. I think one of the things that I think would be super interesting, we've spent a lot of time in the world of dual eligible beneficiaries, talking about state Medicaid agency contracts, and really highlighting the opportunities that states have to leverage those agreements in ways that advance quality and performance of those health plans in their respective states.

So I wonder if that's an opportunity here to really sort of take on that role of here are the kinds of things -- I know there's sort of some commonalities, but I think there's also probably some nuances where certain states have identified real areas of opportunities to drive improvement in PACE program performance, leveraging those two-way agreements. So a more comprehensive listing that sort of gets as some of those areas of best practice I would find particularly interesting, especially as it relates to the things that MACPAC is responsible for around access and payment.

I do think that sort of the responsibilities

between CMS and the states continue to be a little unbalanced as it relates to the PACE program, and would love to hear more about states who are really leveraging these agreements to strengthen their oversight of the programs. Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti. John, then Jami, then Mike.

COMMISSIONER JOHN MCCARTHY: The only thing I would like to flag for us to explore is -- and I actually thought of this too, which is, is the cost of PACE equal to, greater than, less than what states are doing with integrated duals programs or without integrated duals programs.

CHAIR VERLON JOHNSON: Thank you, John. Jamie?

COMMISSIONER JAMI SNYDER: Yeah, and I think my comment is along the lines of what Patti was suggesting. I'm just interested in your stakeholder interviews and learning more about how the additional requirements included in two-way agreements really influence the PACE program's ability to advance access to care and access to quality care. It would just be nice to hear directly from states and from individuals served by the PACE program how

those two-way agreements and those additional requirements really influence the overall performance of the program.

CHAIR VERLON JOHNSON: Thank you, Jami. Mike?

COMMISSIONER MICHAEL NARDONE: Thank you, Brian and Michelle. Yeah, I was curious as to why -- I think I'm following the same train in terms of what others have said before, which is that I'm curious if there are best practices around states using those agreements. And I'm curious as to why the states that do not have a two-way agreement, is there a reason why they have not pursued those types of initiatives. Is it just state capacity, you know, the fact that these programs are relatively small, or is it informational, that there's just not enough information out there around how other states are using these agreements to try to ensure the quality of the PACE programs.

So I think it's kind of having some more information around why or why not that states are employing these tools, because it does seem something they have the ability to do, and trying to understand that better I think would be helpful.

CHAIR VERLON JOHNSON: Thank you, Mike. Dennis.

COMMISSIONER DENNIS HEAPHY: Yeah, my comment was a little bit like John's. I wonder, is there any way to look at PACE and Medicare Advantage plans and learn more about how they compare in terms of quality and outcomes? I was just shocked when I read the report, the variations in reporting and requirements across each state in different PACE programs. So I was wondering, is there a way to simplify it, and going back to the previous conversation, are there a set of principles that could be used that would set up best practices in measuring the quality of PACE programs?

But then again, going back to the MA plans, is there a way to do some sort of comparative analysis regarding the quality of PACE compared with MA plans, and the type of MA plans that are available to people in different states. That might be beyond the scope of the project, but that's what came up for me as I was reading the information. Thanks.

CHAIR VERLON JOHNSON: Thank you. Carolyn.

COMMISSIONER CAROLYN INGRAM: Thanks. Back to Patti and John's comments, would it be possible to make a simple matrix that outlines, you know, checkboxes, what's

required in a PACE contract or what we found in the two-way agreements versus what's required in an integrated product like a D-SNP? And then maybe that would give us some areas very clearly where we could define what principles need to be added potentially to the contracts, into the agreements.

And then to John's comments on rates, I just want to reiterate that I would also be interested in seeing what is the cost difference per person and comparison of that.

And the last piece is just the quality outcomes that Dennis raised. What are the outcomes that we've got, ability to publish on, around PACE versus other integrated products, like a D-SNP? Thanks.

CHAIR VERLON JOHNSON: Thank you. Any other Commissioners?

[No response.]

CHAIR VERLON JOHNSON: Okay. Michelle, Brian, anything else from you, or anything else you need from us?

