PUBLIC MEETING

Horizon Ballroom
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Avenue NW
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Thursday, March 5, 2026
10:35 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
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

[10:35 a.m.]

CHAIR VERLON JOHNSON: Good morning. Good morning. Welcome to MACPAC's March meeting, and we are exciting to have everyone here today for sure. Over the last couple of months we've really taken on some significant policy questions, and now we are actually narrowing the field a little bit more, and moving from exploration more to direction.

I know that my fellow Commissioners are looking forward to a very focused conversation as we get more into these issues. You'll see some policy options today as well as some draft recommendations before us, as well.

So with that, we will turn to Automation in the Medicaid Prior Authorization Process, and I'm going to kick it off with Patrick and Katherine to walk us through some findings, and again some policy options for us. Katherine and Patrick?

AUTOMATION IN THE MEDICAID PRIOR AUTHORIZATION (PA) PROCESS: POLICY OPTIONS

* PATRICK JONES: Thank you. This morning Katherine and I will present principles and policy options

derived from MACPAC's research on automation in the Medicaid prior authorization process.

Today's presentation will begin with an overview of the project and background on prior authorization in Medicaid, followed by a review of project findings, presentation of policy principles and options, and closing with next steps.

Last year, MACPAC began a research project investigating how states, managed care plans, 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 group defines automation as the use of technological tools such as algorithms and AI that supplement or replace human action or decision-making. AI and algorithms are distinct. An algorithm is a procedure or set of rules that is applied to a dataset to achieve a certain function or purpose, and AI is a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions.

We conducted this study to develop a deeper understanding of how automation is being used in the Medicaid PA process, to identify existing federal and state policy levers that govern its use, and to identify where additional policy levers are needed.

To conduct this study, MACPAC and its contractor, Mathematica, conducted a literature review on automation in PA, reviewed state and federal policies impacting the use of automation, and conducted a series of stakeholder interviews.

Prior authorization is the multistep process by which health care payers require medical providers to receive approval before providing a specific item, service, or medication. Generally speaking, the process originates with a provider's determination of the medical necessity of a certain treatment, and ends with an authorization decision from the payer.

Some studies have shown that PA can reduce health care costs without negatively impacting care quality. However, some beneficiary advocates have raised concerns about PA delaying or denying needed care.

Federal statute and regulations allows Medicaid

fee-for-service programs to use utilization management processes such as PA. Regulations also require state managed care contracts to permit managed care plans to use PA. Federal regulations impose requirements on state managed care contracts, such as time frames for authorization decisions. States conduct oversight of plans' use of PA to ensure compliance with these contractual requirements.

Medicaid PA is also subject to federal oversight. CMS can exercise oversight to ensure compliance with federal statute and regulations. CMS also reviews and approves state managed care contracts and assesses contractual compliance with regulations.

Beginning in January 2026, the Interoperability and Prior Authorization Final Rule required states to issue PA decisions within specific time frames for their fee-for-service programs and begin reporting on fee-for-service PA.

MACPAC staff drew the following findings from data collected from the federal policy review, literature review and interviews.

First, we found that states and managed care plans are deploying AI and algorithms in Medicaid PA and

have found a variety of uses for these tools. In our interviews, all states and managed care plan respondents reported some form of automation within their PA process, most often rules-based algorithms using clinical criteria to determine medical necessity. States and plans have long used algorithms in the prior authorization process, but also reported adopting advanced AI-based automation tools for a variety of functions in PA.

A subset of stakeholders reported using automation tools to make PA decisions. These stakeholders consistently reported that their automation tools cannot deny or partially deny requests and can only approve requests or refer them for clinician review.

Next, we found that states and the federal government have limited visibility into managed care plans' use of automation in PA. States may leverage their existing contracts and oversight activities for managed care plans to identify uses of automation, but not all states do so.

Respondents reported that managed care plans may disclose or demonstrate automation technologies but only on a voluntary basis.

We also found current federal policy neither prescribes nor prohibits specific uses of automation in PA. Existing federal policy governs many important aspects of PA. However, there are currently no Medicaid fee-for-service or managed care requirements in either statute or regulation to specifically regulate, guide, or monitor the use of automation.

However, we did find that states have passed legislation regulating payers' use of automation in care decisions. Seven states have passed laws to regulate the use of automation in PA. Six of the seven states' laws mandate that a human clinician review all adverse decisions.

Similarly, we found that some states' managed care plans and IT vendors have established formal AI governance structures to monitor and guide the use of automation in PA. We did find automated PA processes present potential risks to Medicaid beneficiaries, providers, and payers. Stakeholders raised concerns that automated PA systems may make incorrect determinations due to technical issues such as data bias and programming errors. Stakeholders also raised concerns about the

complexity of AI and protections for proprietary software limiting transparency into PA decisions.

Finally, limited federal guidance on automation may be slowing the adoption of automation tools in Medicaid PA. Stakeholders representing states and managed care plans stated that they are reluctant to implement automation in the absence of federal regulations and guidance. Furthermore, stakeholders noted that the variation in state laws creates an uneven regulatory environment that is difficult to navigate.

The findings from our literature review, policy scan, and interviews revealed challenges posed by automation in Medicaid PA. First, there is limited transparency into how automated PA systems work and their impact on costs and access to care. Stakeholders representing beneficiaries and providers stated that they have little visibility into how automation is being used, how automation tools make PA decisions, and the approval and denial rates for automated systems.

The nature of AI itself presents barriers to transparency. Stakeholders stated that the highly complex nature of AI limits understanding of how and why PA

decisions are made. Beneficiary advocates also said that plans and utilization management entities can cite intellectual property protections to limit transparency into automation tools.

Evidence indicates that states have taken little action to increase transparency into managed care plans' use of automation in Medicaid PA. CMS and states have existing oversight mechanisms, such as external quality review, managed care program annual reports, and state contracting authorities, that may provide insight into the use of automation. However, no respondents in our interviews reported using these mechanisms to conduct routine oversight of managed care plans' use of automation.

Limited transparency may reduce states and CMS's ability to oversee potential risks posed by automation. For example, whistleblowers have alleged that commercial insurers, MA plans, and UM entities may have used automation tools to facilitate cost containment strategies that increase adverse determination rates. In our interviews, stakeholders representing providers and beneficiaries stated that they are concerned about the risks these alleged practices pose to Medicaid

beneficiaries.

Limited transparency into automation systems also prevents states and the federal government from monitoring technical issues such as data bias and programming flaws. In interviews, stakeholders warned that data bias may lead to increased adverse determination rates for Medicaid beneficiaries. Additionally, faulty programing can produce inaccurate PA decisions for both complex AI-based systems and simpler algorithms.

We also found that there is limited federal guidance regarding automation in PA, and that state guidance can vary greatly. Federal and state policy govern Medicaid managed care and fee-for-service PA. However, automation has spread rapidly in recent years, and these policies do not directly regulate, guide, or monitor its use in PA.

Language in federal Medicaid managed care regulations does require clinical oversight of adverse decisions, similar to the MA program. However, this language is silent on automation specifically. Furthermore, fee-for-service regulations do not require clinical review of all adverse PA determinations.

Stakeholders representing states and managed care plans stated that the absence of federal guidance makes many states and managed care plans reluctant to implement automation tools. According to these stakeholders, plans and states do not want to implement automation systems that may be disrupted by federal action and require costly reworks in the future.

Furthermore, stakeholders warned that variation in state laws creates additional compliance burdens for IT vendors, managed care plans, and utilization management entities implementing automation.

I'll now hand the presentation over to Katherine who will describe policy principles and policy options that address these findings and challenges.

* KATHERINE ROGERS: Thanks, Patrick. So to these principles, first, Medicaid PA offers administrative efficiencies for payers and providers, which can improve the timeliness of approvals, beneficiary experience, and access to care.

Applications of automation present many benefits, including faster PA decisions, more appropriate and cost-effective care for beneficiaries, and reduced

administrative burden for providers.

In interviews, states and managed care plans reported using automation to synthesize large volumes of information, extract data from electronic health records, and automate authorization approvals. Additionally, providers reported that they use automation to expedite the submission of PA requests and appeals. These efficiencies can reduce costs for both payers and providers and reduce approval times for beneficiaries. So when contemplating the potential risks of automation use, we must also consider these benefits.

Second, transparency and disclosure are important tools in documenting and assessing the use of automation, including the nature of emerging risks. Many states do not report collecting data on how Medicaid plans implement automation tools in Medicaid PA at this time. The federal government does not mandate reporting on how Medicaid managed care plans use automation.

In many cases, plans, UM entities, and IT vendors protect their automation tools as intellectual property or protected business interests, which limits visibility into how those tools function. It is difficult to oversee

automation if its use is not disclosed or known. With limited transparency, states and the federal government are less able to monitor for those potential risks that Patrick mentioned, including inaccurate coding, data bias, and more. Disclosure and reporting requirements may offer states and other stakeholders the necessary transparency to mitigate such risks.

And third, due to the evolving nature of automation technologies and their increasing application, ongoing reevaluation of the oversight policy framework in Medicaid PA is warranted. Automation technology is improving in its functionality and quickly expanding in health care. Just as one example, the number of FDA-approved AI medical devices increased 12-fold in just 5 years, some years ago, between 2018 and 2023.

In interviews, stakeholders predicted that the use of automation in Medicaid PA specifically would also expand. And given this rapid evolution, some of the risks identified by stakeholders may fade and new ones may arise in their place. Policy addressing automation in Medicaid PA should be regularly reevaluated to remove obstacles to technological innovation but also remain responsive to

emerging risks.

Now I'll transition to some policy options also drawn from the findings that Patrick covered.

I will glide through these two slides comparatively quickly, but these outline the findings our options seek to address.

Our findings suggested more clarity would be helpful to stakeholders about the role of clinical oversight in automation in Medicaid PA. We also found that a lack of federal guidance was a source of confusion or potential hesitation in implementing or monitoring automation, and that there are areas of risk in automated PA processes that warrant effective oversight to prevent errors.

Similarly, findings suggested stakeholders could benefit from additional guidance on how existing oversight authority can be deployed to oversee automation in Medicaid PA. Interviews cited transparency gaps in whether or not automation is in place and how it is being used, as well as the potential impacts.

Digging in a bit deeper, our first two options seek to clarify the role of clinician oversight over the PA

process, specifically adverse decisions. Our first policy option, issue federal guidance clarifying clinical expertise must be involved in reviewing and approving adverse authorization decisions. We heard in interviews payers were using a human in the loop for adverse decisions, but we also heard that stakeholders largely were seeking additional federal guidance and clarity on the oversight of automation.

We reviewed the existing regulatory texts and the Medicaid managed care regulation at 42 CFR 438.210, which reads that any decision to deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term service and supports needs.

This language is not tied in regulation to the use of automation, and clarifying guidance could make clear that it requires a person and not automation alone, and specifically one with appropriate and relevant clinical expertise to make such decisions.

In our second option, we are looking to align

language for Medicaid fee-for-service and Medicaid managed care. There is no corresponding provision like the 438 provision I just read in fee-for-service regulations related to prior authorization or utilization management. And this option would recommend amending those regulations to create that consistency.

These options arose, in part, because the use of a human in the loop was a common safeguard cited in our interviews and in the literature. This safeguard can protect against the risk of errant adverse decisions, coding or data bias issues. And while this regulatory language exists in the Medicaid managed care regulation, we heard from stakeholders that clarification of federal policy with regard to automation in the Medicaid PA process would be helpful.

This requirement has parallels in Medicare Advantage regulations, which state similarly that if an MA organization expects to issue a partially or fully adverse medical necessity decision, the organization determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care appropriate for the services at issue before

the determination is issued.

Both the Medicaid managed care regulation and the MA regulations further specify that authorizations for services must reflect the beneficiary's specific medical needs, and this language was further addressed in a 2024 CMS Frequently Asked Questions document, issued subsequent to the publication of the 2024 MA final rule.

In general, that regulatory precedent is fairly clear that clinicians appropriate to the service types considered for PA must be generating or reviewing any adverse decision or authorization before it is issued, and that authorization determinations must account for individual medical necessity.

Consistent with this, in our interviews we found that managed care plans already use a human in the loop to review adverse decisions, even when automation is being used for generating approvals.

While we heard that automation in Medicaid PA may, at this time, be less common in fee-for-service Medicaid than in managed care, we found no evidence to suggest that programs should differ on this provision. And that is the underlying basis for that Option 2.

Finally, guidance clarifying the regulatory text, if issued by CMS, could also clarify other areas of potential confusion or ambiguity, for example, that existing requirements set forth in federal law regarding the timeliness, notice and appeals associated with Medicaid PA are in force with or without automation in use.

Our third and fourth options focus on those existing policy authorities that states can use to promote transparency in the adoption and use of automation within Medicaid PA.

Our third option, issue guidance to states recommending oversight of Medicaid managed care plans' use of automation tools, would assist states in leveraging all existing oversight channels to collect information on and oversee health plans' use of automation in Medicaid managed care.

Our fourth policy option, states should use their Medicaid managed care contracts with Medicaid managed care plans to require disclosure about the use of automation in the authorization process, would be directed to states, and encourage them to use their own authority as the holders of Medicaid managed care contracts to require disclosure and

promote transparency.

These recommendations would address the findings that states have limited insight into managed care plans' use of automation in Medicaid PA. State oversight of plans' use of automation can address risks posed by automation, and states cannot monitor or oversee automation tools they have not identified or documented.

State oversight can increase visibility into automation's use and impacts, providing critical information for future state and federal policymaking. While there is today no federal requirement obligating states to collect information from managed care plans about if and how they use automation in Medicaid PA, states can use their existing contracts and oversight activities for plans to identify adoption of automation.

We heard this information is being disclosed on an ad hoc or incidental basis, during contract proposals, readiness reviews, or ongoing oversight site visits already, even if disclosure is not required. We also heard that in state agencies, time and resources can be a barrier to developing effective new oversight strategies, so states often look to the federal government for guidance to

develop them.

CMS is well positioned to advise states on existing tools they can use to monitor the use and performance of automation. In federal regulations, state agencies must have an effective monitoring system for all managed care programs, which includes broad-based requirements for monitoring, using monitoring data to improve the managed care program, and readiness reviews for new plans. Readiness reviews, for example, must include onsite reviews through which states can require demonstration of MCOs' technology platforms, interview utilization management or IT staff, or otherwise require disclosure and documentation of automation.

Other oversight mechanisms that could be covered in such guidance include the validation and assessment of utilization management policy and procedures through the EQR process, or specific plan metrics for quality and access required for state reporting through the MCPAR.

And finally, and particularly for Option 4, as the signatories to the Medicaid managed care contracts held by health plans, states hold unique authority to impose contract standards for plan performance and reporting, such

as requiring certain disclosures about automation use.

States reported limited visibility into Medicaid managed care plans' use of automation at this time, and implementing new provisions in their own contract language which would grant states one important channel for collecting and classifying information on the use of automation in Medicaid PA, including its applications within the process.

With that we will turn to next steps. 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 principles and options. In particular, are there outstanding questions about the principles or options that staff can answer? Does the presented evidence support the principles and policy options? And are there other factors for staff to consider while developing recommendation language or the rationale?

This concludes our presentation. I do have, on the next couple of slides, the principles and the options all on one or the other slide so that we can refer back to those to discuss. And with that I will turn it back over

to the Commission Chair for discussion.

CHAIR VERLON JOHNSON: Thank you so much. That was really helpful, Patrick and Katherine, and I really appreciate the way that you all laid that out. And I think what stands out to all of us is that automation, of course, in prior authorization is already happening, for sure, but our visibility is really low in terms of how we're looking at that. And we also are very concerned how it's impacting our beneficiaries.

So I think as we open this up for Commissioner comments it would be really helpful for you all to really lean into the human in the loop standard, and give us some insights into how you are looking at that, if that is sufficient. Also the whole concept about transparency, as well. Are the proposed tools, are they really enough to give states what they need in terms of their visibility? And then also I would really like your experience around variability around this issue, as well, as you think about the different states and the different levels of capacity and experience, how can we help in that, as well.

So with that I will open it up to you for Commissioner comments, and I will start with Angelo.

COMMISSIONER ANGELO GIARDINO: Patrick and Katherine, thank you. That was a really valuable analysis of a really fundamental element of health care coverage, the approval and denial of services. And the use of automation is such an important element to that, and I think the way you've approached this is really informative, and I feel like I've learned a lot just listening to you.

And I would just like to commend you on being very thoughtful and measured in how you've approached this, and I think the guiding principles make a lot of sense. And I think you're really providing a lot of different stakeholders with valuable insights into a fundamental element of the approval and denial of services.

So I just offer my support for the guiding principles, and I think you've really contributed a significant amount of information to something that many of us just see as kind of like a basic part of the machinery, but understanding that machinery is essential.

So thank you for your really hard work.

CHAIR VERLON JOHNSON: Thank you, Angelo. I think we all echo that statement for sure.

Anne and then Tim.

COMMISSIONER ANNE KARL: Yeah, I would like to echo what Angelo said. Really great work, and I appreciate your sort of moving forward on thinking about how do we harness this technology that can really streamline and simplify and expedite things for beneficiaries while also recognizing that there are challenges that it brings up. So I think you did a really great job with that careful balance.

I have two separate points. So one point has to do with I think when we're talking about automation and the use of prior authorization, there's two distinct uses. One is in applying existing clinical criteria to a specific patient, and a separate one is actually creating those clinical standards. So it's an AI algorithm that's reviewing the literature, using big amounts of actual health care data to say -- to do some sort of predictive analytics as to who might benefit from what.

That, actually creating the clinical coverage standards using AI tools, to me brings up more concerns in terms of accuracy of training data, et cetera, so things that you sort of alluded to.

My read was that most of the policy

recommendations are really focused on the application of the existing clinical criteria, which I think is fine, and I think is a good place to be starting. I just think it would be helpful in any -- you know, the chapter, et cetera, if it just makes those distinctions clear, and that this is really focusing on the application of existing clinical criteria, and that creating clinical criteria would raise a whole other set of issues that would merit further consideration. So that was one point.

My other point is a simpler one, but I've been hearing anecdotally that as AI tools are being used for prior authorization, that essentially makes it easier for both the plans and providers to go through a prior authorization process, which as like the cost of prior authorization goes down, we -- I've heard anecdotally at least -- that the number of services being subject to prior authorization is shifting.

So I think that might just be an example that when we're talking about Recommendations 3 -- or Policy Options 3 and 4, that maybe just highlighting things that you might want to be tracking include the number of procedures that are subject to prior authorization, because

it's possible that we -- you know, a larger share of services being subject to prior authorization in the plans that are using automation more intensely or things like that. So I think that would just be helpful to keep an eye on as this all develops.

CHAIR VERLON JOHNSON: Thank you, Anne.

Tim?

COMMISSIONER CAROLYN INGRAM: Yeah, thanks. Echo Angelo and Anne's views on kind of the landscape that you've created and the information you've provided. I think this is terrific.

And my point is really maybe building off Anne's second point, and maybe it's too broad for this conversation, but I think it's something we're going to need to talk about, which is as we talk about recommendations for CMS and states in terms of staying on top of and providing oversight, particularly for AI-related automation, I think we need to call out and ask CMS and states to think about what is the framework they're going to use to oversee because for regulation, it's happening too fast, right?

And if CMS is going to regulate, if states are

going to regulate, that's not going to keep up. I mean, to Anne's point, if people are saving money by using AI and they're expanding to other services, I think CMS and state Medicaid agencies have to have -- to think about a more nimble, flexible oversight approach to address emerging concerns on AI as this field continues to evolve because, like so many other things, you know, the world will evolve before CMS or others have a chance to catch up to it.

CHAIR VERLON JOHNSON: Thank you, Tim.

Let's see. John and then Adrienne.

COMMISSIONER JOHN McCARTHY: I have a bunch to say on this one, and it's kind of leading more towards in the future what we're looking at on this one.