BRIAN O'GARA: This has all been very helpful feedback, and we can definitely integrate lots of this when we come back for March.

CHAIR VERLON JOHNSON: All right. Perfect. Looking forward to it. Thank you so much.

All right. I'm going to turn it over to our Vice Chair, Bob.

VICE CHAIR ROBERT DUNCAN: Thank you, Verlon. We'll wrap up the last session, try to get us back on time.

So we're going to be discussing the federal policy framework for beneficiary health and welfare in self-directed home- and community-based services. This is follow-up to a lot of the work that we have done.

Gabby and Katherine are going to present some of that background and some of the areas we've gone, and they're looking for Commissioners' interest in where we move forward to make sure that those that are self-directed in home- and community-based services are being well cared for and meeting the health goals.

So, with that, I'll turn it over to Gabby and Katherine.

FEDERAL POLICY FRAMEWORK FOR BENEFICIARY HEALTH AND WELFARE IN SELF-DIRECTED HCBS

* GABBY BALLWEG: Thank you so much, Vice Chairman, and good morning, Commissioners.

Today, Katherine and I are going to present on the federal policy framework for beneficiary health and

welfare in self-directed Medicaid home- and community-based services, or HCBS.

In this presentation, I'll begin by providing a background on self-directed HCBS and the Commission's prior work on this topic. Next, I will share the beneficiary health and welfare assurances in HCBS, followed by a discussion of the federal policy framework. We will focus on findings across three areas of the framework, incident management, which I will discuss, followed by conflict of interest standards and specialized safeguards for self-direction that Katherine will cover before leading us into our next steps.

At this meeting, our goal is to provide contextual background to the Commission on federal health and welfare standards and their application to self-directed HCBS.

So now turning to the background information, self-direction is a beneficiary-controlled HCBS delivery model that allows the beneficiary to choose their service providers and to have control over the amount, duration, and scope of the services and supports in their person-centered service plan, or PCSP.

It's important to note that self-direction programs operate within the existing federal framework of Medicaid HCBS, so self-direction does not fundamentally change the level of care determination process or what the state or third-party administrator deems as the appropriate level of support in the community for an individual.

Since self-direction operates within the HCBS framework, it must also conform to statutory, regulatory, and subregulatory guidance on HCBS, which we will be continuing to discuss throughout this presentation.

The Centers for Medicare and Medicaid Services, or CMS, requires several components that all self-direction programs must include. These are the person-centered planning process, PCSP, information and assistance in support of self-direction, financial management services, or FMS, a system of continuous quality assurance and improvement, and an individualized budget when the beneficiary is managing their own budget.

In the last reporting cycle, MACPAC conducted interviews with national subject-matter experts as well as state officials and stakeholders across six states. Through our interviews, we found that states have ample

flexibility in administering their self-direction programs and often administer programs across multiple operating agencies.

When providing information and assistance supports, states vary in how they define and structure the functions of each support entity's role and in the collaboration across these entities.

In each state, an array of different players interact in a complex system to offer self-direction, as you can see in this graphic. The state Medicaid agency administers the model, but the Medicaid agency can designate program administration to state operating agencies. States may establish a beneficiary advisory committee to provide input on self-direction to the state Medicaid agency and operating agencies.

The state also delegates investigation and prosecution for instances of fraud and abuse to the Medicaid fraud control unit.

The state agencies contract with vendors to provide information and assistance in support of self-direction and FMS, or the state can provide these supports in-house. The FMS agency collaborates with information and

assistance support roles, including managed care organizations when operating in a managed care environment, in order to help the beneficiary self-direct and resolve issues as they arise.

The beneficiary interacts with information and assistance professionals, like case managers and support brokers, so that they may effectively and safely self-direct their HCBS.

The beneficiary may also select their FMS agency when there are multiple in a state and interact with FMS agency representatives as needed.

With the support of this network, the beneficiary or their representative is able to hire an HCBS worker who could be a family caregiver in some cases in order to provide the HCBS outlined in their PCSP. The HCBS worker is enrolled with the FMS agency so that they may receive payment for approved services.

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

In Phase 1, we also found that the roles of information and assistance support entities can overlap and may be difficult to clearly distinguish from one another. States leverage information and assistance roles and FMS entities to support quality reporting, monitoring, and oversight. However, existing reporting channels and data systems are generally not designed to stratify program data by self-directed and agency-directed beneficiaries at the federal level, and among some states, so there is limited capacity to analyze self-direction specifically.

Limited data reporting for self-directed programs may hinder state and national efforts to ensure quality and conduct effective monitoring and oversight.

When discussing these findings last cycle, the Commission expressed interest in continued policy research on CMS and states' ability to monitor self-direction with the goal of protecting beneficiary health and welfare. For this reason, we have conducted a review of HCBS assurances that safeguard beneficiaries, including those who self-direct their HCBS. Since HCBS provides support for a uniquely vulnerable population, federal assurances exist to protect beneficiaries from potential bad actors. These

assurances do not apply to other Medicaid services or populations.

The health and welfare assurance is a key requirement supporting HCBS operations and oversight. It protects beneficiaries by requiring states to establish systems enforcing health and welfare safeguards. These systems must monitor program performance, report and identify safety issues, and implement remediation when risks to beneficiaries arise. Since self-direction exists within the HCBS policy framework, these requirements apply to self-directed programs as well.

Now we will move on to discussing this policy framework.

To better understand the protections that exist to safeguard beneficiaries, MACPAC staff performed a policy scan of existing federal statutory, regulatory, and subregulatory guidance related to beneficiary health and welfare in HCBS. The scan surfaced health and welfare safeguards across all HCBS authorities and consistent features of certain safeguards across authorities. We also found variation by authority in how safeguards that are specific to self-direction ensure beneficiary health and

welfare.

Moving on to the assurance language, CMS requires that states provide satisfactory assurances of certain health and welfare standards in order to administer HCBS programs, including those in which self-direction is offered. These safeguards are outlined in regulations governing Section 1915(c) authority, and other authorities generally mirror them with minor differences.

States must establish standards for HCBS providers, such as state licensing or certification requirements. They must also ensure services are provided in HCBS settings, demonstrate that they meet the needs of each different beneficiary population the state serves under a Section 1915(c) waiver when the waiver serves multiple populations and operate and maintain an incident management system.

Some, but not all, of these safeguards exist across HCBS authorities, such as the assurance that the state operates and maintains an incident management system.

The 2024 Ensuring Access to Medicaid Services Final Rule, also referred to as the Access Rule, codified and expanded existing guidance from CMS, imposing this

minimum regulatory standard for incident management across authorities that previously only existed in federal guidance for Section 1915(c) authority.

In addition to these safeguards, states must also meet conflict-of-interest standards to protect beneficiaries from potential abuse, neglect, and exploitation. Assurances of beneficiary health and welfare that are specific to self-direction also exist, and we will identify these assurances as we move through the presentation.

Based on our findings from Phase 1 around supporting quality reporting, monitoring, and oversight, and using data systems to better understand self-direction programs, as well as Commissioner interest, we are focusing on specific safeguards for Phase 2: incident management, conflict of interest, and specialized safeguards for self-direction.

With that, I will move on to our first safeguard, incident management.

Incident management systems are the technology and processes that a state uses to monitor incidents. Training and guidance on health and welfare have had a

heavy focus on incident management systems since 2014.

In 2018, CMS began using this framework, relying on six key elements of incident management, which include identifying and reporting, triaging the incident by delegating investigative responsibilities in determining the severity of the incident, investigating and determining the types of resolutions that are necessary based on findings from the investigation, and tracking and trending by collecting available data on incidents, as well as developing trend analysis reports to be shared as necessary, such as with a state's disabilities office.

Incidents can include a range of things that do not pose a major risk to beneficiary safety, such as missing a single incident that harmed the beneficiary. However, some incidents are considered critical incidents that may risk or result in serious harm to the beneficiary.