Again, the work that you've done is great in putting together. It's just that this is such a nuanced area, and it's so hard because you're talking about it at the 10,000-foot -- really 30,000-foot level, not getting down into it, because I think there's some level of PAs that everyone would say, yes, this is definitely, we need prior authorization around this service, but this other service, you know, the answer would be no.

So, for example, you know, in essence, there's

always prior authorization around personal care aide services, right, because you have to have a plan of care before you start. So that plan of care is a PA, right? But for a primary care visit, we'd say, no, you shouldn't have a PA for that. So those are very different things that we're looking at on these.

Even in the research that you did, I mean, there's a -- in the memos that you sent us, you said -- well, it says, not you said, but it says in here, for example, one study applied an algorithm to 64,884 episodes of care and identified 7,679 movable cases where beneficiaries could be shifted to lower-cost sites, saving $8.2 million, without reducing quality of care, right? So that's what that study said.

But I guarantee if we brought those cases forward just in front of those MACPAC Commissioners and we talked about those cases, there would be some people on the Commission or even me saying, whoa, wait a second. You know, moving that to that lower -- that's not what I want for my loved one or for me. I don't want it moved. Yet, you know, how do we get past those things?

You see it all the time with generic drugs.

Again, that's another example. If I talk about generic drugs, there will be some people who will say, no, I can't take that generic drug because the filler is different or these are different colored dye and do we have any, you know, expertise into knowing does that really make a difference or not. So it's just such a nuanced area on these things.

So one of the things -- again, on the policy options, the things we're talking about, I think they're all good. I think the one area that -- where we have to have a human involved -- I'm not against that one, but I just want to bring up the issues of actually having a human involved, because don't forget, you know, back when some of us were Medicaid directors, merely eight to ten years ago, we only had humans involved, and we had all these same issues in this, right?

So, for instance, if you have a human involved and it's somebody who has lower back pain and there's a chiropractor saying that the person needs to come in for adjustments -- I'm going to make up a number. I don't know what it is, but if they say, hey, they need to come in for adjustments, you know, every day for the next 30 days,

well, then you have an internist or orthopedist looking at that who doesn't believe in chiropracty and is looking at it and is saying, again, they're qualified because they're an orthopedist who specializes in lower back. They may say, no, that is not acceptable, and so we would get differences of opinion on that. So just having a human in there doesn't always guarantee that we're going to get the right decision. It could just be somebody who's not kept up on practices.

So, again, I think it's still good, but it's not a panacea that's going to fix all our problems. I don't think you said that. I just wanted to bring that up.

I do think one of the areas we should look at -- and I haven't figured this one out yet, but I'll just throw out a couple of ideas -- is how do you put the monetary incentives in there? I've talked about this a bunch of times. This is where value-based purchasing really can make a difference.

But, you know, if we say PAs cost more on administrative burden, which is true -- like, I'm not going to debate that -- why don't we make the state and managed care plans pay more in those cases, right, to cover the

additional costs that come with those things?

Likewise, if there is no PA in a service, should a state reduce, you know, the reimbursement amount for those things to reflect those two different things? I don't know what those amounts are, but how do you balance those two things out?

And the same thing, we saw this quite a bit where you'd have a provider who would just submit anything all the time because it would just get denied by PA because it's easy. You know, you've got a patient in front of you who doesn't want you to say no. So, like, yeah, we'll just submit it and make the insurance company the bad company, right? So, if a provider has a large number of denials, is that something that should be -- you know, have some type of monetary penalty that goes along with that?

And then lastly, on the reverse side too, which we've talked about is -- and states have looked at this -- for managed care plans, if you have a large number of PA denials that then get overturned by the state, right -- because you can always then go back and get an appeal to the state, which is hard. I'm not saying that's an easy process, but if you do and you have a large number of

turnovers by the state, you know, should there be some type of, again, penalty that's tied to that on the other side?

So those are -- you know, I would like to see us, you know, look at something like monetary incentives as we go forward on these things. Thanks.

CHAIR VERLON JOHNSON: Thanks, John.

Adrienne and then Patti.

COMMISSIONER ADRIENNE McFADDEN: It's always dangerous going after John, but I think I have a few thoughts around this. And thank you all for distilling such a large amount of information into a really digestible overview.

The first I would say is, for fear of sounding a little bit like a broken record, I am all for the policy principles, and I will again say that, to me, there's an excitement around what automation offers with efficiencies and being able to get to decisions in a very timely fashion so that folks can move on to their care in a faster fashion and that providers who are actually requesting these prior authorizations get their decisions faster. Sometimes in real time they get approvals, and so I think that value cannot be underclubbed by focusing on the rare instances of

bad actors.

The other thing I want to just focus in on is the concerns around folks leaning on proprietary systems. Think about how prior authorization is done with just humans without the automation. Two of the main guideline authorities, Milliman and InterQual, have guidelines that are proprietary. There's nobody that can just go out and Google what the guidelines are and know what they are because they're proprietary.

So I think that proprietary piece is actually a little bit of a business advantage for those who are in the industry already, and so I think we're overshooting on wanting to pull back the proprietary piece of this, because those guidelines are not going to be readily available in general unless you purchase them, and that's what we're using today.

In addition to that, the managed care companies also have internal guidelines that are published, so people have visibility into those, and I do think that the policy recommendations that you have around disclosures and transparency can go as far as listing which guidelines that they're using for their algorithms. But I don't know if we

need to go into all the guts and the detail of what's actually happening with that AI, because I think that will stifle innovation.

And, finally, I'll just say I'm a big proponent of AI in general, and so for me, the biggest enemy of innovation is trying to constrain it. And so I'm in favor of putting guardrails around this, but I don't want to put something so tight that you now have an industry that could do so much to improve where we are today by confining them to a limited number of use cases that has all this transparency. And we have now given innovation a really small box to live in and no longer a blue-sky opportunity.

CHAIR VERLON JOHNSON: Thank you.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: I'll keep my comments pretty brief and pertaining specifically to the policy principles and the recommendations.

On the policy principles, on the second item where we talk about transparency and disclosure, I just want to follow up with some of the comments that Anne made, that transparency and disclosure are not just important tools as it relates to documenting and assessing the use,

but actually in how automation is operationalized.

I think it is so important when decisions are being made about a person's care that there is transparency into how those decisions are made, both on the front end to the clinicians who are trying to justify that a service is appropriate and medically necessary, but also on the back end when that beneficiary has been told no and now they're going to try to potentially work with that physician or clinician to overcome that denial.

And so the thing that I worry about with regard to particularly when AI is being used to actually generate criteria, if it's not disclosed, it is really trying to hit. It's like playing pin the tail on the donkey. You have no idea where the donkey is, but you're trying to pin the tail on it, and no one's giving you any information to be able to do that.

With respect to the last one, just to follow up to John's comment, I had this thought when I was reading the materials. You really brought it forward again, John, that we just have no idea where all of this is going. What we do know is that there have been some pretty remarkable studies where we've compared human decision-making with AI

decision-making, and one particular example that I read about was in legal contracts and found out that AI reviewed those contracts much more quickly and much more accurately than really high-paid, qualified lawyers did.

So there could be a future, right, where we get to a point where we want really well-developed AI to be able to make decisions, and so I would just encourage us to think about the policy recommendations also in light of the future.

Yes, we need to come back and look at those periodically, but just, as Adrienne said, trying not to box ourselves in too much for things that we may find ultimately beneficial.

And then on the policy options, a couple of tweaks, and I'll explain kind of what I'm going for, and we can think about language going forward. But on the first policy option with clinical expertise, that involvement is so meaningful. It can't just be a, okay, yes, I agree, okay, yes, I agree, right? We really want an individualized clinical review of that person's unique needs for the service, and again, maybe someday that can be done through AI.

I don't know, but right now, what we're talking about is meaningful involvement, and maybe we can elaborate that in the chapter.

Then the other thing that I would just sort of point to is that we want not just oversight or disclosure about the use of automation, but also the impacts of automation. Like, what is happening with the use of that automation? Is it resulting in higher initial denials that are then subsequently overturned, either by the managed care organization or by the state, right, so making sure that we're really looking at impacts.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti.

Mike and then Heidi.

COMMISSIONER MICHAEL NARDONE: Yeah, I want to thank you for this. I learned a lot as I was reading it, and I would echo a lot of the points that have been made here.

I just wanted to add that I appreciated you kind of tying it into what Medicare is considering for their MA plans. I think it's really important that there's consistency in terms of -- I don't think you want Medicaid

having one set of kind of requirements and policies and Medicare Advantage another set of policies. So there's the potential when we're just looking at Medicaid for there -- not to clarify but confuse, and so I think that coordination is really an important point.

You made it in your presentation. I think it's something that should be stressed as we're looking at the chapter.

And maybe that ties into Tim's point around nimbleness in terms of, you know, what is the structure for ensuring that, you know, we can be quick enough in terms of -- but also across CMS, not just at Medicaid, for actually being able to kind of review and understand what's happening and what changes need to happen with respect to the regulatory framework.

Now, the Medicare Advantage, you know, comes out with regular annual guidance. That's one mechanism, but, you know, I wonder if something more is needed, and I realize that might be beyond the scope of this paper, but I do want to highlight the Medicare Advantage and Medicaid tie-in and the coordination, which I think is important.

CHAIR VERLON JOHNSON: Thank you, Mike.

Heidi?

COMMISSIONER HEIDI ALLEN: Well, this gives me a chance to say -- to bring up a topic that I love to bring up on a regular basis, which is that the Medicaid program does not have an annual beneficiary survey the way that Medicare does, and so we do not have a way to hear from people about their personal experiences with the programs, and so just noting that.

But I do agree with a lot of the things that were said and, in particular, what Anne brought up about the black box, and I'm curious how an appeal process would work when you're going in front of a decision that you can't speak to how it was made. You have a provider who will say this person needs it, but then you have the decision was made by the managed company, but you can't say why.

That, to me, seems kind of confusing, or if that evidence was normed on a population that are not anything like Medicare or Medicaid populations, like a commercial population, so it doesn't reflect the needs of Medicaid patients, how you would know what data was used to make that decision. That seems really concerning.

And then I agree with Patti about the idea of a

meaningful human in the loop. I think some evidence looking at commercial use of these AI tools was that it was -- that providers were making decisions in under two seconds, and that that clearly isn't meaningful.

And then the last thing I want to say is we're talking about EQR and MCPAR as tools, but it's interesting to me that states aren't using them, And I wonder if that's that they're not well suited to use them.

And I think that they may -- maybe it is and maybe it isn't in that, but I do think that if we can call out specifically what it is we're hoping to see, like Patti noted, which is that we want to see how it's changing outcomes, and so maybe less emphasis on what data sources would be used or suggesting that potentially these could be good data sources, but stressing the need to be nimble and stressing the need to have actual outcomes on things that have been mentioned here, which is like rates of denial, rates of denials that were appealed successfully, and also changes to the number of procedures that require prior auth.

I think those are things that we could kind of tweak and make the recommendations a little stronger.

Thanks.

CHAIR VERLON JOHNSON: Thank you, Heidi.

Sonja?

COMMISSIONER SONJA BJORK: Thank you. I won't be repetitious of other Commissioner comments.

But I wanted to mention that I particularly favor the policy option that goes for consistency between fee-for-service and managed care. It just seems strange not to require that for some of the really special populations that are carved out of Medi-Cal managed care. It might be just as important or even more important to make sure that we have the same rules that everyone's operating under.

That really helps the beneficiaries. They might have a family that has some folks in Medi-Cal managed care and another person in their family is fee-for-service.

It also helps the providers know that the same rules are going to apply if they're going to assist the beneficiary in an appeal. They don't have to think of two different rules, two different sets of rules in order to help with the appeal.

So I appreciate that part of the policy recommendations. Thank you.

CHAIR VERLON JOHNSON: Thank you. I echo that as well.

Mike, did you have your hand up? No?

Okay. John.

COMMISSIONER JOHN McCARTHY: One of the other things, as I was listening to the other Commissioners and Heidi and Patti both brought this up, I think for us to think about this too, like some type of policy recommendation that this needs to be studied as we go forward, like what is the impact, whether it's MACPAC doing that study or somebody doing the study, you know, on a state in some of these areas to know that.

The other area is -- and this gets back to transparency -- I think -- and I agree with Sonja that the managed care and fee-for-service should always be the same. But we need more transparency at the state level for providers to see what services are going to be PA'd, and when is that going to be applied and not applied and how do we do that? Is it on some website, you know?

And then also how often can managed care plans change things? So, you know, what I ran into often is a service wasn't being PA'd, and then a PA is applied, and

you would go in and talk to providers. They'd be upset about it. They'd say they had no notice. You go talk to a managed care plan, and the managed care plan said, we did give them notice. And if you go look, they did give them notice, but it was in a way that maybe it wasn't saw -- you know, you could see it. So is there a way that we can have policy options at -- or promote ideas that you make those things more transparent on a state website that you can go to, that they can only be changed once a quarter or things like that?

Having said all of that, I also don't want to be tone deaf to something that Mike said earlier. We are in a time right now of budget constraints. There's also a lot of talk about fraud, waste, and abuse going on, and that's what PA is supposed to help slow down.

And I think you're looking at some of the services that we are having a lot of discussions around, especially in behavioral health, where there was a lot of PAs removed during COVID periods and now states are taking a look at some of those different areas. We've seen explosive growth.

So again, it's like, how do we look at PA? And

it would be helpful for you guys. How is PA being used as a tool to help combat fraud, waste, and abuse? And is there anything that you found that we could point to on some of those?

And you probably have to be at a very specific level. You know, like for these services, this is what we found, not just in general.

Thanks.

CHAIR VERLON JOHNSON: Thank you, John.

KATHERINE ROGERS: Verlon?

CHAIR VERLON JOHNSON: Yeah. Do you want to add?

KATHERINE ROGERS: Can I just speak to the first part of that? There are provisions in the interoperability rule that speak to the transparency of PA requirements. So we can add to that and take a -- that's not the last thing that you said, but one of the things that you said. I wanted to mention that.

CHAIR VERLON JOHNSON: Thank you.

Jennifer. Jen. Jennifer. Jenny.

COMMISSIONER JENNIFER GERSTORFF: Thanks, Verlon.

So I know some of the concepts in the research so far seem split, like more applicable to when the algorithm

is being applied for PA versus developing the criteria for PA. And I know that you're going to kind of work on clarifying the split of those.

But I just want to highlight that I think the potential risk for patients is more prominent in the development of the criteria than the application of the criteria. But at the same time, I think there is a risk in the application for the data that's used. So an AI algorithm is going to be as good as the data that it's using, right? And so any information that's missing or inconsistent or not standardized can create issues that might go unseen, and that just kind of reinforces the importance of having meaningful human review of those denials.

And I think somehow, we should incorporate something on that data quality observation and the disclosure of like making it more transparent, should disclose what kind of data is used, what's not used. So, for example, when a human is reviewing whether someone should have a service or a drug treatment, they may review a physician's notes. Is your AI algorithm reviewing physician notes, and is that appropriate for that to do?

CHAIR VERLON JOHNSON: Thank you.

Sonja and then Adrienne.

COMMISSIONER SONJA BJORK: Thank you. My hand is up on behalf of my neighbor, Commissioner Ingram.

COMMISSIONER CAROLYN INGRAM: Thank you, Commissioner. My hand-raising activity doesn't work on my computer. So she's helping me out there.

I appreciate the work everybody's put together, and all the questions are really good.

The one question I wanted us to continue to monitor, we have a lot of legislative sessions operating right now, and there is legislation in a lot of states around this issue. And so as we're looking towards policy decisions we want to make, I think it'd be good if we could keep our eye on that language -- sometimes there's model language that comes out of NAIC -- and see if there's something there, because I agree with my fellow Commissioners. It would be better if we could offer up ideas for standardization across Medicaid, Medicare, and others, so that states and health plans and everybody involved are not just reinventing the wheel over and over again. So if we could just monitor that during these

legislative processes that are going on, that would be appreciated.

Thank you.

CHAIR VERLON JOHNSON: Thanks, Carolyn. Thank you, Sonja.

All right, Adrienne.

COMMISSIONER ADRIENNE McFADDEN: This is just an idea for potentially the narrative piece of this going forward, which is that AI is not just being used by managed care companies. It's also being used by providers, and there's a dearth of information and regulations for that application as well.

And so I think there's -- Jenny sort of alluded to this in her comments, but the information that goes into these is also going to reflect what comes out, and so if the AI-generated content from the provider is processed and it's not really great information, that can also lead to bad outputs as well. So I just think it would be interesting to put that piece of the utilization in the narrative.

CHAIR VERLON JOHNSON: All right. Thank you.

Any other hands?

All right. Well, clearly, we are all excited about this conversation and the research you're doing around it. I mean, let's understand that AI is moving very fast, and whatever we're talking about today is going to change tomorrow for sure.

And I also heard a lot of conversation about the human in the loop, and it's really important for us, of course, to figure out these adverse decisions and to really have an appropriate person with a clinical background. So I appreciate the emphasis that folks have placed on that.

I also think we should kind of rethink about how we look at human in the loop in general. One of the things that we like to talk about in my space is human in the lead. I think we take that kind of approach, then we can obviously know, you know, to the points already raised, this is someone who was really making those decisions based on their clinical expertise.

So, again, really appreciate all the work you're doing here and looking forward to future conversations around it for sure. Thank you.

And let me, I should ask, is there anything else that you need from us?

KATHERINE ROGERS: I don't think so. All this feedback was really helpful. Thanks so much.

CHAIR VERLON JOHNSON: Thank you.

All right. Okay. All right. So we have Holly and Chris joining us, and we're going to start talking about managed care accountability, and if you all recall at our last meeting, we discussed some policy options. Today we'll be reviewing some potential draft recommendations.

So, Holly and Chris, I'll turn it over to you.

STATE AND FEDERAL TOOLS FOR ENSURING ACCOUNTABILITY OF MEDICARE MANAGED CARE PLANS: DRAFT RECOMMENDATIONS

* HOLLY SALTRELLI: Great. Thank you, Verlon, and good morning, Commissioners. Today Chris and I are going to present draft policy recommendations for state and federal tools for ensuring accountability of Medicaid managed care plans. These build on the policy options most recently presented at the January 2026 meeting.

First, we'll start with a brief background on Medicaid managed care accountability and a review of our key findings from the environmental scan, stakeholder interviews, and Managed Care Program Annual Report, or

MCPAR, analysis. Then we'll walk through the two draft recommendations, including the rationales and implications for Commissioner consideration, and then we'll conclude with next steps.

As a reminder, managed care is the predominant Medicaid delivery system in most states. Almost three-quarters of Medicaid beneficiaries are enrolled in a comprehensive, full-risk managed care organization, or MCO, with managed care capitation payments accounting for more than half of Medicaid benefits ending in fiscal year 2024. States contract with managed care plans, selecting them through a competitive procurement or noncompetitive application process.

Our work examined the accountability tools available to states and CMS to ensure managed care plans comply with federal and state requirements, which tools are used in practice, and whether additional tools are needed.

While states generally reported having sufficient tools, such as sanctions and incentives, to oversee plan performance, we identified opportunities to improve the consistency and completeness of managed care accountability data and to help states more effectively use available

performance data.

We'll start with reviewing the findings from our study.

Following an environmental scan of federal rules and a 40-state review of enforcement tools, we conducted 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 went through September 2023 through August 2024, and represented 34 states. From our analysis, we identified opportunities to improve the use of performance data for managed care accountability.

A key finding from our interviews is that states frequently address compliance issues through informal channels before escalating to formal sanctions. All state Medicaid agencies we spoke to hold regular meetings with MCOs to proactively identify and address performance issues, and for first-time offenses or failure to meet minimum quality standards, states generally tried to resolve issues informally first before moving to formal action. However, we found the current MCPAR instructions

do not provide sufficient clarity on what constitutes an informal intervention and whether certain actions, such as verbal warnings and informal performance improvement discussions, should be reported.

Public reporting of corrective action plans, or CAPs, and other sanctions was widely recognized as an important accountability tool by stakeholders.

States began submitting MCPARs in 2022, but a 2024 Government Accountability Office (GAO) review found reporting was inconsistent and incomplete. Our own analysis of performance year 2023 echoed these findings.

We found the MCPARs supported our interview findings that states were more likely to take intermediary steps, such as CAPs, before levying monetary penalties. We saw that 25 different states used CAPs as a tool, versus 11 states that reported civil monetary penalties, and 10 states with liquidated damages. However, we did not see many compliance letter actions being reported, which may indicate that states are not reporting the full range of formal and informal actions.

As another example, one state did not report any liquidated damages in its MCPAR sanctions, but according to

the state's own website their managed care compliance actions totaled $33.8 million in liquidated damages for the same time period. This discrepancy likely reflects a difference in how state and CMS view liquidated damages. The state does not consider them a penalty, even though CMS includes liquidated damages as an intervention type in the MCPAR.

We also found that states need better tools to assess plan performance across multiple data sources, even beyond MCPARs. Although managed care plans are required to report performance data across a variety of sources, such as the MCPARs, external quality reviews or EQRs, and the forthcoming quality rating system (QRS), these data 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 managed care plan.

Several interviewees wanted better information to compare plan performance within and across states. For

example, a couple of stakeholders suggested that CMS could help states review past performance by developing a national database of plan deficiencies and sanctions.

Next, we'll review the two draft policy recommendations designed to address these identified challenges.

The first recommendation states:

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions, taken in response to plan noncompliance, that should be reported in the sanctions section of the Managed Care Program Annual Report, pursuant to 42 CFR 438.66(e)(2)(viii).

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 sanction or corrective action plans imposed by the state or other formal or informal interventions with a contracted managed care plan to improve 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.

Our stakeholder interviews found that states commonly use informal accountability actions before escalating to formal sanctions, but it is unclear how and whether these informal interventions could be captured on the MCPAR.

The goal of this recommendation is not to document every communication between the state and managed care plan, but to capture notable communications and

interventions in response to a lapse in plan performance. As such, CMS should determine a threshold for reporting informal interventions. For example, CMS could exclude routine monitoring calls from reporting.

MCPARs are still in the early years of implementation, so states may still be getting used to the reporting requirements, making this a potentially fruitful time to provide additional guidance and standardization.

MACPAC previously made recommendations in its March 2024 Report to Congress to improve the usability and transparency of denials and appeals data included in the MCPAR, recognizing that clear data definitions and reporting instructions were essential for making MCPAR data useful for oversight and monitoring purposes.

We identified the following potential implications of this policy recommendation. This recommendation would require increased administrative effort for CMS to identify where additional clarification and standardization are needed on the MCPARs. CMS would then need to develop and disseminated updated instructions, data definitions, and/or reporting template for the MCPAR.

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 the required information consistently.

For enrollees, improved MCPAR data quality would enhance transparency regarding how states hold plans accountable for performance and more complete and publicly accessible information on sanctions and corrective actions could help beneficiaries make more informed choices during plan selections.

For plans, managed care plans should not see a substantial increase in administrative burden because they are not directly submitting MCPAR data, though plans may face indirect effects if states request additional documentation to support more complete reporting.

And finally, do we not anticipate a direct effect on providers.

Moving on to our second draft recommendation, which states:

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reporting data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to strengthen procurement activities, improve beneficiary experience, and oversee managed care plans.

In our study, we found that states currently struggle to access and use multiple sources of managed care performance data together effectively. Several interviewees suggested that CMS could help states by developing a national database of plan contract violations and sanctions to support transparency and state efforts to contract with high performing managed care plans.

National experts noted that the MCPAR is a good first step in collecting plan level data, but that understanding plan 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 would allow states to understand what performance looks like across the country.

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

In our March 2025 Report to Congress, the Commission made recommendations on EQRs, including the need to reduce areas of duplication with other federal quality and oversight reporting requirements and to create more usable reports that identify key takeaways on plan performance.

This recommendation would build upon those prior recommendations by combining the information across the different federal ports on managed care quality and oversight. For example, combining information on sanctions from the MCPAR with EQR findings on the development and validation of performance measures and QRS metrics on access and quality outcomes would provide additional context and a more holistic view of plan performance than

just a count of sanctions itself.

For the implications, this recommendation would result in an increased administrative effort for CMS to develop a public database that combines existing data sources as well as supporting technical guidance.

For states, this recommendation would provide a more complete picture of plan performance and could improve their ability to procure high performing plans and implement more effective accountability provisions and contracts.

Access to better comparative data would support states beyond procurement, as well. States could benchmark their program's performance compared to other states in terms of outcomes and compliance. This type of comparison could also help states identify gaps in their oversight practices or identify emerging compliance issues in other states.

This option would not necessarily increase the administrative burden on states, because this would focus on helping states make better use of the data they are already required to collect and report, not collecting new data.

For enrollees, performance data that are publicly available and readily accessible can improve beneficiaries' ability to make informed decisions during plan selection, and improved plan performance resulting from more effective state oversight could lead to better access to care and quality of services.

Plans already report these data and would not experience new reporting requirements. MCO representatives from our interviews noted that any public reporting of sanctions or other performance information should include appropriate context, and this combined database would help provide that additional context.

And finally, we do not anticipate a direct effect on providers.

Staff would appreciate commissioner feedback on the draft policy recommendations. We are drafting a chapter for the June Report to Congress, and if there is support for moving forward with these recommendations we will return with the draft chapter and recommendation language for a vote at the April meeting.

To summarize, these two recommendations seek to improve the usability of managed care performance data and

provide states with additional tools to assist overseeing plan performance. This slide can be used to ground our discussion, and with that I will turn it back to Verlon.

CHAIR VERLON JOHNSON: Thank you. That was so helpful. It is really good to see that we have these draft policy recommendations in front of us.

I want to turn to my fellow Commissioners. I know there are lots of questions out there, so I will start with Jami.

COMMISSIONER JAMI SNYDER: Thank you again for this important work. I just want to reiterate the importance of the first policy recommendation in really laying the foundation for any sort of database that is developed. Consistency in reporting, I think, is really critical to ensuring that the database can actually be useful to states.

And I noticed in the first policy recommendation we speak to CMS offering guidance on the type of accountability actions that should be reported. But I know in some of the material that you provided and, in the slides, you really did speak to the creation of some consistent definitions. I wonder if in the policy

recommendation we actually need to call that out more clearly, because I think creating a definition for each of those accountability actions is really, really critical to consistency.

And then the other item that I just wanted to kind of revisit is around the informal interventions. Would you mind just kind of restating, from your perspective, what would be captured under informal interventions?

HOLLY SALTRELLI: Yeah. So we, in our perspective, it would be CMS's job to determine and communicate the threshold for informal interventions, but our recommendation is that any clear documentation distributed to plans about their performance, in writing, should be captured in the MCPAR. So again, our goal is not to document every communication between a state and a managed care plan but to capture notable communications and interventions in response to a lapse in plan performance.

COMMISSIONER JAMI SNYDER: Okay. And I just wonder if we need to more clearly state that in the policy recommendation.

HOLLY SALTRELLI: Thank you.

COMMISSIONER JAMI SNYDER: Thank you.

CHAIR VERLON JOHNSON: Thank you, Jami. April, and then Mike.

COMMISSIONER APRIL HARTMAN: I just want to say thank you for that information, and I want to say, for both of these, that I think the benefits to providers that there are some, it is very similar to what is there for enrollees, in that those of us who practice in states with multiple MCOs, we don't always contract with all of them. So having some information to know which ones we want to contract with or not would be helpful. So I think that this would be of use to providers also, in a big way.

HOLLY SALTRELLI: That's a great point. Thank you so much.

CHAIR VERLON JOHNSON: Thank you so much, April. Mike.

COMMISSIONER MICHAEL NARDONE: Thank you. This is really helpful, and I'm glad we're continuing the exploration of these issues. I fully support the recommendation around MCPARs. You know, it is clear that this is pretty much in its early stages, and so the more we can be clear about the guidance around that. And I know

CMS, as you mentioned and I have seen the guidance that CMS has already issued around MCPARs, to clarify, and I think that process has to continue, so we can get to a point where the data is really useful to all concerned.

And I would echo Jami's point around informal interventions. I was thinking about the number of times that I would talk to a plan when I was a Medicaid director, and kind of understanding what does that mean. And at some point, having too much information isn't really useful, and those states that really are much more aggressive in terms of monitoring their plans would, by nature, have more informal interventions, because that's what they do.

So I think trying to get a better handle on what that really means would really be helpful, because I don't think we want to overrun the MCPAR system with interventions that really aren't helpful to moving ahead.

I wanted to just maybe comment a little bit on Recommendation 2. I think that is all very helpful and I'm very supportive of that. I want to make sure that we do kind of bring, when we are writing this up as a chapter, I do want to make sure that we are bringing QRS fully into this. I know that's not a system that goes up until 2028,

but that's going to have standardized metrics, 16 mandatory metrics, a lot of the things that I think are basic quality metrics that we want to know about all plans. And they look very familiar to me from when I was Medicaid director.

So I want to make sure we fully kind of incorporate that in the draft, that we give a little more discussion to that than I think we've had in the past.

I also want to just caution when we're talking about how this information can be used in procurements, that that is really a challenging issue for states. You know, I've been on the Medicaid side of this and I've also been on the consulting side of this, and one of the key pieces is you can only evaluate what's on the page of the RFP when you are reviewing applications.

So kind of having this database out there that maybe suggests that Plan A or Plan B is maybe not as strong in Arizona or whatever state, the different states -- sorry, Jami -- but, I mean, another state, you can't really use that information.

Now, I think there are ways, and I've talked to my colleague, John McCarthy, about this, because I think he implemented some of these changes, where you can bring that

information into the procurement. And I think that's where your recommendation around providing some sort of guidance or groups -- I'm blanking on the term you used -- learning collaboratives around that, I think that's where that really comes into play. Because I think that there are strategies that I think states can employ to make sure that they are pulling in this information and doing it in a way that maybe won't violate some of the procurement rules around it. You know, procurements are a pretty contentious issue right now, so I think kind of helping with that would be, I think, a valuable exercise.

I guess the other, and maybe this is another piece of this that I always think about when I'm reading about how do we monitor accountability of health plans. Understand that much of this data that's being provided is old by the time that states get it. I mean, the CAPs data, the HEDIS data is 1 to 2 years old when it's actually being published and put up there.

As a Medicaid director, you are having to do this real time. And so that's why those informal kind of discussions are really important. You know, you're looking at data from quarter to quarter or month to month in some

instances.

So I hope that we, at some point, and it's maybe not this round, but are we looking at are there best practices that states are employing? Are there dashboards that states are employing, on a real-time basis, that could be maybe helpful to other states that maybe don't have as much experience with kind of overseeing managed care plans.

You know, I hope that maybe at some point we're getting to that, and that also feeds into kind of learning collaboratives and that sort of effort. But I just wanted to make those two points. I appreciate the direction that these recommendations are going in. Thank you.

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

COMMISSIONER PATTI KILLINGSWORTH: Thank you both. I also echo appreciation for the good work here. I want to echo the comments from both Jami and Mike around the informal intervention and other accountability actions, and just being sure that we don't inadvertently create a chilling effect on state oversight of other managed care plans.

So I would offer up, just as a starting point,

some potential language for you to consider, which would be interventions encompassing documented deficiencies in plan performance requiring action by the plan to improve performance. So that it's not suspected. We're not gathering information. We know there is an issue with performance, and we are having at least conversations about a deficiency that has been documented, and we are expecting some change to happen as a result of that. Just as a starting point. Thank you.

CHAIR VERLON JOHNSON: Thank you. John.

COMMISSIONER JOHN MCCARTHY: On Policy Option 1, I mean, I am assuming that CMS is working on those things. So I know, as it came up earlier, what we should still say, though, is because you don't know if they're going to do it. MCPAR is new. We knew it was going to take some time, so what we have makes sense. I always worry that if we have a recommendation finally coming out it will be after CMS already made the changes. So that's one.

Policy Option 2 has really been bugging me, and I couldn't figure out what it was. And then Mike, I think, finally helped me realize what my issue was, as he often does, which is, it's really two different pieces we have in

there, as it currently reads. And so the first part of doing the database makes a ton of sense from the standpoint of, okay, you have a place to look. What I really would like it to say, though, is that CMS should be doing that bigger oversight, to be able to look at the database, and then talking to states about, hey, are you seeing these things in your state, because a state may not see that stuff.

So to me it sounded like having a database, but what is CMS's role in oversight and to help other states.

I think that Draft Recommendation 2 should be broken into two pieces. So there should be a third recommendation, which is that last sentence, which is CMS should also issue guidance and toolkits. Make that a third recommendation.

And on that, I don't know if we should keep the strengthen procurement activities in there. For now it's fine. I agree with Mike; the issue becomes on procurement. The way they are done per state laws is what information can you look at, and then how do you use that.

So I'll just give you an example, and these are made-up examples. This is not a real-life one. But what

if you have a national plan that's in 25 states, and it comes out that last month, right before the procurement, there is just a total disaster in a state around access to care, like 50 percent of the people can't get access to care. So then some states are in active procurement, and they say you have to report that, so that gets in there. Okay. So in one state out of 24 they have this one big disaster.

Now another plan is in also 25 states, and they have had not a big thing like that, where 50 percent of the people don't get services, but 2 percent don't get service. But it's consistent in every state. Whereas the other one was 2 percent, no problems, just in one. How do you score that? And that's what you really get down to on these things.

So I don't know if this necessarily leads to that, but I do think for managed care oversight there are things that CMS could be working on. And I don't know if CMS should issue it, or if it is an NAMD issue, or state issue, but coming up with a new way to do procurement I think is something that many states are trying to figure. And I think managed care plans would like to see some of

that, too, where it's less subjective and more objective. Thanks.

CHAIR VERLON JOHNSON: Doug.

COMMISSIONER DOUG BROWN: Thank you. I want to just, on Recommendation 1, I want to make sure that if we're going to be reporting penalties that they are the meaningful penalties. And I guess to Patti's point, if it's beyond just the normal discussion back and forth of correcting issues that go on between plans and states to enhance the programs. It's to enhance the programs. It's the penalty piece. So I'd want to limit meaningful elements, or it just gets lost with everything else if you're overreporting every communication and every minor issue that comes up. And these are massive plans and they are very difficult to manage, and there are always going to be things that pop up, right. And some states are much more aggressive with their MCOs than other states are, so they will be managing that to different levels.

I would also, potentially you could [audio disruption] this, and like OIG audits there could be responses included from the MCOs about the situation, so that there could be a point and then a counterpoint to what

was behind that issue within that particular state, that if the state reported a certain issue, the MCO would have a chance to kind of respond to that, in the report or somewhere it could be documented in that way. So I just want us to think through that a little bit more, but I'd like the recommendation to be really to the point that it matters a lot, and it's significant in that reporting. Thanks.

CHAIR VERLON JOHNSON: Thank you, Doug. Any other questions or thoughts? Okay, Holly, Chris, any follow-up questions from you?

HOLLY SALTRELLI: This is very helpful. Thank you, everybody.

CHAIR VERLON JOHNSON: Thank you for your presentation.

CHAIR VERLON JOHNSON: All right. We are now at the point where we are going to move into public comments. So we invite people in the audience to raise your hand if you'd like to offer a comment. Please make sure that you introduce yourself and the organization you represent. And we also ask that you keep your comments to three minutes or less.

So with that, all right, it looks like Kim Pettman, you are up.

PUBLIC COMMENT

* KIM PETTMAN: Hello. Can you hear me?

CHAIR VERLON JOHNSON: We can. Thank you, Kim.

KIM PETTMAN: Okay. I have a disability so I'm asking if I could have four, if possible. Would that be acceptable?

CHAIR VERLON JOHNSON: That is acceptable, yes.

KIM PETTMAN: Okay. Thank you. A quick introduction. I recently found out about you guys, and because I am a former state Medicaid Advisory Committee member and because of the advocacy I do, I was glad to find out about your group. I have no idea how I found out about it, but I wanted to thank you. I did ask for an accommodation in advance, and your people were really great about it.

I am asking that I could please talk with one or more Commissioners and one or more administrative staff after this meeting, offline, and maybe some other people that are listening. I will try to condense what I say.

You guys mean well but you are missing so much.

I am a person who is former librarian. I was on the Medicaid committee. My bachelor's is in communication. But my biggest qualification for what I say is I'm living in a group home, I'm 61, and I'm living in Minnesota, and have been trying for 10 years to get my Human Services Committee in my state and the insurance companies and the hospitals to understand how things are working or not working.

I also took statistics, and my biggest request to you guys -- in Minnesota we say "you guys" -- your N number is really low or nonexistent for your decisions that you're making, on one group of people, which is a huge group. It's the community. It's people, including some very smart people, of all walks of life, who are living in nursing homes, group homes, assisted living, transitional care units, and also literally living in hospitals.

We've got a big problem here in Minnesota, and we've got this fraud issue. The fraud is hurting people in so many ways. And it's really hard to reach different people at the agencies, whoever is in office.

I would like you guys to think really hard how are you reaching out to people who are living in these

settings and know, in each state -- and can also give ideas for all the states -- there are things that you guys are missing.

So my recommendation is please include the public as stakeholders. Before you send in any recommendation, have, at least four times a year, in a plain language way, a community friendly way, where you are specifically including at the table people living in these settings. Because you're missing a lot of stuff, and I and other people would love to help you. It will work a lot better. And somebody at your organization has my contact information. Please include me. Please include others. I know you mean well. If you include us, you are going to have better results.

And I really am grateful for your organization, and thank you.

CHAIR VERLON JOHNSON: Thank you so much, Kim. We appreciate your comments, and we do have your information and we will be in contact.

Let's see, any other comments from the pubic?

[No response.]

CHAIR VERLON JOHNSON: Okay. Well, hearing none

I do want to remind you that if you do have comments later you may submit them through our MACPAC website. And now we will take a lunch break until 1:30 p.m. Eastern. We'll see you soon. Thank you.

* [Whereupon, at 12:06 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: Good afternoon, and welcome back, Commissioners, and welcome back public.

We're going to get started with Sheila and Joanne bringing us up to speed after our conversation in January about appropriate access to residential treatment in Medicaid. If you remember, part of the discussion centered around the feasibility of a federal database, and they've done a lot of work and are going to share the results and looking for feedback after that.

So, with that, Sheila, take it away.

ACCESS TO APPROPRIATE RESIDENTIAL TREATMENT SERVICES FOR YOUTH IN MEDICAID: DRAFT RECOMMENDATIONS

* SHEILA SHAHEED: Great. Good afternoon, Commissioners.

So today, we're returning to discuss policy recommendations for appropriate access to residential behavioral health treatment services, and so as a reminder, MACPAC's June 2025 report to Congress included a chapter with findings from our research on this topic, and last

month, the Commission discussed policy options for addressing the key challenges that emerged in that work. So this session, we are sharing some additional information and revised draft recommendations based on your feedback in January.

So we'll start with a brief review of our key findings with a focus on new developments since we last spoke. We will then discuss our updated draft policy recommendations for discussion by Commissioners.

Key findings. So, as the Commission has stressed, residential treatment is a last resort, but for the population of youth who require this level of care, our research found that it is not easy to find. Specifically, we found that there's a lack of easily attainable and specific information about the facilities that are serving Medicaid beneficiaries, and there's difficulty finding -- and that difficulty finding information makes it challenging for families and providers to understand the available treatment options.

So existing resources of residential treatment facilities for behavioral health provide some but not the full complement of information that families and providers

need to be able to understand whether a particular facility can meet the child's needs.