Prior to the Access Rule codifying and expanding incident management system requirements and regulation, CMS recommended states develop a single definition of a critical incident. CMS recommended states develop the single definition to include accidental or unexplained death and allegations of abuse, including physical,

psychological, emotional, verbal, and sexual abuse, as well as neglect and exploitation.

Before the Access Rule, under Section 1915(c) authority, CMS already required states to continually identify, address, and prevent instances of abuse, neglect, exploitation, and unexplained death. They also required that states demonstrate a system is in place that resolves incidents and prevents similar ones from occurring in the future.

States were also required to establish and follow policies for restrictive interventions; for example, policies requiring those who use restrictive interventions, such as a protective device to reduce behaviors that can injure the beneficiary or others, to be trained in their use, as well as the use of de-escalation strategies. And, states were required to establish and monitor overall health care standards.

In implementing the Access Rule, CMS codified and expanded the Health and Welfare safeguard for incident management, reflecting the requirements that already existed for Section 1915(c) waivers and guidance, and expanding them to other authorities. This safeguard

requires that states operate and maintain an incident management system that includes the six elements of incident management we discussed in the graphic on the prior slide.

The safeguard includes a minimum definition of a critical incident, which expands on and clarifies the previous definition as established in CMS guidance documents, to include the misuse or unauthorized use of restrictive interventions or seclusions, a serious medication error that poses risk to the beneficiary, or an unexplained or unanticipated death, including a death caused by abuse or neglect.

Other safeguards in the Access Rule codified for incident management systems include the requirements that the systems be electronic and make data shareable across investigating entities, the requirements that investigators report the resolution of their investigations into a critical incident within a state's established time frame, and that HCBS providers report critical incidents.

The Access Rule also includes safeguards around data utilization and management, specifically that claims data and available data from across state agencies must be

leveraged in to identify any unreported critical incidents.

States must also meet minimum performance standards and documentation requirements, mandating that 90 percent of critical incidents be investigated, resolved, and, among incidents that need it, undergo corrective action. All of these processes must occur within the state's established time frame.

These provisions of the incident management safeguard as established in the Access Rule must be implemented by July 2027, except for the provision that requires states to implement an electronic system, which must be implemented by July 2029.

The provisions apply to HCBS authorities that offer self-direction and to HCBS delivered via managed care. However, it's important to note that Section 1905(a) authority is exempted due to regulatory differences.

It is important to note as well that although we have not met the implementation date yet, many states already meet some or all of these requirements for their HCBS programs, as CMS has recommended them for over 10 years.

And with that, I will pass it over to Katherine,

who will continue this conversation, beginning with the required protections for beneficiaries from a conflict of interest.

* KATHERINE ROGERS: Thank you, Gabby, and good morning again, Commissioners.

As Gabby mentioned, I'll review protections against conflicts of interest. Conflicts of interest, or COI, standards are essential in HCBS because they can serve both important program integrity roles, protecting the state and stakeholders from improper financial conflicts, but they can also impose important protections that help assure beneficiary welfare and safety.

Every HCBS authority incorporates some COI provisions, and those that are mandated in federal policy vary by authority. These COI standards typically exist to put a firewall between the entity who authorizes or assesses the need for services in some capacity and the entity who is paid to deliver those services. For example, typically, a provider delivering HCBS cannot also develop the PCSP through which HCBS are authorized or provide case management, since case management is typically responsible for service planning.

They may also place a barrier between people responsible for making certain decisions and the provision of services; for example, preventing a representative for a beneficiary from also providing paid care.

While the minimum COI standards are outlined in federal authorities, states may elect to incorporate others or standards of their own design into their programs. For example, federal standards for only one HCBS authority, the 1915(j), prohibit representatives from delivering HCBS, but states still implement this requirement in other programs.

And, of course, once a state has incorporated a COI protection into an authority it's implementing, the state must enforce and oversee the COI standards, even, you know, independent of whether or not it's required by the federal authority.

Our review surfaced a number of assurances that are specific to self-direction. These may be specifically designed to address unique features of self-direction programs or address a need that may not exist in the same way in an agency model.

Beneficiaries may authorize a representative to assume responsibility for their care. This is not specific

to any one authority, or really even HCBS, but every HCBS authority includes protections for the use of an authorized representative, including some specific to self-direction. The use of representatives in self-direction does invite additional protection since the beneficiary plays a distinct role when self-directing their services, and when they delegate responsibility for their care to an authorized representative, that individual assumes those roles.

Under the provisions for 1915(i), representatives must undergo an evaluation of their ability to self-direct on behalf of the beneficiary, if so designated. And under the 1915(j), the state may even establish a policy to require a representative be designated if the beneficiary demonstrates an inability to self-direct their services after receiving additional support and training.

More generally, states must establish policies governing the use of authorized representatives, including how they can be approved, what decisions they may make, and how they can be held accountable for making decisions in the best interest of the beneficiary.

The state plan 1915(j) option is a lone policy

authority that covers self-direction exclusively, and therefore, the specific health and welfare assurances that appear here and not elsewhere are unique to a self-directed model. These safeguards address the unique authorization model considerations; for example, tracking and monitoring service utilization and spending to ensure a beneficiary is neither underspending and potentially experiencing an access to care issue or is at risk for an adverse incident or overspending and at risk of prematurely using up their budget, which could create a care delivery concern down the road.

Other protections direct states to ensure continuity of care for transitions for individuals who are moving from a self-directed model to an agency model to protect beneficiaries from health risks incurred during service changes, and other safeguards specify requirements to ensure information and assistance activities deliver sufficient support to self-directing beneficiaries; for example, by requiring support broker services. These can be specified but are not mandated in other authorities like 1915(c).

Importantly, 1915(j) regulations specify the

roles of the various parties involved in carrying out these various protections.

With that, we can turn to our next steps.

Today we are seeking Commissioner feedback on this policy scan and areas for further inquiry. The existing policy framework establishes a consistent incident management system across authorities, but different authorities vary in the required safeguards specific to self-direction. Are unique safeguards needed for self-directed programs to assure beneficiary health and welfare? Should there be more policy infrastructure specific to self-direction?

The Access Rule added requirements for the health and welfare assurance, including mandating the use of a unified minimum definition for incidents and requiring more standardized and electronic incident reporting. How might states' implementation of these requirements be shaped by the specific safeguards in place for self-direction?

And with that, I'll turn it back to you, Vice Chair, to facilitate our discussion.

VICE CHAIR ROBERT DUNCAN: Thank you, Katherine. Thank you, Gabby. Nice job on both refreshing us from the

work done in the past and identifying potential opportunities.

So I'll open it up to the Commissioners now. Are there other areas that you would like to see the team dive a little deeper into?

[Pause.]

VICE CHAIR ROBERT DUNCAN: All right. Patti?

COMMISSIONER PATTI KILLINGSWORTH: Sort of waiting for Dennis if it happened that he would jump in first.

So this is a tricky area, right? It is a specific part of the program that is designed to give greater control and authority to the people who utilize services, and so I think we have to find a careful balance between honoring that and allowing them to exercise the autonomy, the authority that they're being given in this process, with an appropriate level of oversight to ensure health and safety.

So I'm hesitant to say, oh, yes, we definitely need more policy infrastructure around health and welfare. I don't feel like either as a former state official or looking at all the information that's been gathered, that

there's some sort of red flag that says, oh, we need more policy infrastructure to make sure that people in self-direction are safe.

In fact, I think there's a great risk -- and I think Dennis will talk about this much better than I -- that in our well-intentioned efforts to keep people safe, we may well restrict them from living the lives that they want to live, and that's certainly not our goal here. Our desire for safety should not take away the dignity of their choice to be able to live the lives that they want.

So I would say that we should gather information from the state environmental scans. I think it's really, really important here that we hear from the people who are utilizing this model of service delivery from advocates who are supporting and also giving voice to their perspective, and that we proceed with great caution so as not to do something that might be well-intentioned but have unintended consequences.

I would remind us that the big OIG report that sort of elevated concerns around health and safety did not involve people in self-direction. It involved people who were living in group homes, as I recall. So we just need

to react appropriately and not overreact and strike that right balance.