Last month, Commissioners asked about other federal efforts to develop and maintain bed databases. So today, we're sharing some additional information. For example, the Centers for Disease Control and Prevention, or the CDC, developed and now maintains the Hospital Bed Capacity Project as a component of its national -- of its National Health Care Safety Network, which tracks health care associate -- health care-associated infections.

So CDC phased in the implementation of this project over 12 to 18 months across three states, and so this project supports the ongoing automated collection of hospital bed capacity information, and the jurisdictions or states and facilities that are involved in the project aim to update the database at least hourly.

So the bed database reporting is led by the jurisdictions, which set up governance committees to guide this work, and so this project does face certain challenges, including hospital willingness to participate due to limited staffing resources, the time necessary to develop and run capacity reports to be shared, and IT

requirements.

SAMHSA developed and maintains their findtreatment.gov website, which allows users to search for behavioral health treatment facilities based on factors, including location and acceptance of Medicaid, but it was not intended or designed to provide information on bed availability. Findtreatment.gov is updated annually from facility responses to SAMHSA's National Substance Use and Mental Health Services Survey, and SAMHSA updates facility names, addresses, phone numbers, and services weekly for facilities that inform the agency of changes.

SAMHSA initially conducted an extensive gap analysis prior to development of their database. Though not a bed registry, the considerations, challenges, and limitations associated with maintaining the website are pertinent to -- are pertinent, and so some of those challenges include ensuring that provider information is consistently accurate and clear.

So the Office of the Inspector General has previously raised some questions concerning the accuracy and completeness of the site's information, but SAMHSA has since addressed those concerns.

We learned that it can also be challenging to get facilities to participate in the survey year after year and ensuring the accuracy of the information submitted, and so SAMHSA maintains a user support team that is responsible for addressing respondent and facility concerns.

They also send pre-populated surveys to already-registered facilities for efficient resubmission of their information year by year.

So I'll be going through this slide and the next slide briefly.

As you all may recall, our work found that there is limited data available to understand the use of residential treatment facilities, 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 in settings other than PRTFs, and an analysis of PRTFs only would provide key information but likely be of limited generalizability.

CMS publishes the T-MSIS Behavioral Health Data Book, which provides some information on residential treatment use, but it does not differentiate use by children and adults or use in in versus out-of-state

facilities.

So out-of-state placements, at a national level, there is no single data source that examines the use of out-of-state residential care. This 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.

So our findings show that securing appropriate residential treatment options can be challenging for children with more complex needs, and this can also lead to out-of-state placements.

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.

So now we'll transition to our draft policy recommendations.

This is a brief highlight. So, as a reminder, our first recommendation is intended to address the lack of complete and up-to-date information on facility beds -- on facilities and beds and would have the Department of Health and Human Services develop a centralized directory of

facilities.

The second recommendation 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. The objective of the last recommendation 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.

So Draft Recommendation 1, directing the -- a directory of youth residential treatment facilities. To ensure that states, families, and providers have complete, accurate, and up-to-date information about residential treatment facilities and bed availability, Congress should require the Secretary of the U.S. Department of Health and Human Services, or HHS, develop, maintain, and make publicly available a federally administered, up-to-date directory of youth residential treatment facilities serving Medicaid beneficiaries.

The Secretary should work with HHS agencies, including the Centers for Medicare and Medicaid Services,

or CMS, and the Substance Abuse and Mental Health Services Administration, or SAMHSA, state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this directory. At a minimum, this directory should include information on the behavioral health conditions that facilities specialize in treating, ages served, regularly updated bed availability for in- and out-of-state Medicaid beneficiaries, and accessibility of facilities and services for individuals with disabilities.

The Secretary should leverage information that is already being collected by federal agencies and states while also integrating other information needed to determine whether the facility can meet beneficiary need.

So there currently -- for rationale, there currently is no federal requirement that relates to CMS's role in facilitating access to this type of information for its beneficiaries. Although some information is collected by federal agencies, including CMS's Quality, Certification, and Oversight, or QCOR, website, and SAMHSA's findtreatment.gov website, not all information is easily accessible or attainable for all providers that serve Medicaid beneficiaries. Nor is all the information

accessible or attainable for beneficiaries and caregivers themselves.

And so federal -- for implications, so federal agencies may need additional resources and staff to develop, implement, maintain, and oversee the registry, and so states may experience greater ease in identifying facilities with -- in identifying facilities that are available.

States may be asked to take on responsibilities such as educating providers and users of the registry and monitoring use of the registries

Enrollees may experience greater ease in identifying facilities with available beds. Plans may experience greater ease in identifying facilities that have available beds, and plans may also have to take on responsibilities that include working with facilities to update the registry or encourage use of the registry.

Providers may also experience greater ease in identifying beds, and they will have to also update the registry according to specifications.

So Draft Recommendation 2, report on the use of residential treatment services. To ensure that reliable

and consistently-collected data are publicly available, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services, or CMS, to regularly report on the use of residential treatment services by children and youth in Medicaid, including services provided by psychiatric residential treatment facilities, or PRTFs, non-PRTFs, and out-of-state residential treatment providers.

This report should provide available data on the characteristics of youth using the services, including demographics, disability and co-occurring conditions, and urbanicity and rurality, types of services used, average length of stay, and discharge outcomes. The report should include data on the use of emergency departments for behavioral health needs, such as emergency department boarding by youth with Medicaid.

If data are unavailable to report on key measures, CMS should develop a plan for collecting and publicly reporting on the data elements.

CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts.

So this recommendation is intended to increase data availability on the use and users of residential treatment services, particularly those children that are out of state. There is limited reporting available on the use of these services by children, and having this data could provide greater insight into what is and is not working and might provide some ability for states to identify ways to target needed interventions.

Similar to Option 1, there are no federal rules that currently require this kind of reporting from CMS.

So federal agencies -- so CMS will need staff and resources to review data and develop and produce the report, and so states may have to take on additional data collection and reporting, and they may also experience some costs that are associated with systems changes. However, they will have new information on the use of residential treatment services.

We do not anticipate any direct effects on enrollees or plans. Providers may incur resource expenditures related to systems changes or any staffing.

So Draft Recommendation 3, minimum requirements for discharge planning. To ensure that youth discharged

from out-of-state residential treatment facilities return to their communities and receive needed services, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services, or CMS, to amend 42 CFR 441.155 to establish minimum requirements for discharge planning processes that mandate that the process involve families and caretakers and identifies an appropriate community provider or alternative residential placement prior to discharge. CMS should also establish minimum requirements for coordinating and sharing information between the out-of-state provider and the post-discharge providers.

And so federal PRTF rules currently identify discharge planning as a required component of plans of care but do not elaborate on the requirements for those discharge plans or planning processes.

CMS has highlighted the importance of discharge planning and beneficiaries' return to their home communities upon discharge in the context of other CMS programs, including Medicare.

Medicare rules for hospital discharge include conditions of participation that are specifically related

to discharge planning, and they require but are not limited to connecting beneficiaries with community-based services, discussing a beneficiary's options with both them and their caregiver, and recording those discussions in their patient record. Also, routinely reassessing the beneficiary's discharge plan throughout their treatment to determine if any updates are needed.

Discharge planning policies do exist at the state level, or at least in certain states, but those policies are generally linked to state-licensed activities and not Medicaid requirements.

So, for implications, CMS will need staff resources to develop and publish any new rules, and so states may need to develop and disseminate guidance to plans and providers regarding discharge planning and may also need to engage in oversight and monitoring.

Enrollees in out-of-state placement and their families and caregivers will have a clearer understanding of how discharge plans should be developed, and they may also experience smoother transitions back to their communities.

Plans would establish guidance for network and

non-network providers regarding discharge planning and coordinating the return of youth to their communities, and plans would also gain information about the needs of youth in out-of-state facilities.

Providers may need to spend more time on discharge planning than they currently do, and post-discharge providers will have information about the health care needs of youth coming into their care from out-of-state facilities.

So, for next steps, Commission feedback on the following would be helpful. On our refined policy options -- sorry -- on our draft recommendations, any additional considerations for those recommendations and anything that you would like to see highlighted in the June 2026 chapter.

And from there, I'll pass it back. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Sheila. I appreciate that. I also want to say thanks for the continued work and following up on some of the questions and issues we brought up in January.

While I know this is not the panacea, end-all for the answers to this, I do think these recommendations and policies are a good step forward in trying to identify

opportunities to improve the care of the Medicaid beneficiaries.

So, with that, I'll open it up to my fellow Commissioners for comments, feedback. Heidi.

COMMISSIONER HEIDI ALLEN: Thank you so much for this work, and this has been a long journey of collecting information and hard to get a lot of the information. So we've had to do a lot of primary data collection interviews, really digging, really appreciate the thorough work that you all have done.

I am a little confused about our recommendation about the bed directory, because we're talking about registries, but a directory is not a registry, at least as it was presented in the materials.

So, like, a directory would be a list of every state, their facility, a couple of demographic or characteristics of who they serve, but a registry, in the way that it was talked about in materials, is really a more dynamic look at where people are. And some of the anecdotal evidence from states that have that is that it is reducing wait times for people who are maybe waiting in a hospital or an emergency department and, in general,

keeping things moving in a quicker way.

So I, personally -- while I recognize that it's interesting that our last meeting, we were talking about generative AI that could come up with their own clinical guidelines, and right here, we're like, oh my gosh, it'd be so difficult to know if there's a bed that's open.

I think it's worth the advancement in technology and infrastructure for people to know where beds are and what kind of beds they are and who they serve so that we can start moving people out of acute care settings and into appropriate placements.

But I want to most specifically talk about the kids that are having trouble getting discharged, and we heard this in interviews that when we have out-of-state placements, there's kind of a phenomenon of "out of sight, out of mind" that can occur where a kid no longer meets criteria for that level of acuity, but the receiving state or the state that owns that kid is, like, we don't have a place to put them, and that the kids are languishing in these systems well beyond when they should have been discharged.

I think that just saying having a discharge plan

is kind of inadequate, because you could write down, we're seeking appropriate places for them to live.

I just feel like -- I worked in that setting, and it is like a carceral setting. You can't go outside on your own. You can't date. You're not allowed to have any relationships. Your education is limited to these small environments. You don't get to take electives. You don't get to play sports. These kids are missing out on so much of what a normal childhood adolescent is. If they have treatment goals, they don't meet criteria for being there, it's a violation of the American Disabilities Act of least restrictive environment.

It's also extremely inefficient use of taxpayer dollars, because not only are you paying for a higher level of care, but you're paying for it outside of the state, so you're paying more. We should consider this an urgent policy issue that needs to be addressed.

So I would like to think of a group of people who are appointed to examine cases on a monthly basis of kids who no longer meet criteria for an out-of-statement but are there simply because a discharge plan hasn't been put in place, so that people have to visit those cases every month

and see the same file every month and find an appropriate way to get them back in their home state, back in their community and engaging in a developmentally appropriate life.

I don't know what that could look like. I'd be very interested to see what kind of research you could find. But I know that we have many bites of the apple at MACPAC, and I think that we're probably at some point going to look at the quality of these facilities.

But this is a different issue. This isn't the quality of the facilities. This is the way that the Medicaid program is handling discharges, and I want to make sure that we don't miss this bite of the apple in order to get Medicaid agencies really, really figuring out how to bring kids home when they're ready.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi.

Anne.

COMMISSIONER ANNE KARL: I don't have nearly as many smart things to say as Heidi, but just two minor comments. One, I think one of the things we talked about last time was just the ability to feel like the registry is

up to date, that it's not useful if it's not up to date. It looks like you did a lot of work to see how other registries are being used and what's effective and what's not. So I think just making sure that that's highlighted in the chapter so that there is really a lot of design work that goes into the accuracy.

The other thing that I was just hoping you could clarify, and maybe it's revising some of the language in the recommendation, was I think it's the third recommendation on the discharge planning, just look on who will be subject to that. Because it feels like it would be hard for the out-of-state hospital to be doing discharge planning, which is essentially in the other state. So just being more clear about are we asking that out-of-state facility to be doing the discharge planning, or are we imposing a requirement on the Medicaid agency to have some way to do more sophisticated discharge planning for people in out-of-state facilities.

VICE CHAIR ROBERT DUNCAN: Thank you, Anne. Mike, then Patti.

COMMISSIONER MICHAEL NARDONE: Yeah, thanks for this work. I wanted to kind of speak to the timeliness of

having that information up to date on the registry. And I was wondering, one of the things I saw in the description, a memo, was there were a lot of issues that some of these other databases encountered, like the ability to recruit providers and make sure that they were participating. And it seems to me we might have the same sorts of issues moving to this type of system, or more real time. I'm not saying we shouldn't. I'm just saying there are going to be issues that arise like that. It is also important that there be a staffing component that's dedicated to this, because it is going to require real resources.

So I'm wondering if there are, you mentioned the findtreatment.gov kind of addressed some of the concerns that have been raised. I was wondering, are there strategies that they employed to address some of these challenges that maybe we should bring into and talk about in the chapter? I didn't see that, necessarily, in the memo. Maybe I didn't read carefully enough. But I just think that to make this a reality, this does seem like, no disrespect meant to where we are trying to get to, we really do need to make an investment in this if it's going to work. And if that's the technology, if there's a

technology solution, that's what I wanted to maybe see. Like what was going to make this different than some of those efforts, or what were some of those strategies that might be employed?

VICE CHAIR ROBERT DUNCAN: Thank you, Mike. Patti.

JOANNE JEE: Let me just comment. So the issue of ensuring that a provider participation or the facility participation in the registry is definitely a theme that came up, and a recognized challenge, obviously.

SAMHSA's system is actually a database, and it's not a registry. But it is voluntary. So they field a survey and they ask facilities every year to respond to the survey. But they -- they and CDC; I'm kind of going back and forth here -- but in recognition of the need for accurate and up-to-date information and the burden that providers and facilities may face, they are engaged in constantly thinking about how they are gathering the data and trying to address that burden question.

So in the case of SAMHSA, for example, what they are doing is providing a prepopulated form back to facilities who were prior year respondents, the idea being

that the facility then just needs to review and correct, and hopefully that's like a lower lift than actually have to do data entry and that kind of thing. So they are thinking about those kinds of things.

In the case of CDC, where participation is also voluntary, they are really trying to leverage relationships that they have in states, and then have those sort of state entities leverage the relationships with the facilities, as well.

One of the things that, in the case of the CDC model, that they are doing is, a standard that they would like to achieve, is updates every, you know, very frequent updates. But they acknowledge that, you know, these facilities have different levels of busy-ness over the course of a day, hour to hour. As far as I know, and I could be wrong, but there is no penalty associated with a late update, and they are sort of accepting updates up until like an hour, that kind of thing. So they are trying to build in some flexibility into that.

Neither said that they had identified a solution that was going to maximize participation of facilities in the way that they would like to see. So it's a recognized

challenge.

VICE CHAIR ROBERT DUNCAN: Thank you, Joanne. Anything else, Mike?

COMMISSIONER MICHAEL NARDONE: No. I did have a comment on Recommendation 3, which is I just think we should, at least I think what the goal of that is to have people come back to their home state and their home community. So I think that should be in the language where we're talking about the discharge plan. It doesn't specifically say preferably back to their home community or make some reference to that. I just think that is maybe something we could add to the language to make it clear that that's what our goal would be.

And one final question. I was just wondering, are the out-of-state placements going back to the state as well as the Medicaid plan, to make sure that they know what the status is of the client that's been referred out of state?

JOANNE JEE: On Recommendation 3, on the discharge planning, the idea is that the entities who are sort of involved in the care of that individual would be involved in the discharge planning. That's the idea. You

know, it could probably be as expansive as it needs to be.

COMMISSIONER MICHAEL NARDONE: I just wonder if we needed to be clearer about that. And maybe it is clear in the lead-up and the discussion as you were writing the chapter, but I don't know that the actual language, I think, just refers to -- and I don't have the language -- that the contract be with -- I'm sorry. So the minimum requirements for coordinating are shared between the out-of-state provider and post-discharge provider. I mean, I guess we would also want to make sure that the Medicaid plans and the relevant actors are involved in that discharge planning.

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

COMMISSIONER JAMI SNYDER: So a few comments just on each of the recommendations, and thank you all for this work. It's really important.

With regard to the registry or the database, I understand what we want to achieve. I think it's good thing to want to achieve. I'm really concerned about the feasibility of it. It seems to me that anything that relies on voluntary reporting is probably a nonstarter.

It also seems to me that anything that is not really timely, like updated almost real time, is not very useful information. Knowing how quickly beds can turn over, if it hasn't been updated that day, you don't really know if there's a bed available at all.

And the other thing I would say is that data definitions would be really critically important because what does an available bed mean? Does it mean just simply a bed that's licensed and not filled, but do you have workforce to be able to support that person at the level that's really needed? That's a growing issue that many of these facilities have beds, but they don't have workforce to be able to serve people. So we could send people on a wild goose chase if we're not careful.

So I just don't feel like I'm settled enough on the feasibility about the recommendation for that one, although I recognize the goal and why it's important.

On the use, absolutely we need more data with regard to use. And it seems to me that it's an appropriate place for us to get at this really important issue that Heidi raised, which is children who are in out-of-state placements but who no longer meet criteria for the level of

services that they are receiving, and knowing how many of those kids they are, how long they have been there since they no longer meet criteria, and maybe even getting to, and what are we doing about it. But certainly sort of elevating our level of awareness about kids that are not getting an appropriate level of care because there doesn't seem to be that next step down for them.

And that kind of leads me then to the third recommendation around discharge planning. I feel like we have to be much more specific about our expectations. You can identify a provider, and that provider may or may not be willing and prepared to actually take that child upon discharge.

So it's more than just naming a provider. It is meaningful coordination between that residential placement and that provider to make sure that that child is actually ready to discharge. So I think we have to be much more specific there.

And I would say, in regard to Anne's comment, has to involve, if not fall primarily to the entity that placed the child there in the first place, whether that was a health plan or a Medicaid agency. If it's an out-of-state

placement and Medicaid is paying, somebody is authorizing those payments, and that is somebody who is charged with figuring out what the next service or placement is for that child.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti. John, Jami, and then Sonja.

COMMISSIONER JOHN MCCARTHY: We've been looking at this for a little while and obviously things change as we've been looking at stuff. So I just want to bring this one up, that fraud, waste, and abuse is such a big issue right now in Medicaid, and obviously if a child is being kept in a PRTF, whether it be in-state or out-of-state, and they no longer meet that criteria, as Heidi brought up, that would be waste. I mean, that is just pure waste.

So do we look at any, and I don't think we have, any recommendations around like turn off FFP federal match for kids that have gone beyond those periods? Because, again, they get incentives for states to move on things. If you turn off FFP for those kids, that might be one of those things that would help promote that.

JOANNE JEE: Yeah, that didn't really come up over the course of the work. I'm just trying to remember

back to all of the interviews and the reading and stuff like that, I don't recall that that particular situation was raised.

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

COMMISSIONER JAMI SNYDER: Yeah, thanks again for your continued work on this topic. I just want to echo the sentiments of some of my fellow Commissioners around the challenges associated with maintaining a registry that really speaks to that availability. And going back to some of Patti's comments, I really do feel like in order for a registry pertaining to bed availability, in order for it to be valuable it really does have to be real time, when states and plans are actually looking for beds.

So I guess I would suggest that we just sort of double down in the chapter around kind of the resources that will be necessary in order to maintain this type of registry. And also, we may want to think about incentives that could be offered to providers to report timely so that, again, the registry can be valuable to those who interface with it.

VICE CHAIR ROBERT DUNCAN: Thank you, Jami.

Sonja.

COMMISSIONER SONJA BJORK: I'm a proxy for Commissioner Ingram.

VICE CHAIR ROBERT DUNCAN: Carolyn, go.

COMMISSIONER CAROLYN INGRAM: I tried to wave to you, Bob, but you didn't see me.

VICE CHAIR ROBERT DUNCAN: I thought you were just saying hello.

COMMISSIONER CAROLYN INGRAM: Yes, that was it, exactly. Just a couple of things in terms of feedback. I had one question on Recommendation 2, when we talk about outcomes, and we want to track all these things, like around demographics of the population and then what the discharge outcome was. I'm questioning kind of what we mean by that exactly. People could get discharged and then what do you want to know about the outcome? Did they get placed somewhere, or did they get discharged back to their home community? Was it not safe so they discharged them to the current community they are in? You know, trying to figure out what we really mean by that. So I think we could do some more work in that area to be clearer.

And then I do agree with some of the other

Commissioners that brought it up about how difficult this is going to be to be able to track it live. But if this is something we really care about, I think it's worth the struggle to try to figure out a way to do it. There is a lot of technology that can help us.

But I would also encourage us, as a Commission, outside of this, to start thinking about what do we think we could review that we could take away. And we keep going back to states right now and saying, "Do this thing," then "Do this thing" and then "Do this thing." And they're strapped, and this type of thing is going to be complex and going to be hard for them to implement. So what else do we think about, as a Commission, in terms of are there things in the past that maybe we thought were important but aren't anymore because the data is really not used or it's not being collected appropriately? Are there things that we could suggest go away eventually for states? Thank you.

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

COMMISSIONER HEIDI ALLEN: I was just going to add onto a couple of things that I heard. In terms of a directory, I was a social worker in this field, and if

you're a social worker in this field you know what the placement options are. Like a directory is not that much better than Google. I could google "residential care facilities" and get a list. What you really need to know is are they accepting patients, and in that it's helpful to see if they serve people that maybe you didn't know.

And I honestly think the technology or the onus is on the provider, not on the state. It's on the state to tell the provider that we expect to see this. And it could be as simple as a green, we have beds, red we do not, and red could include we have beds but we don't have staff. I mean, it doesn't have to be super complicated.

But I think when you're making a policy recommendation you really want to advance policy, and I think that we really should advance beyond Google and what Google can do. Yes, it's a technological reach, but I don't think it's a huge reach. And I think that in the materials there were some examples of what's being used in nursing homes, like expedited pre-authorization, things like that, that could be used to incentivize providers to do that.

And then the last thing I want to say, and this

is hard to capture but I think it's really important, is that what often happens when a kid has met the treatment goals that were laid out for them and they are ready to discharge, and then they don't discharge is that they completely fall apart, and then they become acute again.

And so this idea of, you know, this is why I feel like it's so important to have some people who are aware this person is ready to discharge, and actively engaging in a plan, because if you wait two months and you're a kid who has done everything they told you to do, for sometimes 15 months or 2 years, 3 years, and then they tell you, "No, we have nowhere to send you," what are you going to do. You're going to run out of group. You're going to turn a table over. You're going to yell at a staff. You're going to hit a wall, and do all the things that put you right back into the high acuity state that says you're not ready for discharge.

So if you haven't worked in that environment then you haven't seen it, but I saw it happen. There was a state that we worked with, that I'm not going to name, but they sent kids completely thousands of miles away from home to age out. They came, they'd come at 15, they'd come at

16, and they would stay until they were adults. And it did not matter what that kid did, how good that kid was. They were not going to get to go home. And paid for by the Medicaid program. That should just be so unacceptable. And watching the kids just deteriorate when their opportunities were taken from them, and the promises that were made aren't kept is so devastating.

So I guess what I'm looking for is some teeth in that, like really some consequences. John mentioned a financial penalty. But I honestly think it's just having eyes on it on a regular basis, with a group of people whose job it is to say, "We're on it." And if you are looking at the same kids every month, you will find a way. You will make calls. And it may have to happen on an individual basis that you find these special providers. But I think it's worth getting those kids out of that out-of-state care and back home.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi. Any other Commissioners?

[No response.]

VICE CHAIR ROBERT DUNCAN: So I'd just like to add, you heard it in a couple of different phrases. Heidi

talked about the cost of keeping a kid beyond the time that they should be there. Mike talked about the investment. John talked about the fraud.

I think the reality of this is we're spending dollars where they shouldn't be spent and not getting the outcome for that child. And so I'd like to think of this as an investment and providing that potential access to the right care at the right place, and the discharge planning process is part of that.

The other is, I think you did a wonderful job in the information you sent, highlighting some of the other registries, databases, and pieces in place. I think taking the best practices that they have learned from what's working well, what's not, will be important as we think through this work and what we recommend.

And to Heidi's point earlier, earlier today we talked about AI and technology. How does that play in? But I think you've done a wonderful job of pulling this all together. And I will ask, do you have what you need to move forward with the next steps?

JOANNE JEE: Yeah. Lots of food for thought. We'll think about what we can do with some of the comments

here and see if there are ways to accommodate, if there is a little bit more research we can do, and we'll see what we can do.

VICE CHAIR ROBERT DUNCAN: Well, thank you very much, and we appreciate the work, and appreciate you, like I said, responding to our questions in January, when we raised these. So thank you.

VICE CHAIR ROBERT DUNCAN: All right, with that we will transition to another one of my favorite topics, children and youth with special health care needs. As Linn and Ava make their way, I'll remind the Commissioners, in January we reviewed seven different recommendations. We asked the team to go back and look at this. And today they come back with some reframing of the language and adjusting, and we have moved from seven to potentially six recommendations, and they will walk us through. So our hope is to give them feedback on the language so they can prepare for the chapter.

So with that, Linn, Ava, take it away.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) TRANSITIONS TO ADULT COVERAGE: DRAFT RECOMMENDATIONS

* AVA WILLIAMS: All right. Good afternoon, Commissioners. Today Linn and I will be presenting our draft recommendations for children youth with special health care needs transitions of coverage.

I will start with a summary of key challenges with the transition from child to adult Medicaid. Then I will start the discussion of the draft recommendations, their rationales and implications, before handing it over to Linn who will finish presenting the draft recommendations before they end with next steps.

These challenges should look familiar as they are key challenges staff have already identified in previous meetings.

First, beneficiaries and their families may have insufficient time to prepare and respond to Medicaid redetermination notices.

There are no federal requirements around how far in advance states must send beneficiaries notices requesting additional information needed to complete their redetermination, and without advance notice, children and youth with special health care needs may not have enough time to submit needed documentation in order to maintain

their Medicaid coverage into adulthood.

Staff also found that there is a lack of clarity around the effect of the loss of Supplemental Security Income, or SSI, on a beneficiary's Medicaid eligibility from notices from the Social Security Administration, also known as SSA.

Next, many beneficiaries experience multiple transitions as they approach adulthood apart from the Medicaid redetermination such as 1915(c) waiver transitions and the age 18 SSI redetermination.

It can be difficult and overwhelming to navigate all of these transitions, and many beneficiaries churn or disenroll when they age out of child Medicaid eligibility.

Lastly, there is variation in the support beneficiaries and their families receive with the Medicaid redetermination process. Beneficiaries may not have a dedicated case manager or care coordinator to help them navigate the redetermination process, and of those who do, the support can still vary.

Next, we will present the draft recommendations meant to address these challenges.

This figure should also look familiar to you. It

shows which challenges the draft recommendations are meant to address. Staff revised the draft recommendations to reflect Commissioner feedback from the January meeting.

The first recommendation is intended to ensure beneficiaries and their families have sufficient advance notice of their Medicaid redetermination in order to prepare for the transition to adult Medicaid.

The minimum population of children and youth with special health care needs for this recommendation includes but is not limited to children who were enrolled in Medicaid through SSI related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett Pathway for children with disabilities, those eligible under the Tax, Equity, and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care. The population is the same for each recommendation.

Beneficiaries and their families need advance notice of the upcoming Medicaid redetermination. This notice should include what beneficiaries should expect from the redetermination process such as changes to eligibility

criteria for adult eligibility pathways as well as information and documentation they need to provide.

CMS should require states to send a notice informing children and youth with special health care needs that the renewal process has been initiated a minimum of 60 days in advance of the end of their eligibility period.

Additionally, based on Commissioner feedback, 60 days is meant to be a minimum, and states can send notices as early as feasible.

CMS would have to commit time and resources to issue guidance related to this new requirement.

States that do not already send beneficiaries notice of their upcoming redetermination may have increased administrative burden to identify these children and youth with special health care needs population and target notices.

Enrollees will receive advance notice and will have more time to prepare for their upcoming redetermination.

Plans may have fewer beneficiary disruptions of coverage and care, and lastly, providers and transition coordinators may have more advanced notice of the upcoming

redetermination.

The second recommendation is intended to ensure beneficiaries and their families have enough time to respond to requests for information in order to maintain Medicaid coverage as an adult.

The population of children and youth with special health care needs for this recommendation is the same as the previous one.

If a state is unable to complete an ex parte redetermination without additional information from the beneficiary, the state will send a notice requesting additional documentation. But it can be difficult for beneficiaries and their families to provide information in the required time frame. For example, beneficiaries may receive a notice too late to respond after the deadline or do not receive the notice at all. So states that do not already provide beneficiaries with a minimum of 30 days to respond to requests for information should implement this minimum response time. Similar to the last recommendation, 30 days is meant to be a minimum, and states can provide beneficiaries with more time if feasible.

There's no anticipated federal effect.

States will have some administrative burden to revise notice procedures to accommodate the-30 day response time. Enrollees will have more time to submit the required information in order to Medicaid coverage into adulthood. Plans may have fewer beneficiaries experience disruptions in coverage and care, and lastly, providers may have more time to send beneficiaries requested medical records.

Now I'll hand it over to Linn.

* LINN JENNINGS: Thanks, Ava.

So, moving to Recommendation 3. This recommendation is intended to ensure that beneficiaries receive notices from SSA about changes to their SSI eligibility and their SSI-related Medicaid eligibility that include easily understood and accurate information about how a loss of SSI could affect their Medicaid coverage.

In response to feedback at the January meeting, we've amended this recommendation to direct CMS to coordinate with SSA rather than having states coordinate direct SSA on reviewing and updating model language. So the model notice language should clearly and accurately indicate that the individual may retain their Medicaid coverage while the state Medicaid agency takes additional

steps to redetermine the individual on a new basis of eligibility.

Additionally, this model notice language should describe in general terms the steps individuals need to take to complete the Medicaid redetermination that are specific to 1634, SSI criteria, and 209(b) states.

When beneficiaries lose SSI, they receive a notice from SSA, not Medicaid -- state Medicaid agencies, about their SSI denial and information about the Medicaid eligibility.

In our interviews, we heard that the information beneficiaries receive from SSA about maintaining Medicaid coverage is sometimes unclear and doesn't explain the state Medicaid agency's general next steps for redetermining coverage and when the beneficiary's Medicaid eligibility may end. This can lead to beneficiary and family confusion about their Medicaid enrollment status and the steps they need to take to maintain coverage.

Currently, there are no federal Medicaid or SSA requirements for SSA and CMS to coordinate on the SSA notice language sent to beneficiaries who lose SSI. So, under this recommendation, CMS would coordinate with SSA to

review and develop model SSI notice language about how a loss of SSI affects Medicaid eligibility so beneficiaries are aware that Medicaid coverage is not immediately terminated.

In the development of this model notice language, CMS should seek input with states and advocates to ensure that the model language is accurate and understandable to Medicaid beneficiaries, and this model notice language should also include information pertinent to the type of Medicaid determination state.

So, for example, a 1634 state, SSI eligibility automatically confers Medicaid eligibility, and individuals who have SSI are not required to apply to Medicaid separately. So the model notice language for 1634 states should specify that Medicaid eligibility is no longer automatic and individuals now have to directly communicate with the state Medicaid agency on issues regarding their Medicaid coverage.

For implications, CMS would have to commit time and resources to review and update SSA notice language. For states, they may need to provide input on notice language to ensure that the accurate and clarify the effect

of a loss of SSI on Medicaid coverage. For beneficiaries, they may better understand the effect of losing SSI on Medicaid eligibility and the steps that they need to take to remain Medicaid-covered.

For plans and providers, to the extent that improved notice language eases the beneficiary's Medicaid redetermination process and continuity of coverage as an adult, plans and providers may have fewer beneficiaries experiencing disruptions in coverage and care.

So, under Recommendation 4, this recommendation is intended to address disenrollment among children and youth with special health care needs during their transition to adult Medicaid and improve coverage stability during this transition to adulthood. This recommendation directs state Medicaid agencies to implement the state plan option to provide Medicaid up to age 21 for children. And in response to feedback last month, we've clarified that states should implement this option for, at minimum, children and youth with special health care needs who are not eligible or enrolled in any other mandatory or optional pathway.

Our findings suggest that about 17.6 percent of

children and youth with special health care needs are disenrolling or churn when they are transitioning to adult coverage, and this can result in a disruption of coverage and care.

Research has also shown that there are financial implications related to coverage disruptions and policies that do aim to reduce it.

A number of studies have found that churning may increase overall Medicaid costs for beneficiaries of all ages due to pent-up demand for care and increased emergency department utilization after gaps in coverage.

Additionally, studies have shown that churn can lead to increases in state Medicaid agency administrative costs due to additional redeterminations and renewals.

On the other hand, policies to reduce churn, such as providing 12-month continuous coverage or to continuous eligibility to children, has also been shown to increase federal and state costs because of increased enrollment and potentially covering individuals who are no longer covered for Medicaid -- or eligible for Medicaid.

So, based on our findings in the literature, there's strong evidence that extending child Medicaid

eligibility up to age 21 and delaying this transition to adult Medicaid may ease the coverage transition for beneficiaries and families by giving them more time to complete the multiple program transitions that they're navigating during this time and improve coverage stability while they're transitioning to adulthood.

So, under this recommendation, we direct states to implement the state optional pathway to extend child Medicaid eligibility up to age 21 for individuals who are not eligible for another mandatory or optional pathway.

States have a number of flexibilities in designing this pathway, and so, in implementation, the state should consider their targeted population. For children and youth with special health care needs, if it goes up to age 20 or 21, and the household income limit and range.

In the examples, there are four states that have implemented this pathway, and they've taken a few different approaches with this. So, for states that are expansion states, individuals can only be eligible for this pathway if their income exceeds that of the upper limit of the expansion pathway for adults. So their base income starts

at 133 percent, and then all three of the expansion states have a different upper income limit.

So, for the implications, CMS would have to commit time and resource to reviewing state plan amendments. For states, they have flexibility to determine the eligibility criteria for this optional pathway, and the state's budget implications are dependent on how broadly or narrowly a state decides to define these criteria.

For beneficiaries who would otherwise disenroll at 19, because they are not eligible for any other mandatory or state optional pathway, this would be an additional pathway that they could potentially allow them to remain enrolled if they meet that criteria.

For plans and providers, to the extent that the states choose to implement this option, plans and providers may have fewer beneficiaries experiencing disruptions in coverage and care.

For Recommendation 5, this is intended to ensure that children and youth with special health care needs receive a full 12-month continuous eligibility period in their final year of child Medicaid eligibility and potentially reduce the risk of disenrollment due to being

redetermined more than once during this final -- or during this transition period.

So, in response to feedback last month, we made a few changes that are reflected in the draft language. This recommendation directs Congress to amend section 1902(e)(12) to require states to provide children and youth with special health care needs with a continuous eligibility period that lasts 12 months from the date of the eligibility determination. And the full 12-month CE period applies to beneficiaries who receive coverage from either a mandatory or optional state child eligibility pathway.

So this recommendation is broader than the policy option presented in January because it ensures that if a state has an optional child eligibility pathway, as the one described in Recommendation 4, the state would be required to provide 12 months' continuous eligibility to beneficiaries covered under that pathway as well.

Beginning in 2024, states are required to provide 12-month continuous eligibility for all children under age 19, and that requirement ends when the individual attains 19. Congress made this CE policy mandatory in response to

research that shows that continuous eligibility can reduce rates of churn and improve access to short- and long-term health outcomes for children.

Research shows that Medicaid disenrollment is greatest for youth between ages 18 and 19 due to a number of reasons, including that beneficiaries and families experience administrative barriers with the redetermination and are navigating multiple simultaneous program transitions.

As one of the ways to address disenrollment and churn among children and youth with special health care needs as they transition to adulthood, Congress should amend the 12-month CE requirement for children and youth with special health care needs in two ways.

First, the CE requirement should tie the end of the 12-month CE period to the end of the eligibility pathway's upper age limit to account for some state extension of coverage to ages above 18, and this change would ensure that if children and youth with special health care needs are covered under a state plan, a state optional pathway that provides coverage up to age 21, that those beneficiaries would continue to receive 12-month CE for the

entire period.

Second, the CE requirement should be amended so beneficiaries receive the full 12-month CE, even if that CE period extends beyond the eligibility pathway's upper age limit, rather than having the CE period end when an individual attains the eligibility period's upper age limit, meaning that if an individual is in a pathway that ends at age 19, when they turn 19, their eligibility period would go through the end of their 12-month CE period rather than ending at 19.

This change would reduce beneficiary and family burden with completing multiple redeterminations in this final 12-month period leading up to them aging out of child Medicaid.

So, for the federal implications, providing 12-month CE through the end of the child's eligibility pathway's upper age limit would increase the number of months of continuous coverage. Additionally, CMS would have to commit more time and resources to issuing rules.

For states, this will directly affect state Medicaid agencies, as states would be required to provide children and youth with special health care needs with 12-

month CE through the end of the child's eligibility pathway upper age limit.

For beneficiaries, families, and caregivers, they may experience a decrease in administrative burden in the final 12 months to aging out of child Medicaid by only having to go through Medicaid redetermination one time.

Additionally, for those under a state optional pathway that extends Medicaid coverage for individuals up to age 20 or 21, they would now also receive the 12-month CE through the end of the eligibility pathway's upper age limit.

For plans and providers, to the extent that this improves continuity of coverage during this transition period, plans and providers may have beneficiaries experiencing fewer disruptions in coverage and care.

Under Recommendation 6, this recommendation is intended to ensure that states understand how existing authorities can be used to support children and youth with special health care needs with their transition to adult Medicaid coverage.

So, in January, we presented two policy options to CMS for issuing guidance related to existing state

authorities, and we've combined these options into one recommendation.

So this recommendation directs CMS to issue guidance to states on existing authorities for supporting children and youth with special health care needs with Medicaid redeterminations and transitioning to adult Medicaid coverage.

Currently, there's no CMS guidance on existing authorities supporting children and youth with special health care needs with their Medicaid redetermination and transition to adult Medicaid coverage. National experts and national- and state-level advocates share that many children and youth with special health care needs would benefit from having a dedicated case manager or care coordinator to ease the transition to adult Medicaid.

CMS should issue guidance on existing optional authorities to support this transition, including existing authorities that can be used to provide children and youth with special health care needs, a dedicated case manager or care coordinator, such as targeted case management or through a 1915(c) HCBS waiver, specify transition planning procedures and child-only 1915(c) HCBS waivers that are

related to supporting beneficiaries and their families through the Medicaid redetermination process, and the state optional pathway to extend child eligibility up to age 21.

So CMS would have to commit time and resources to issuing guidance. For states, they will have greater clarity on the available existing authorities to support children and youth with special health care needs transitioning to adult Medicaid. For beneficiaries, families, and caregivers, they may experience improved support during this transition. For plans, they may need to develop payment policy or guidance for providers to support the implementation of some of these authorities, and then for providers, they may engage in supporting children and youth with special health care needs with the transition to adult Medicaid.

So we'd appreciate your feedback on these draft recommendations, rationale, and implications, and which recommendations you would like to advance for a vote at the April meeting. These six recommendations are complementary efforts to improve the transition to adult coverage, but they could also stand on their own. Additionally, we'd appreciate any feedback you have on particular points or

findings that we've shared over the last few months that should be emphasized in the chapter.

So, for this discussion today, we've included some questions on this slide, and I'll turn it back to the Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Linn. Thank you, Ava. Again, continue to work, appreciate you taking some of our feedback last, and again, in January. I wanted to say last month.