And now I will defer to Dennis, who is waiting to speak.

VICE CHAIR ROBERT DUNCAN: Dennis?

COMMISSIONER DENNIS HEAPHY: So I agree with everything that Patti said.

I'm cautious. As someone who's a self-directed individual, I'm cautious even to say that we need more oversight and safeguards of people who may use guardians in their self-directed care, because then we're actually interfering with the family system often. The family knows what's best for the individual, because they interact with that individual, and the individual is part of the whole development of designing their program, what they need, what they want to do.

I think we need to go back to how all this came about, and it was actually the independent living movement came about in response to and revolt against institutionalization. It feels as if some of what we're doing, not intentionally, is actually moving towards a nursing home without walls model, where the goal is to keep

people safe in the community rather than supporting their ability to actually live in the community and achieve their goals.

I'm thinking like Ed Roberts, who used an iron lung and would never have been allowed or permitted to go to Berkeley, University of California, if he had not been permitted to get out of the nursing home and actually live in the dorm. Under these rules, he might not be permitted to live in a dorm, because it might not be considered safe for him to do that.

So I think we need to be cautious about the balance between safety and consumer choice, control, and dignity of risk. I think it might actually be important to include that in the document, how really what we're looking for is a balance between ensuring people in terms of the ability to employ control, choice, and dignity of risk, while balancing that with some of these protections, because we really do need to protect against the medicalization. I really do view it as a nursing home without walls model.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Mike, then Heidi.

COMMISSIONER MICHAEL NARDONE: I was just going to say that it seems like there are the regulations -- what I'm really curious about is the state environmental scans, because I think that it will really go a long way towards informing and understanding whether or not the incident management practices that states have in place more generally for the HCBS consumers is sufficient.

I guess I would want to understand particularly some of the automation of that information in terms of the data that would produce, and I guess I'm kind of feeling like moving to specific safeguards for self-directed programs needs to first proceed from do we have the appropriate safeguards for people more generally in the HCBS population.

So I'm hoping maybe the state environmental scans will help inform that. I'm interested in whether or not when we do the scans, does the framework, does it say that -- does it tell us that kind of the basic framework that CMS has kind of put in place -- are the standards generally more robust than those, or there things that states have to do in order to increase the incident management

capabilities?

So I'm kind of feeling like I would like to understand that better before I kind of am saying, well, there should be specific safeguards in place for self-directed programs. I'd like to understand if the system operationally is working as intended across states.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike.

Heidi?

COMMISSIONER HEIDI ALLEN: Yeah, I just wanted to do a plus-one to Patti and Dennis' comments.

I also firmly believe that the definition of what is safety and who gets to decide that is a disability justice question, and that we should take that framework and our considerations moving forward.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi.

Anyone else have any input or thoughts?

[No response.]

VICE CHAIR ROBERT DUNCAN: Gabby, Katherine, do you think you've got something to work from there to continue the work?

GABBY BALLWEG: Yeah, definitely. That was helpful feedback. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you.

With that, Madam Chairwoman, I will turn it over to you for public comment.

CHAIR VERLON JOHNSON: All right. Thank you so much. Thank you, Bob. Thank you, Gabby and Katherine, for sure.

So we are at the end of our discussion, and we're going to now open it up for public comment, as Bob alluded to. So, at this time, I do invite all of our listeners to raise your hand if you would like to offer a comment. Please make sure to introduce yourself, of course, and the organization that you represent, and as always, we do ask you to keep your comments to three minutes or less.

So, with that, let's see if we have any comments. Give it a few more seconds.

[Pause.]

CHAIR VERLON JOHNSON: All right. It looks like we don't have comments today, so that is okay.

Oh, we do have one. Katie, you're up.

PUBLIC COMMENT

* KATIE PAHNER: Thank you very much for the discussion today. My name is Katie Pahner, and I represent

the National PACE Association, the trade association for the almost 200 PACE organizations across the country. We thank MACPAC for your continued interest in and focus on PACE.