So, fellow Commissioners, as they've laid out, they took some of the requests we made and input and have tried to rework that into the recommendations and like to hear your thoughts and comments, both on the language and implications and anything else.

With that, I go to Patti.

COMMISSIONER PATTI KILLINGSWORTH: Ava and Linn, thank you.

I don't think there's a topic that I'm more passionate about personally or that I'm more conflicted about as a Commissioner than this one, and so I want to explain why I'm conflicted a bit.

I want to start by sort of parsing out what we

set out to do with the project, which I think is to look at transitions to adult coverage, right? That's sort of what we set out to do, and the goal was to make sure that kids who were eligible for Medicaid and continue to be eligible for Medicaid as adults didn't get lost in the transition process, right?

I think you've laid out some great policy options that make progress in that regard, allowing more advanced notice, allowing more time to respond, providing support to them during the process, right? All of those things that I think really help to get to some of those procedural pieces I think are steps in the right direction.

In my perfect world, children and youth with special health care needs would transition seamlessly into adult Medicaid eligibility categories and continue to have access to all of the benefits that they need to support them as adults. We don't live in a perfect world, and what I'm struggling with is we've kind of moved beyond the bounds of our stated project goals to some recommendations that are really about creating eligibility where there is none, right? We're creating optional eligibility pathways or continuous eligibility that allow kids that we're sort

of acknowledging are not going to continue to be eligible adults. We're just going to keep them on the program longer, and then they're going to go through the same thing that they were going to go through anyway, which is this disenrollment.

Not to minimize the value of 12 more months of coverage, right? If you are the parent of a child with special health care needs, you want that kid to have the best coverage they can for as long as they can. But I'm struggling in the current budgetary environment to direct states to implement optional eligibility pathways at the same time that we're telling them to cut hundreds of millions or billions of dollars from their state Medicaid budgets.

It feels like we're not paying attention, I think, to the fiscal environment within which we are. So I'm struggling with sort of the ideal policy state and the fiscal realities of where we are, and I'm wondering if we've pressed a little bit beyond the scope of our original stated goals in an effort and good, good desire to keep coverage for these kids.

So I'm not exactly sure how I would vote yet on

all of the recommendations. I can tell you that one, two, three, and six, I'm good. Four and five, from a pure sort of policy perspective, I think they're good policy. I'm not sure that I'm comfortable, especially with the optional, with directing states to do something with respect to an optional. It feels like we're telling them how to structure their Medicaid programs in a time where they're making really hard choices about who they cover, what they cover, and how they pay for it. And I'm not sure that I could support that.

Thank you.

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

Any other feedback from any of the Commissioners?

Mike?

COMMISSIONER MICHAEL NARDONE: I was going to say that, you know, I have some of the similar concerns that Patti has. I know that -- I know, though, that we are going through a process.

First of all, I want to thank you for this work, and say I think I've been struggling, because as I look at, you know, children and youth with special health care

needs, these are some of the most, you know, challenging cases. We should be figuring out, like, how do they continue to get coverage. It eliminates churn. You know, it does potentially save money to the system. I think we need to be able to make that case, right?

And I think one of the things I talked about last time, I think -- I can't remember, but I think we talked about, you know, trying to get some sort of analysis of, like, what's the fiscal impact, and, you know, how many people are really impacted by this policy, because I think it's, like, probably a relatively small number and can be, you know, justified by, you know, kind of the fact that it is a relatively small number. And targeting these services to these kids, you know, really can, you know, be kind of budget-neutral, right? I don't know that that will be the answer, but I, you know -- or that it's an investment that we think is worth making, knowing full well what that investment is.

You know, I do kind of also share the concern that, you know, at a time when I think states will be facing, you know, some real fiscal issues going forward with H.R. 1, that, you know, the direction, the languages

states should, --you know, I think states are going to really be struggling with what are the optional services that they cover, like, what are the changes that they need to make to their Medicaid program to adopt to the changing world, and is this the thing -- is this what -- is this where they put their money?

So I think we're going to really have to make, I think, a really strong case in the narrative, and, you know, I think we need to go full -- I think we have to go with our eyes wide open on what this policy means.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike.

We've got April, John, then Doug.

COMMISSIONER APRIL HARTMAN: Thank you.

I just -- I guess when I think about this, I think about a lot of the kids that I take care of in our complex care clinic, and these are the kids that are transitioning out, right? As a pediatrician, number one, it is hard to find an adult doctor that will take care of them. That takes a while, and then there's so many other things happening. Now that they're turning 18, the parents often have to go to court to make sure that they can stay as the one who's making decisions, that they're unable to

make decisions for themselves, that there's a lot of things happening with a lot of these kids that have these special health care needs. These are not just your run-of-the-mill regular kids. These are kids that have a lot of health issues, and if they lose their insurance, they show up at the ED. They show up places where you don't want them to be seen because it's not that continuity of care.

I think that I'm very supportive of extending some services, go through some of the other transitions that are happening at 18, just to kind of help those families get things straight and they're not losing their insurance during that time. I think that is going to be an important piece of this, just from the provider and patient point of view, just because there is so much that has to happen as some of those other things kick in at that 18-year-old, when they're supposed to be an adult and able to take care of themselves but not able to do that.

And so just kind of keeping in mind that it's a really hard time for a lot of other things that are happening. It's not just health care that's changing at that time, and shifting from pediatric care to adult care is no small task.

VICE CHAIR ROBERT DUNCAN: Thank you, April.

John, then Doug.

COMMISSIONER JOHN McCARTHY: I agree with Patti and Mike on this one and the comments they had.

I think one of the things that has come up a couple of times when we talked about this topic -- there's two pieces, right? There's the transition. It's eligibility. So if you lose your eligibility, there's no transition. But I think there's a little bit of what we need to keep focused on transition too.

But I want to come back to last month when you all presented the data to us. I thought we brought it up then. But when you look at the data and you look at some of the states that have really high percentages of people maintaining their eligibility, then you have some states that have very low numbers, what I was hoping for is that we could do a deeper dive on some of those states with the high numbers to find out what are they doing and being able to hopefully find something in there that's common. We could do some recommendations around that.

Likewise, for the states that have very low numbers, what is going on there that we could have

recommendations of -- I shouldn't say recommendations, but learn better what not to do.

And I know you presented, Ava and Linn, three columns in this one, which is just the remain covered without aging out, and then that's disenrolled and then re-enrolled within 12 months. So I don't know if that's a good number or a bad number, because obviously somebody lost continuity of coverage.

Then the last one was disenrolled and don't enroll within 12 months. So you would assume that means that they were no longer eligible. I think Patti brought that up. That's just the case. So that's a part of trying to figure it out.

There's one state I'm looking at here right now where that number is 21 percent, where they do not re-enroll in 12 months. And the number that stay covered is 74 percent, and 4 percent re-enroll within 12 months. So you could see that 4 percent could be a problem. But is that 21 percent a bad number or a good number, or they don't qualify in that state any longer? So, again, what does that transition look like for those kids?

I appreciate all the work you're doing, but I was

just really hoping we get a little bit more in this area for the recommendations of whether operationally, what are some of these states doing that are better than other states. Thanks.

VICE CHAIR ROBERT DUNCAN: Thanks, John.

Doug.

COMMISSIONER DOUG BROWN: I'm also struggling in the same way Patti is struggling with this. I can certainly get behind recommendations one, two, and three. The other ones, I need to contemplate further.

I think one of the comments I made previously was I'd love to see that we cover this group up to age 21 across the board. I think that's a future aspirational goal, given the other comments around financial conditions and the contractions that's going to go on in the Medicaid space. I still would love to see that, but I'm not sure that it is reasonable at this point to kind of push forward with that as a recommendation at this time.

So thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Doug.

Jenny, then Heidi.

COMMISSIONER JENNIFER GERSTORFF: Around that

topic, I think I disagree with my fellow Commissioners on pushing forward in a system right now where we're cutting. I completely understand, and I feel that, but when I'm voting on the recommendations, I will be thinking of future conditions, so not necessarily where we are right now.

If these are going to be good policy, then I think we should recommend them, even if right now is not the right budget season to be doing that. If we don't recommend them, they're just lost forever, potentially. But if we recommend them and in 10 years, the budget situation is better, more under control, then they can resurrect with a recommendation that's already been made.

VICE CHAIR ROBERT DUNCAN: Thank you, Jenny. I appreciate that. That's what I was wrestling with in my head around good policy or not good policy, so thank you.

With that, we'll go to Heidi, then Angelo.

COMMISSIONER HEIDI ALLEN: So I agree with Jenny, and I just want to say that we make our recommendations to Congress. We just say what we think is the best policy, and we recommend that Congress, and then Congress decides what they want to do with that and whether or not they think it's worth telling CMS to do something.

So I feel like, in some ways, we can always just make the recommendations. It's based on the best interest of the people that we're serving and expect that the political process will take care of itself in deciding the rest of it. So that's my thoughts.

VICE CHAIR ROBERT DUNCAN: Okay. Angelo, then Ann.

COMMISSIONER ANGELO GIARDINO: Yeah. First, thank you for taking this on. It's really a complicated bowl of wax, so thanks for helping us.

I guess where I'm trying to make sense of is this is a very vulnerable group. None of the information you've presented in the many months we've looked at this has said that their needs changed. It's just that they're getting older, and then they're not eligible. So you're trying to create a bridge to something.

Transitioning from programs and losing eligibility and getting eligibility and then having all the variation among the states, I would just say the policy directive needs to be the longer you can keep these kids covered, the more likely people can come up alongside of them and help them find out what the next destination is.

So I'm not an elected official. So I don't have to deal with all of the prioritization, because that's why we elect people. So what we're supposed to say is what the policy needs to be so that there's a longer bridge.

What I know in taking care of people that are transitioning, the more time they have, the more likely they are to find a good destination. The shorter time they have, the more likely that it's going to be disruptive. And for a kid with special health care needs, if their care plan is disruptive, they have serious conditions. That's why they had all this eligibility and coverage before.

They haven't become people that don't have special needs. So they need a longer bridge, and the more time they have, the more likely people will come up alongside of them and their families and help them find the next destination.

So I support all the recommendations, and I think the longer we can give them, the more likely they'll find what the next step is, because their needs haven't gone away.

So thank you for doing this work.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo.

Anne.

COMMISSIONER ANNE KARL: So I appreciate all the comments from the Commissioners. I do think that this -- all the questions people are raising are really interesting and challenging.

I want to -- just much more specific question, thing that I've been grappling with is, on Recommendation No. 5, where it talks about the continuous eligibility period lasting 12 months, I was just thinking about the equity implications about -- let's say that there's a state that extends eligibility to age 20. If there's somebody who gets redetermined two days after they turn 19, they're basically going to get cut off right when they turn 20, maybe they get two days later. Whereas if you get someone who gets redetermined, just kind of luck of the draw, two days before they turn 20, they basically get coverage until they're almost 21.

So I was just wondering -- I was sort of thinking to myself, like, are people going to be trying to game, when do they get their redetermination, because it basically buys them an extra year of coverage? So I just wanted to put that out there, that that seemed like one

implication that wasn't lifted up of the CE period and just the fact that it would create this sort of, like, random bits of unfairness across different people.

VICE CHAIR ROBERT DUNCAN: Thank you, Anne.

Any other Commissioners with comments, concerns, or issues?

Yes, Sonja.

COMMISSIONER SONJA BJORK: There's a pretty big cost associated with the churn when people fall off eligibility. They're going to end up back on. In the meantime, they didn't get the care they needed, like April pointed out, and then things could have deteriorated, and they end in the ER.

I used to be an attorney for youth in foster care, and I saw that happen a couple times. Sure enough, they did get eligible again, but in the meantime, a lot of really difficult situations that cost the whole system, a lot of extra dollars arose, much less the personal implications for the child. It's a pretty scary time trying to find adult doctors that take care of these complex medical conditions, and everybody cares so much about kids.

Then when they become what we all consider an adult, oh, okay, they're not in the popular category anymore to get enough attention, and so I support all of the recommendations. And I would just like to see a little attention. I know we've looked in the past at how much churn costs, but I think when you weigh out these things, you can see that it's really important to maintain coverage for this population.

We're not asking for a change for everybody across the potential populations that are covered by Medicaid. We're asking in particular for this population, because of their medical needs, and so I just wanted to make sure that we looked at that a little bit as well.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Sonja.

I want to echo; I appreciated Commissioner Hartman's comments. Being a parent who has made this transition twice with kids, it is difficult, and there are a lot more nuances taking place besides facing this and weighing that in. So I appreciate Commissioner Hartman's comments as well.

So, Linn, Ava, do you feel like you have enough

to get us to the next step?

LINN JENNINGS: Yeah. This has been very helpful and helpful to hear all sorts of different elements to really emphasize in the chapter, so we appreciate it.

VICE CHAIR ROBERT DUNCAN: Oh, excuse me. We've got Commissioner Angelo.

COMMISSIONER ANGELO GIARDINO: I guess one thing that might be helpful, if you could just perhaps help us think this through in the next time we talk about it. But, at the state level, when these kids, if we kind of shorten the bridge and just let what happens happen because we don't want to make the bridge longer, having had responsibility for public hospitals in the past, when these kids are -- their care is disrupted and they end up in the public system, the state and the county will pay for them. But that state and county that apparently, we're forcing to have more Medicaid, the state and the county will pay for this care. It won't be in the Medicaid program, but there will be a cost, and the public will shoulder that cost, and it will be higher because they didn't have coordinated care under the Medicaid program.

So I just want to dissuade everyone from thinking

that you're letting the state save money by not extending the care. The state and the county will pay for the public hospitals that take care of these kids. So if you could help us get an insight into how much that costs the state by not having a bigger bridge, that would be helpful.

Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo.

All right. Seeing none other, you've got your work cut out for you. Linn, Ava, appreciate it. Thank you so much.

Madam Chair, I turn it over to you for public comment.

CHAIR VERLON JOHNSON: All right. Thank you. It was a great conversation. Lots of information.

All right. So we are now going to open the floor for public comment. We invite all of you in the audience to raise your hand if you'd like to offer comments, and always remember to introduce yourself as well as the organization you represent. We also ask that you keep your comments to three minutes or less.

So first up is Peggy McManus. The floor is yours.

PUBLIC COMMENT

* [Pause.]

CHAIR VERLON JOHNSON: Peggy, you're okay to speak. Peggy, can you unmute yourself if you're speaking?

[Pause.]

CHAIR VERLON JOHNSON: All right. So we will come back. She may be having technical difficulties.

Let's go to the next person, which is Lynn Lewis. The floor is yours.

LYNN LEWIS: Yes, I'm Lynn Lewis. I'm an independent consultant. I advise consumers and families and business in terms of when they make health care decisions in terms of what kind of insurance they need, they can qualify to, ,and what their eligibilities are.

In terms of the Medicaid conversation, I often see right now the system from federal level as well as the state level are not integrated in the sense quite often like the recommendation is to extend the Medicaid offering to age 21 under the ACA coverage. Any person become 18 or older, they can qualify for additional coverage. So in terms of if they are still maintaining on Medicaid coverage, there's a conflict in terms of which coverage

they are eligible to.

The other question right now from the legislative point of view is CMS has not really integrated the data to determine their eligibility based on the income in terms of Medicaid or ACA or Medicare coverage. So we are proposing to CMS to make changes in terms of how to integrate in different platforms to make eligibility timely determination so people would not fill in the gaps of without coverage.

The other encouraging news is this morning we had a hearing in the Senate presented by CMS, Dr. Thomas Keane, to testify in terms of new technology, how to integrate in different platforms to make progress on current policy process there to make it easy and accessible.

That's all.

CHAIR VERLON JOHNSON: Thank you so much for your comment.

I will go back to Peggy McManus.

[Pause.]

CHAIR VERLON JOHNSON: Okay. All right. Any other comments? Let's see.

[No response.]

CHAIR VERLON JOHNSON: All right. Well, thank you for the earlier comment, and I also want to remind all of you that if you have additional comments, feel free to submit those to the MACPAC website.

And now we will go on break until 3:15 Eastern time. Thank you.

* [Recess.]

CHAIR VERLON JOHNSON: Welcome back. We are now going to turn our attention to PACE. We had a lot of conversations around it in the past, and I think we are going to talk about interview findings right now. Brian and Michelle, I will give it over to you.

EXPLORING THE ROLE OF THE STATE MEDICAID AGENCY IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE): INTERVIEW FINDINGS

* BRIAN O'GARA: Thank you, and good afternoon, Commissioners. Today Michelle and I will be presenting findings from our interviews on the role of the state Medicaid agency in the Program of All-Inclusive Care for the Elderly, or PACE model.

We'll begin with the briefest of backgrounds on this work. We'll discuss key takeaways in five areas from

our interviews, and then we'll end with next steps for this work.

In January, Michelle and I were here virtually, and we presented findings from a review of three key federal and state documents that govern PACE, both federal and state oversight, including the required three-way program agreements between CMS, states, and PACE organizations; optional two-way program agreements between states and PACE organizations; and requests submitted by PACE organizations under Section 903 of the Medicare and Medicaid and CHIP Benefits Improvement and Protection Act of 2000, also known as BIPA 903 waivers. This was the first phase of our new work examining the role of the state Medicaid agency in overseeing PACE organizations, and today's presentation will cover the interview findings associated with this new work.

While the review of these documents provided many insights, federal regulations and policy guidance, including these documents we reviewed, generally do not specify how CMS and states should collaborate in oversight activities or provide detailed guidance on how states should carry out oversight.

To understand more about how states define and implement their oversight roles and to identify areas of overlap or gaps in oversight we spoke with state officials and one state PACE association across six states, as well as federal stakeholders from CMS, the National PACE Association, and an independent PACE expert. And these interview protocols were designed to build on the document scan that we conducted and presented in January. The interviews explored how states interpret their role of overseeing PACE organizations, conduct ongoing oversight, and decide whether or not to use specific tools for oversight, such as the two-way program agreements.

The interviews were also designed to address gaps left by our document scan, including how states monitor PACE for performance and quality, and ambiguity in the federal-state division of oversight responsibilities.

Congress, when it permanently authorized PACE, assigned several roles to state administering agencies in terms of oversight, and these are primarily framed as joint federal and state responsibilities. These state oversight functions are implemented through federal regulations at 42 CFR 460, ongoing CMS rulemaking, typically through annual

Medicare Advantage and Part D rules, and required three-way program agreements.

States have broad authority to access provider data and records, including financial, medical, and personnel information, and they can also request reports from PACE organizations.

CMS is statutorily required to conduct both trial period and ongoing audits in cooperation with the states, including on-site visits, fiscal and capacity assessments, and compliance reviews. And independently, states may terminate PACE program agreements for significant quality deficiencies or substantial noncompliance, and can work with CMS to require corrective action plans or withhold payments.

Importantly, all of the interviews that we spoke with agreed that states have the sufficient statutory authority to oversee PACE organizations. What we found is that states, of course, interpret and implement these oversight functions in different ways.

Officials from two of the states that we spoke with described their roles narrowly, emphasizing oversight as a partnership with CMS and focusing primarily on

monitoring for compliance to federal requirements, through tasks such as coordinating audit schedules with CMS, participating in joint calls, reviewing information submitted to the Health Plan Management System, or HPMS, and conducting compliance checks in order to avoid duplication of federal activities.

In contrast, officials from the four other states described a broader and more proactive oversight role, which they fulfilled by conducting independent audits and readiness reviews, investigating complaints, overseeing contract deliverables such as appeals and marketing materials, and managing Medicaid payment processes. Several officials in these states emphasized monitoring for PACE performance and quality in addition to compliance, including tracking participant outcomes, reviewing corrective action plans, and implementing value-based payment reporting systems.

Some of these states described their oversight responsibilities as distinct from and complementary to CMS activities, citing concerns that federal audits, particularly after the initial three-year trial period, may not occur frequently enough to ensure ongoing program

integrity.