PACE plays an important role in supporting state and federal goals to serve individuals who need long-term services and supports through capitated integrated care models. Through its community-based, comprehensive, and highly coordinated approach, PACE enables participants to remain independent in their homes for as long as possible.

Most PACE participants are age 65 or older and have complex health needs. On average, participants have six or more chronic conditions, and nearly half of participants have dementia.

NPA appreciates the thoughtful questions, comments, and engagement from MACPAC Commissioners and staff. We especially value MACPAC's deeper examination of variation and program agreements, oversight, and monitoring. This is an area of keen interest for NPA as well, and we are actively working with PACE organizations and states to better understand these differences. The information provided today is very helpful.

PACE organizations have shared that variation in state administration and oversight can increase administrative burden. They are also interested in understanding national variation to identify opportunities for greater alignment and streamlining across states and with the federal government. So these efforts by MACPAC are very timely.

PACE has a long, well-documented history of delivering high-quality, person-centered care that meets the unique and often complex needs of its participants. A recent HHS study identified PACE as a consistently high-performing integrated care model, finding that full-benefit, dual-eligible beneficiaries enrolled in PACE are significantly less likely to experience hospitalizations, emergency department visits, or placed in a nursing facility compared with similar beneficiaries in the control group.

At the same time, establishing a uniform set of PACE-specific performance measures that are meaningful, actionable, and appropriately tailored to the PACE population will be critical to sustaining these high-quality outcomes without imposing unnecessary

administrative burden on PACE organizations.

We look forward to the March meeting and learning more from the stakeholder interview findings. Please do not hesitate to reach out to NPA at any time with questions or requests for additional information. We would truly welcome the opportunity to continue the discussion and address the questions and issues raised today. Thank you again for the informative discussion.

CHAIR VERLON JOHNSON: Thank you so much, Katie, and for the offer.

Next up, we have Camille Dobson.

CAMILLE DOBSON: Good afternoon, Commissioners. Camille Dobson, the Deputy Executive Director at Advancing States. I know I'm a regular visitor with you all, but you're doing such great work that affects our members, that I really wanted to comment on both of the topics that the team covered today.

We are spending a little bit of time in Advancing States at a staff level looking at PACE. Our members, I'm sure the NPA will tell you, there's been an explosion in growth of PACE in a number of states across the country. And the two things, sort of the interest and oversight and

monitoring and looking at comparable quality and outcomes and cost data, I think is very relevant for our members.

I would offer that our National Core Indicators for Aging and Disability Survey, which is a quality of life survey for older adults, people with physical disabilities, that right now up to 35 states administer. Many states include their PACE beneficiaries in those samples, and so we're getting ready to pull out some of that data that would provide some comparative quality of life indicators to HCBS programs that are delivered through MLTSS or in fee-for-service that I think would be interesting for the Commission to have access to, and we're happy to share that.

On self-direction, again, the growth in self-direction from over the public health emergency and the continued growth in self-direction, also an area we're spending a lot of time helping our states think through additional criteria, making sure that the health and welfare protections are appropriate, but not -- as I think Dennis and Patti mentioned, not overwhelming the desire of individuals to have autonomy and dignity of risk.

So I guess I would just say thank you for doing

the work. They're very on point for the things that our members are interested in, and we look forward to the ongoing work; in particular, I think, looking at the state agreements for PACE and what that looks like and how states could elevate those in a more consistent way to ensure the equitable outcomes for individuals that are in an integrated program through D-SNPs versus those that are in PACE.

So thank you. Appreciate your time today.

CHAIR VERLON JOHNSON: Thank you, Camille. I always appreciate you joining.

Any other comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. Seeing none.

I do want to remind you that if you do have additional comments that come up, you can feel free to submit that through our MACPAC website for sure.

So, again, this was the last agenda item that we had today. So I do want to thank you all for joining and participating with us over the last two days for sure. Our next public meeting will take place on March 5th and 6th. There will be additional details about that on the website

as usual.

But with that, I do want to adjourn this meeting and to wish you all a great weekend and to encourage everyone to stay warm. Take care and have a great day. Bye-bye.

* [Whereupon, at 11:58 a.m., the meeting was adjourned.]