Federal officials we spoke with emphasized that states determine their own oversight role and priorities, and when we asked about the federal role in ensuring that states carry out state-specific responsibilities, federal officials shared that they confirmed the existence of required state processes in the three-way program agreement but did not describe evaluating how states implement these required processes or how effectively they function in practice.

States also assigned different agencies to administer and oversee PACE, which may shape how oversight activities are organized and implemented from state to state. Among the six states we spoke with, three of them designated the Medicaid agency as the lead administering agency, while the other half assigned this role to the Department of Aging.

States reported using a variety of tools to oversee PACE organizations. Among the six states we interviewed, three reported using these two-way program agreements. Officials found that the two-way program agreements valuable because they allowed a state to include

state-specific contractual requirements beyond the standard three-way program agreement and fellow regulations, which they said helps provide more explicit compliance standards, strengthens the state's authority when issuing findings, and offers clear guidance to PACE organizations on required corrective actions.

Officials in the two states that we spoke with that do not use two-way program agreements generally considered them redundant with requirements already covered in federal regulations and the three-way program agreement. And state interviewees did not identify BIPA 903 waivers as having a significant impact on their oversight responsibilities or activities.

State officials also reported a variety of tools other than two-way and three-way program agreements to conduct oversight and monitoring of PACE organizations. Some examples include state-specific audit tools to collect data, policy letters to communicate state requirements, and clinical coverage policies developed for various Medicaid provider types. All of the states that we spoke with also used state regulations and licensing requirements to support PACE oversight efforts.

Five of the states include enforcement actions in their oversight approach, such as enrollment restrictions or fiscal penalties, though these tools appear to be used rather infrequently.

Finally, officials from all six states reported using data submitted by PACE organizations to HPMS as part of their monitoring processes. PACE organizations have to collect and submit quality reporting data to CMS on a quarterly basis. States can request access to relevant HPMS modules, and generally review the data during quarterly CMS-led meetings with PACE organizations, though federal officials indicated uncertainty about how many states regularly access these data modules and how the data is used for oversight responsibilities at the state level.

And with that I will turn it to Michelle who will speak more about HPMS and measuring quality.

MICHELLE CONWAY: Thanks, Brian. As Brian mentioned, PACE organizations report a variety of quality data to CMS in accordance with federal requirements. This reporting includes information on enrollment, appeals and grievances, falls, immunizations, ED visits, and other critical incidents like abuse, adverse drug reactions, and

infectious disease outbreaks. The reporting is specific to PACE organizations and does not include any standardized quality measures, and the data are also not released publicly.

Outside of federal requirements, states that participated in our interviews took a variety of approaches to measuring quality and outcomes in PACE. All the states we interviewed collect some level of quality or performance data from PACE organizations.

Four of the interviewed states require reporting on participant satisfaction, which PACE organizations commonly evaluate using the Integrated Satisfaction Measurement for PACE, or I-SAT, tool. A PACE provider association estimated that about 95 percent of PACE organizations use the I-SAT to collect data on participant satisfaction.

Previous interviews with state and federal officials revealed that participant satisfaction survey results are not routinely shared with CMS, although CMS may review these survey results as part of quality improvement discussions with PACE organizations.

One state we interviewed has a more comprehensive

quality strategy for its PACE organizations, including a value-based payment program to incentivize performance improvement. Another state uses a portal for PACE organizations to submit quality data on a quarterly basis, in addition to the federal reporting requirements, including data on immunizations, ED visits, hospital admissions, falls, and demographics. While the state noted that some of these metrics overlap with the data PACE organizations submit to CMS, the state said it is tracking them in greater detail.

Interviewees also noted that some states require PACE organizations to submit a variety of data to a PACE provider association data system. The quality measure domains in this system include voluntary disenrollments, ED visits, fall rates, death rates, immunizations, and hospital admissions, so again, some overlap there.

Several states highlighted limitations to their ability to measure PACE organization performance and participant outcomes. For example, the state that implemented a more comprehensive quality program noted that current state budget constraints and limited access to data have prevented the state from fully implementing its

program. Another state mentioned challenges identifying standard quality performance and outcome measures for PACE organizations, and requested CMS's assistance developing standardized national PACE quality measures.

A national expert noted that there are some opportunities available and data already collected. For example, the interviewee noted that standardized assessments like the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based, or HCBS CAHPS, Survey, or the I-SAT, could provide meaningful insights into PACE participant experience and quality, although the small number of PACE participants created challenge with data collection.

In our interviews with state officials, we found that states that focused more on monitoring compliance than on assessing performance are less likely to report concerns with capacity limitations. Of the six states interviewed, three reported adequate staffing capacity and bandwidth for overseeing and monitoring PACE organizations. In contrast, three states mentioned concerns with limited state resources, especially with rapid growth in the number of PACE organizations and increases in PACE enrollment in

their states.

The variation in oversight capacity for states reflects different perspectives of states' roles and responsibilities for oversight and monitoring. The three states that noted concerns with state capacity also reported that they monitored the performance of PACE organizations as well as their compliance compared to some other states that tend to focus more on monitoring compliance only.

Additionally, states with more and newer PACE organizations tended to report more constraints on available resources and capacity for oversight. One state in particular with capacity concerns noted that it is pausing its review of applications for new PACE organizations or service area expansions for the next two years. The state noted that it had also requested that CMS implement stricter federal application guidelines for new PACE organizations and service area expansions, to close loopholes that have allowed some organizations to submit multiple simultaneous applications to a state. During this pause, the state is also considering opportunities to include PACE oversight with its larger oversight approach

for other integrated models, including D-SNPs.

Some interviewees other than federal officials noted what they saw as limited federal capacity for oversight of PACE organizations beyond the initial three-year trial period. A PACE provider association mentioned that federal oversight tends to focus on monitoring during the trial period, and that CMS seems to have less capacity to conduct longer term oversight. A state official suggested that CMS does not have the budget to do on-site monitoring beyond the trial period, and therefore relies on states to do longer term monitoring.

Federal officials noted that CMS resources play a role in their risk assessment process for determining when to audit PACE organizations after the three-year trial period.

State and federal officials all highlighted the collaborative relationship between CMS and states in conducting oversight and monitoring of PACE organizations. For example, all agreed on the utility of the quarterly and monthly calls that CMS holds with states and PACE organizations.

However, several interviewees also identified

opportunities to improve coordination of oversight, particularly with state and federal audit processes. Several states noted that before the COVID-19 pandemic, states regularly participated in CMS audits of PACE organizations. However, state and federal officials reported that federal audits are now conducted with more limit state involvement. One state reported that CMS does not invite the state to participate in federal audits beyond being informed of the timing of the audit and potentially participating in a few calls during the process. However, another state noted that it attends and participates in CMS trial period audits, sitting in on daily calls with PACE organizations in which CMS auditors review documentation and findings.

Federal and state officials also mentioned that states can review a summary of CMS audit findings. Federal officials noted that CMS invites states to participate in key discussions in their audit process, but says that states do not invite CMS to participate in state audit activities.

Though CMS encourages states not to duplicate CMS audits, interviewees said there is often overlap. Some

states noted that information and data collected as part of their own state audit processes replicates part of the federal audit process, and the PACE association also commented that states regularly audit some similar aspects of PACE operations that overlap with federal audits, including level of care assessments, grievance, and serious disciplinary reports.

Some states suggested that there could be more of an opportunity to partner with federal officials to conduct audits together or better coordinate or align the audit processes.

Federal officials confirmed that CMS conducts three annual audits of PACE organizations during the trial period. After that three-year trial period, CMS audits PACE organizations based on a risk assessment, as I mentioned on the previous slide, that includes a variety of factors such as enrollment, past audit results, and CMS capacity and resources.

State officials noted there has been a decline in the frequency of CMS audits beyond the trial period, with two states noting that there had been no CMS audits of PACE organizations in their states for several years.

Outside of audits, one state commented on a need for better data sharing from CMS, saying it was a challenge to assess these organizations' financial stability without Medicare data sharing, for example.

Finally, a PACE provider association suggested that additional state and federal technical assistance could help PACE organizations shift to a more proactive approach to oversight.

Turning now to next steps, we will return in April with policy options, and we will end here with some questions to start our discussion. Thank you.

CHAIR VERLON JOHNSON: All right. So that was really helpful. PACE is a topic we have been talking about for a little bit here. I think what really stood out to me in the conversation is how states carry out their oversight role. It seems like some of it is collaborative, some of it is hands-on, some of it is more capacity limited. So we'd really like to learn a little bit more about that one.

But with that let me turn it over to my fellow Commissioners to see what questions or thoughts they have. All right, John, you are up.

COMMISSIONER JOHN MCCARTHY: I was just looking

at some of the PACE numbers, and I was wondering if the reason, in your interviews, you had some of those disconnects between states and the feds is because of how few people are enrolled in PACE in certain states. So for instance, I was just looking, ATI did a report recently. D.C. has one PACE site with 56 people in it. So like I wouldn't be shocked if there was not coordination. Whereas California has got 26,000. I know Mike and I have had this conversation. Pennsylvania is a pretty big PACE state. They have got 8,000 people.

Was there anything that you saw in there that's like larger states with larger populations have more coordination or less coordination with the federal government on this?

BRIAN O'GARA: I don't think we heard anything strictly related to the size of the PACE population. I think some of the states we spoke with, with larger populations, maybe tend to take a more performance and quality-based approach to oversight. But I don't want to say that's a rule of thumb.

What we did hear, I think, from some of the states with larger PACE populations was, of course, the

issue of capacity and demands. But I don't think anything specific to their relationship with CMS, no.

COMMISSIONER JOHN MCCARTHY: And let me make clear. I'm not against quality in PACE. We definitely need to do it. But if you look at the total picture of basically 86,000 people enrolled in PACE program in the United States, and we've got 68.8 million people enrolled in Medicaid, and with CHIP it's like 70-some, this is a tiny population we're looking at here.

I think the one thing that I was -- not the one thing; there are many things that you brought up that are really good points. But the lack of coordination on those audits to me is an area we definitely should be exploring and looking at recommendations of how can we, in my opinion, require coordination on those audits. Because just from a provider standpoint, I get it. You've got people coming in, auditing different things, so that's one. And the other thing that you brought up was the lack of data, the states not being able to get to the Medicare data. On that one I would actually like to see, is it a possibility that we could look at coordination around rate setting, so that everyone is rate setting at the same time

and coordinating on that part of it. Thank you.

CHAIR VERLON JOHNSON: Thanks, John. Let's go to Mike.

COMMISSIONER MICHAEL NARDONE: Thanks, Brian and Michelle, for this presentation.

I was wondering, it sounded like there was one state that -- maybe two, that really actively used the two-way agreement, if I'm interpreting your presentation. I was wondering, can you talk a little bit more about that state and what they did, and is that a model for other states?

BRIAN O'GARA: Yeah. And I was smiling because I was realizing, yeah, I forgot to mention that what we presented on in January was that, of course, 16 states and D.C. used these two-way program agreements. That's what we found during our document review. About half of the states with PACE are relying on these additional tools, and, of course, I left that out conveniently.

So it's 16 states and the District of Columbia. That's a really good question. I think what we found through our document review in January and additionally through interviews that we've conducted recently is that

states really are using these in a variety of ways. We found that generally they're supplementing existing oversight requirements, you know, around auditing, around data that has to be reported.

And this is -- we can get you a lot more details from our January memo that details the document scan findings. But in terms of the states we spoke with that used the two-way program agreements, we found that they were mainly supportive of them because it was an avenue to introduce state-specific requirements, and then, of course, to be able to issue findings and hold plans accountable without necessarily involving CMS.

Of course, the states are more likely going to involve CMS because oversight is such a collaborative process. But what we heard is that the two-way program agreements give the state Medicaid agency another avenue to conduct oversight, to issue guidance, to provide more detailed guidance, and then, if necessary, to hold organizations accountable, and, you know, issue potential enforcement actions.

COMMISSIONER MICHAEL NARDONE: And am I right that -- it sounds like there does seem to be some kind of

agreement or consensus from all stakeholders -- and tell me if I'm wrong -- that there is a value -- and I can certainly see the value -- of having some sort of standardized metrics on which to, you know, assess performance of the PACE program. And I'm just wondering, is that a correct interpretation? And if so, you know, I think it would be valuable to weigh in on that and make a point.

Maybe that's a springboard for a potential policy recommendation.

BRIAN O'GARA: Yes, I would say that that's a correct characterization.

I think most likely -- that's the most universal thing we've heard, I think, from last year and from this year. Nearly everyone we spoke with across both phases of this work were supportive of a national set of standardized quality measures.

I think CMS would even love to be able to do this and compare plans across states and within states. Federal officials mentioned they did attempt to design a set before, but it is such a difficult population to capture and then to compare across organizations that they ran into

trouble with that.

But, yes, we heard from most of the interviewees across all stakeholder groups that they would be supportive of a -- they would be supportive national standardized quality measure set.

CHAIR VERLON JOHNSON: Thank you.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Let me start with sort of the positives. I think PACE is an incredibly -- I mean, in many ways, a gold standard in terms of integrated care, right, integrating all of the services, all of the funding. It's very interdisciplinary in so many ways. It's a great care delivery model.

And when it came about in the '70s, there really wasn't anything like it, right? We didn't have other kinds of integrated care options available, but now we do. We do through MLTSS programs and D-SNPs and all sorts of different ways of trying to achieve integrated care.

And what I keep hearing, I think, from the findings is concerns around a lack of capacity at both the federal level and the state level to really be able to oversee the programs well.

As a Commissioner, where we spend a lot of time talking about transparency and accountability, I think what I struggle with, with PACE, is that they're not in any way subject to the same level of expectations, transparency, accountability as other kinds of integrated care models are. So it seems on its face to be a great care model.

If you go look at it, they certainly look like a great care model, and yet the data isn't there to tell us about the quality. The data isn't there to tell us about the outcomes. And largely, the data isn't there to tell us about what people are actually even getting in PACE, especially for the things that are sort of delivered by the PACE organization themselves, which tend to not be encountered.

So, as John pointed out -- like, how many years are we in? Like, 30-plus years in. Actually, more than that. Fifty-plus years in. We have still a relatively small number of people but nothing really standardized in terms of accountability and transparency of data so that we can really look at how these organizations are performing and how they're performing relative to other integrated care models.

So I certainly support seeing some sort of standardization, not just in terms of a set of quality metrics, but even in terms of accountability and oversight mechanisms so that this sort of one entity isn't -- this one integrated care model type isn't sort of set apart and treated completely differently from all of the other care delivery models.

We couldn't conceive of managed care organizations, you know, receiving an audit once every two years and very little oversight in between and no reporting. None of that stuff would ever happen. It just seems to me it's time to raise the bar so that we -- you know, we can really understand what we're getting and hopefully be able, you know, to feel good about expanding the availability of these programs, but knowing that there's transparency and accountability as a part of that.

CHAIR VERLON JOHNSON: Thank you, Patti.

Others? All right. Oh, here we go. Heidi. Thank you. Sorry I missed you.

COMMISSIONER HEIDI ALLEN: So I just want to say this is not my expertise, which I think in some ways makes it probably like a -- just an outsider opinion where we've

had so many state people come. We've had so many patients or, like, you know, different groups of people come and testify, talking about how wonderful PACE is and loving PACE and wishing -- you know, I remember one state official said that they wish they could get their parent into PACE.

And I think of a D-SNIP or a FIDE and I think of those as, like, those are integrated insurance products, but they're not integrated delivery systems. This is more like a Kaiser model, right, where you have the payer and the provider being the same, and that's why they don't count encounter data because they're trying to -- they have an incentive to keep people well and out of hospitals and keep people in their, you know, day centers.

And so comparing them in a way is a little apples to oranges, because you -- do you compare them to the delivery system that contracts with the D-SNPs, or do you compare them to the insurance company outcomes? Like, I don't really -- I think that what I hear is that there's a lot of evaluation going on and that it seems to be kind of in partnership with the state, with CMS.

And I think that where there's a lot of consistency is this idea of, like, could we have -- should

we add HEDIS measures? Should we add, you know, some outcome measures that would help us see quality better? And I would be really supportive of that.

And hearing from the PACE agencies, what they're -- you know, every time we have this conversation, when we get done, there's somebody from a PACE, you know, organization who says, like, we're okay with collecting data. Like, yeah, you know, but like really taking feedback about what would be meaningful data and what would be helpful and being able to do apples-to-apples comparison across PACE data.

But I just always want to, like, not try to make one thing into something else when the one thing is something that seems to be working.

I would rather -- you know, like if any way, if anything, we would like to see probably more places where people can just talk to their providers in a casual basis in the little cafeteria area and have, like, this -- like, more community-based care model than, you know, people having to be in long-term services and supports, like nursing homes.

So that's just what I want to say in response to,

like -- I sometimes feel like we have this kind of undercurrent of that there's something insidious going on in PACE, and what as an outsider, what's hard for me is all I've ever heard from people are, like, really positive things about their PACE programs. And so some of it is I'm, like, what problem are we trying to solve? And let's make sure that we don't over-solve the problem to the extent that we take away what actually is really wonderful about PACE.

CHAIR VERLON JOHNSON: Thank you, Heidi.

Others?

[No response.]

CHAIR VERLON JOHNSON: All right. So, Brian and Michelle, I think this was very helpful. I know you're planning on coming back in April with some policy options, right? So, I mean, I think you heard from the folks who talked about their concerns or their thoughts around that.

So, you know, clear expectations maybe around quality oversight will be helpful. There are some ideas around data and how to get that. Maybe some coordination between CMS and states, right, could be another piece of that, and then also have maybe state capacity, right?

Really thinking about state capacity without limiting their flexibility could also be helpful.

Anything else that you all need or clarifying questions you need from us as you go forth and conquer?

BRIAN O'GARA: No, this was helpful as always. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you both. Appreciate it.

Okay. So we are now moving into our final public comment period, and so with this, the floor is now open for public comments. We invite you in the audience to raise your hand. If you would like to offer comments, please remember to introduce yourself and the organization you represent, and we do ask you to keep your comments to three minutes or less.

And we have one. Katie, you are up.

PUBLIC COMMENT

* KATIE PAHNER: Thank you. Good afternoon. My name is Katie Pahner, and I represent the National PACE Association, the trade association for more than 200 PACE organizations nationwide.

We continue to appreciate the Commission's

thoughtful questions and its focus today on ensuring strong oversight value and accountability across integrated care models, including PACE.

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.

NPA has heard from both states and PACE organizations about the importance of a collaborative approach between CMS and states in overseeing PACE. As we noted in January, variation in data integration and oversight can increase the administrative burden for PACE organizations.

At the same time, programs are interested in better understanding national variation to identify opportunities for greater alignment between state and

federal requirements. In that respect, MACPAC's work is both timely and welcome.

We've also heard that state capacity and resources can sometimes affect both oversight and the ability to support program growth, underscoring the importance of continued coordination between states and CMS.

Additionally, the federal application expansion process can present challenges. As highlighted in MACPAC's June 2025 report, the current process may limit the timely expansion of PACE, and we welcome efforts to explore opportunities to streamline and modernize it.

As noted in today's presentation, PACE already operates under robust federal oversight and quality requirements, including CMS audits. At the same time, we welcome discussions about developing a more uniform set of PACE-specific performance measures that are meaningful, actionable, and tailored to the population served while avoiding unnecessary administrative burden.

NPA supports continued progress towards a national PACE quality measurement framework and welcomes ongoing engagement with MACPAC and CMS to ensure these

efforts and strengthen quality and outcomes for PACE participants.

We look forward to the Commission's forthcoming policy options and welcome the opportunity to continue this dialogue.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Katie, for those comments.

Any other additional comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. We're hearing none. If you do think of additional comments, please feel free to go to our website to submit those comments for sure.

So, with that, we are now adjourned until tomorrow. We will meet again at 10 a.m. Eastern time. So have a wonderful evening, and we'll see you then. Thank you.

* [Whereupon, at 3:50 p.m., the meeting was recessed, to reconvene at 10:00 a.m., Friday, March 6, 2026.]

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PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, March 6, 2026
10:03 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
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

[10:03 a.m.]

CHAIR VERLON JOHNSON: All right. Good morning. We're going to go closer to policy, and this morning, we're going to kick off with provider enrollment and credentialing.

With that, I will turn it over to Patrick and Melinda.

PROVIDER ENROLLMENT AND CREDENTIALING IN MEDICAID

* PATRICK JONES: Thank you.

This morning, Melinda and I will be presenting a draft of the chapter on provider enrollment and credentialing in Medicaid for the June 2026 report to Congress.

Today's presentation will provide an overview of chapter content, starting with background and federal requirements for Medicaid provider enrollment and credentialing. Next, we will provide an overview of the enrollment and credentialing processes, including a comparison of the processes in three states.

We have a bit of an echo. Thank you.

Then we will discuss enrollment for select

provider types and challenges related to enrollment and credentialing, and finally, we will close with conclusions and next steps.

The primary responsibility of every state Medicaid agency is to facilitate access to covered health services for its enrollees. To do so, each state Medicaid agency must engage health providers to participate in the Medicaid program. Medicaid provider enrollment and managed care credentialing processes aim to ensure that Medicaid enrollees receive care from qualified providers.

Provider enrollment and credentialing processes are also key mechanisms for preventing the enrollment of providers who have engaged in fraud, waste, or abuse.

Provider enrollment is the process by which state Medicaid agencies determine whether health care providers who apply to participate in Medicaid are appropriately licensed according to state law, are not excluded from federally funded health care programs, and meet other applicable federal and state requirements.

Provider credentialing is the process by which MCOs verify that a provider is qualified to deliver care to the plan's enrollees within the scope of their specialty or

provider type.

Federal regulations describe the processes that states must follow to enroll providers. This section of the presentation will describe key federal requirements for the enrollment and credentialing processes.

As part of the enrollment process, state Medicaid agencies must screen providers based on the risk level assigned to their provider type in Medicare. The three risk levels -- limited, moderate, and high -- reflect the perceived risk of fraud, waste, and abuse posed by each provider type. For example, physicians are a limited risk provider type, whereas newly enrolling home health agencies are considered high risk.

States must set risk levels for provider types either equal to or greater than those set in Medicare. States must define risk levels for provider types that Medicare does not recognize.

States must also collect basic biographical and practice information from every provider who enrolls in their Medicaid program. This includes information such as the provider's name and date of birth, Social Security number, and national provider identifier.

Federal regulations also require Medicaid providers to disclose information to the state Medicaid agency about ownership and control, business transactions, and any relevant criminal convictions.

Going deeper into screening requirements, Medicare regulations define screening requirements for each risk level, which are shown on this slide's graphic. The state Medicaid agency must complete the screening activities for providers in each risk level. The screening activities are cumulative across risk levels, which means that all screening activities from every preceding category must be completed. For example, for moderate risk provider types, states must complete all of the activities listed for limited risk providers in addition to the activity listed for moderate risk providers.

State Medicaid agencies can rely on screening activities conducted for enrollment in Medicare or another state's Medicaid or CHIP program. They can also delegate screening activities to MCOs or other third parties.

State Medicaid agencies must intern to an agreement with all individuals and organizations that provide services to Medicaid enrollees under the state

plan. The state Medicaid agency executes the agreement once it has conducted federal and state-specific screening activities and collected applicable disclosures. State Medicaid agencies generally must collect an application fee from enrolling institutional providers before they execute the provider agreement. MCOs must enter into a separate provider agreement with each provider with whom they contract. Managed care network providers generally must have agreements with both MCOs and state Medicaid agencies.

Federal regulations and guidance specify circumstances in which state Medicaid agencies must deny enrollment. These reasons include, but are not limited to, failure to submit timely and accurate screening information, a criminal conviction related to Medicare or Medicaid within the past decade, and termination from either Medicare or another state's Medicaid or CHIP program.

Federal regulations require state Medicaid agencies to terminate a provider's enrollment for certain reasons. Causes for a mandatory termination closely mirror the circumstances in which states are required to deny enrollment.

State Medicaid agencies must also report providers who they terminate for cause to CMS. The CMS Data Exchange, or DEX system, is a database of terminated providers, including providers terminated from Medicare. It is also the platform for states to report their providers they have terminated.

State Medicaid agencies must also revalidate a provider's enrollment at least once every five years. The revalidation process is similar to the initial enrollment process.

Provider credentialing is a component of MCO's selection of network providers designed to ensure that such providers are qualified to care for Medicaid enrollees. All providers participating in managed care networks must be credentialed. States must develop credentialing policies for their MCOs based on parameters described in federal regulations.

First, each state must establish a uniform policy for credentialing and recredentialing providers. In this context, uniform means that states must develop and apply these policies in a consistent way that engenders equitable outcomes, prevents discrimination, and allows MCOs to

create networks that fulfill their enrollees' needs.

Second, states must require MCOs to document their credentialing and recredentialing processes. There may be instances in which a state's Medicaid fee-for-service program does not recognize certain types of MCO network providers. In these cases, federal rules do not require the provider to enroll with the state Medicaid agency.

Melinda will highlight examples of these providers later in the presentation.

Federal requirements represent the minimum activities that state Medicaid agencies must complete to enroll and screen providers and to establish policies for MCO credentialing of network providers. However, states have the flexibility to implement additional screening requirements, such as requiring more frequent revalidation, checking databases not required by federal regulations, and implementing risk levels and screening requirements that are stricter than Medicare's.

States also have the flexibility to set reasonable standards for Medicaid provider qualifications and to set additional denial and termination conditions

beyond those required in federal regulations.

I'll now hand the presentation off to Melinda, who will describe the provider enrollment and credentialing process in more depth.

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

This next section highlights how states and MCOs operationalize the provider enrollment and credentialing processes.

We'll start with provider enrollment. The process varies by state but generally consists of the steps shown on this slide. The provider submits an application and required documentation, which are reviewed by the state. The state then conducts the required screening activities and executes the provider agreement.

Along the way, the state may deny the application if the provider does not complete requested revisions within a specified time frame or if the provider does not pass the screening requirements.

Certain aspects of the provider enrollment process may vary by state. To get a sense of that variation, we looked at provider enrollment processes in

Ohio, Oregon, and Pennsylvania and identified a number of areas where their requirements appeared to differ. These differences related to enrollment requirements for MCO network-only providers, licensure requirements for out-of-state providers, reliance on screenings conducted by Medicare and other states, use of additional database checks, and revalidation requirements.

With respect to revalidation, for example, Ohio requires some providers to revalidate every three years to align with a recredentialing process, whereas Oregon and Pennsylvania require providers to revalidate every five years, the minimum required under federal law.

We'll turn now to the managed care credentialing process, which occurs during or after enrollment, depending on the state.

The process starts with the provider submitting a credentialing application and required documentation, which are then reviewed by the credentialing entity. That entity could be the Medicaid agency, the MCO, or a contractor, depending on the state and the plan.

The credentialing entity verifies the information on the provider's application, and if the provider meets

the credentialing criteria, they proceed to contracting with the MCO.

The provider's application can be denied if they don't submit timely revisions when requested or if they fail to meet the entity's credentialing criteria.

Again, the process can look different by state. In Pennsylvania, where there is a decentralized credentialing system, providers complete separate credentialing processes with each MCO, which may require different forms and supporting documentation.

In Oregon's standardized system, providers also submit separate credentialing applications to each MCO. However, MCOs are required to use a standardized credentialing form to help streamline the process and reduce administrative burden for providers.

Perhaps the most streamlined approach is a centralized system, like the one in Ohio, where providers credential with multiple MCOs through a single application.

Providers who are newer to the Medicaid program or who practice in non-medical settings can be particularly challenged to complete the enrollment and credentialing processes. In this section, we'll talk about enrollment

and credentialing for four such provider types, drawing again from our review of policies in Ohio, Oregon, and Pennsylvania.

Federal law generally requires school-based services providers to enroll with the state's Medicaid program, even if it's the local education agency that is billing for their services. School-based services are most often delivered through fee-for-service, and in those cases, school-based services providers do not need to credential with MCOs.

Schools are not traditional health care settings and may lack the institutional knowledge and resources to help their providers enroll in Medicaid.

Recent federal guidance and the expansion of school-based services in some states have raised concerns about the administrative burden for school-based providers who must enroll.

Coverage of doula services is relatively new for many states, and therefore, doulas may lack experience with and administrative support for enrollment and credentialing. Ohio, Oregon, and Pennsylvania permit doulas to enroll as Medicaid providers if they meet state

certification requirements.

States are also increasingly covering community health worker, CHW services, and may have varying rules regarding CHW enrollment and supervision.

In Ohio and Pennsylvania, CHWs do not enroll in Medicaid, though MCOs are required to cover their services. In Oregon, CHWs enroll as a non-payable provider type, and they work and bill under the supervision of a licensed provider.

Finally, the chapter highlights peer support specialists who help enrollees with behavioral health conditions engage with needed care. Ohio, Oregon, and Pennsylvania cover services provided by peer support specialists but have different policies regarding their enrollment.

Our review of the literature identified several challenges associated with provider enrollment and credentialing. States can be challenged to complete the required screening and verification processes within the 60-day timeline CMS recommends because of the volume of applicants and the time and resources required to complete the screenings.

Previous audits have found issues with state compliance with federal provider enrollment and screening requirements as well as state payments to providers who are either not enrolled or did not meet enrollment requirements.

Providers may also find the enrollment and credentialing processes complex and burdensome. This may be more often the case, as I previously mentioned, for non-institutional providers who are newer to the Medicaid program, as well as providers seeking to contract with multiple MCOs.

The need for certain providers, such as doulas, to establish and document supervisory relationships can also be a barrier to provider enrollment. The additional time and effort associated with building these relationships may deter some providers from participating in Medicaid.

Finally, the chapter notes that it can be challenging for providers to enroll in multiple state Medicaid programs when they are caring for patients who reside in other states. States often rely on their own screening process rather than that of Medicare or another

state, which means that out-of-state providers may be subject to duplicative screening processes. The requirement to separately enroll with multiple state Medicaid agencies can burden providers and delay care for enrollees.

In conclusion, the Medicaid provider enrollment and managed care credentialing processes help ensure that only qualified providers furnish care to enrollees and bill Medicaid. States have flexibility in how they design these processes, and the choices they make can have implications for program integrity as well as provider participation and access to care for enrollees.

Further examination of the challenges we identified, including through conversations with states, providers, and other stakeholders, could help identify potential opportunities to mitigate them.

As a next step, staff will update the draft chapter based on your feedback and prepare it for publication in the Commission's upcoming June report to Congress.

We have a few questions that we're hoping Commissioners can address during the discussion this

morning. First, are there areas where Commissioners would like to see further clarification in the chapter? Second, are there challenges with provider enrollment and credentialing that Commissioners are interested in further exploring in future work? And finally, do provider enrollment and credentialing requirements strike the right balance between safeguarding program integrity and ensuring sufficient access to care for enrollees?

Thank you, and I'll turn it back to the Chair.

CHAIR VERLON JOHNSON: Thank you. Thanks, Melinda. Thanks, Patrick. That was helpful, and this was our first opportunity to learn a bit more about this area as a Commission.

So, before I turn to Commissioners, we'll keep the questions up there, but, again, think of it in two ways. One is, what else can we -- what else do we want to hear about in the chapter? Also, from your own experiences, are there things we want to get a little bit deeper and granular on? Then the second thing, too, is, as this is the first time we're taking a bite at this, is this something you want to consider moving forward on even more so?

So, with that, I will open it up for questions and comments. All right. April and then Patti. Thank you.

COMMISSIONER APRIL HARTMAN: Thank you for your work on this.

I guess my big feeling when I read this chapter is it seems like this is the process for large systems to credential and enroll people, but this is not the experience of small practices or single providers, especially those -- we're trying to get more people to go into rural areas, and those tend to be one- or two-people practices. Some of this is a lot more challenging than I think what is represented here.

I'm just thinking, like, in our state, we have four MCOs, and so someone who is going into a practice, they have to enroll in fee-for-service. Then they have to enroll if they're going to take -- decide are they going to take those MCOs, all of them, two of them, one of them, and then they have to separately contract with them to set up fee schedules. It's a long process.

I know there was some verbiage in there that it could retroact as far as a year. Like, they could start

providing some services, but small practices cannot afford to see people without getting reimbursed. So this process can be very long and drawn out.

When you look at primary care, that enrollment and credentialing is just the first piece. If you're going to do EPSDT, you then have to do an application with VFC to be able to provide vaccines for children, which is a whole different process, site visit, big application that you have to fill out and make sure that you're meeting all those requirements. Then you have to, you know, make sure that you're doing everything that you should with the MCOs. It just goes on and on, and it's not -- it's not a simple thing, straightforward process, and it's very burdensome and costly.

So what you have in these areas is people who just say, well, I'll do this one, or they ask around, hey, what's just the best MCO to, you know, credential with, because I'm not going to do all of them. Then you tend to see some shifting in how people are placed.

The other thing that's probably the biggest headache for providers when it comes to MCOs is that when you sign up with an MCO, their goal is to assign a primary

care provider to every person. So if I sign up for all four MCOs, I'm one person, but what they tend to do is they auto-assign a full panel of patients to me -- each of them assigns a full panel of patients to me, and so I'm one person having four times the number of patients or five times because fee-for-service is going to give me some people too.

So there's no way that I can be an adequate network or provide service, but as each of these MCOs is evaluated, it's just how many primary care per member do you have? It's not looking that all of them have the same person, and so we're overburdened and unable to actually provide the quality of care that we want to.

When we try to say, okay, let me limit, you know, don't auto-assign, let me just say I can take X number of patients, well, then they say that you're not qualified for incentive programs or other quality things that may help supplement the low reimbursement that you're already getting from those Medicaid.

All this stuff disincentivizes people to even be Medicaid providers, especially in the rural areas. If you're a large hospital system, it's a little bit

different. You can kind of balance that with other things, but it's really, really difficult to be a medical provider in a smaller independent group.

CHAIR VERLON JOHNSON: Thank you for that perspective. Very helpful.

Patti.

COMMISSIONER PATTI KILLINGSWORTH: April, that was really helpful. Thank you.

My question really was just asking about your own observations as we think about payment and access, where -- as you were putting this together, which was really helpful, by the way, where did you see the greatest opportunity for potential policy changes in order to improve access for beneficiaries or to address payment adequacy and efficiency and accountability, those pieces?

I think April's point is really helpful as it relates to health care providers. My own experience is more in the realm of long-term services and supports providers, which for many years were not part of managed care systems, but more and more are becoming so. I think they face their own unique challenges in sort of making that leap from typical provider enrollment in a fee-for-

service delivery system to multiple managed care organizations. So that might be an opportunity, but I'd be really interested to hear any thoughts that you have around that based on your study.

MELINDA BECKER ROACH: I think that's exactly the question that we are asking of ourselves now, especially as we are contemplating potential future work. And I do think there were certain things that emerged from the literature that seemed to be opportunities to make it easier on providers to participate in Medicaid and enroll with multiple MCOs.

One of the thing we identified was sort of a lack of state reliance on Medicare and the screenings conducted by Medicare and other state Medicaid or CHIP programs, which could help sort of alleviate or minimize the need for providers to undergo that process again when they're enrolling in another state.

There is also the question of the state's approach to credentialing, which I walked through, as far as the decentralized, standardized, or centralized approach, and that seems like a real opportunity for states to help minimize the burden for providers, in instances

that, for example, Commissioner Hartman was referencing, where you have providers seeking to participate in multiple networks. That can be so complex when you are individually going through a process with each MCO and the forms and the documentation are different. So taking an approach like we saw in Ohio seems to be promising, and it's something that we could look further into.

Patrick, I don't know if you wanted to add anything as far as opportunities.

CHAIR VERLON JOHNSON: All right. Thank you. Heidi, and then Sonja.

COMMISSIONER HEIDI ALLEN: Yeah. So I really appreciate all the things that April brought up, and I think that these are the kind of concerns that we need to dig really deeply into. I'm curious if there's managed care organizations that require exclusivity. I'm curious if they all are, or it's common to put penalties, essentially, if you try to establish a quota.

I train social work students, and I'm constantly trying to get them to agree to take Medicaid when they leave school. And one of the ways that we talk about doing that is creating a balanced payer mix, so that you can

afford to see Medicaid and yet if Medicaid assumes that you're going to see a whole panel, then you can't create a balanced payer mix, so you just opt out of the program. Or if you aren't eligible for incentive quality and incentive programs that make that more accessible then you're less likely to participate.

And I actually had a really interesting -- I spoke at a conference where I was trying to convince mental health providers to take Medicaid. And a woman who had a small clinic decided that she would engage with Medi-Cal, based on that talk. She was like, "Okay, I'm going to do it." And then she said that because of the delay in payment that she ended up having to take a second mortgage out on her house to pay her clinic staff, because there was such a delay in the time from when they saw patients to when they were able to actually make payroll.

So she started a nonprofit where she's trying to get philanthropy to contribute money to a fund that would allow people to start a Medicaid practice but keep them from having to go out of business in the interim from when Medicaid starts to pay.

And I think these are real challenges for

participating in the Medicaid program that we need to think creatively about. Are we making it easy or are we making it impossible for providers to participate? And I think that to have meaningful networks, where they're actually, like April described, where not every single MCO is listing this person as a full panel member, but where patients can look at the network and reach out to somebody and assume that they'll actually get to be seen. I mean, these are the kinds of issues that we really should tackle. So I appreciate the work that we're doing to start to look at it. Thank you.

CHAIR VERLON JOHNSON: Thank you, Heidi. Sonja.

COMMISSIONER SONJA BJORK: I'm a proxy for my neighbor again.

COMMISSIONER CAROLYN INGRAM: My raising hand problems continue. So just a couple of areas that I wanted to make sure that we think about adding in. One is how IHS and Tribal 638s are actually treated in the process of credentialing and recredentialing with not just how that's managed at states but also within managed care companies. They have their own requirements and process, so I think we need to just make sure that's documented and respect that.

And I think it's helpful also for organizations that work with them, such as managed care companies or other groups, to understand that process. So it would be great to have it documented in this chapter.

The other area I think that's helpful to think about is what are states doing to work across each other with this process in terms of combating some of the fraud and abuse that's out there. I appreciate the feedback from April and the things that she's sharing, and a lot of what managed care companies do is trying to catch some of that fraud and abuse up front, and why people have to go through certain processes.

The next piece I would ask, if we are going to move forward and look at something like I think the common credentialing that's in Ohio is to study a couple of different states. I believe California has a process, as well. I'm not sure how well it's used. I don't know if Arizona does. But to look at a couple of states and figure out how well it's actually working. Because in our studies, while it sounds great on the front, on the face of it, to have a common credentialing process, sometimes we find that providers don't really take it up and use it. So you set

it all up and nothing happens with it.

So it would be great to see, if we are moving forward with some of those questions, how much they are really effective. Are providers actually using them? How long did it take to put in place? How much did that cost? Because it's actually a costly process to hire an entity that's going to do it across all the managed care companies at once, so it costs the state more money. So just some of those considerations. Thank you.

CHAIR VERLON JOHNSON: Sonja.

COMMISSIONER SONJA BJORK: Now I'll do my own comment. Thanks. A couple of factors to consider. One is that there's a difference between enrolling in the Medicaid program and then credentialing. In California, as Commissioner Ingram mentioned, there is the PAVE system, and that's how you enroll in Medicaid, but that doesn't mean you're credentialed.

The other factor I wanted to bring up is some states require the managed care plans to be NCQA accredited, which in California that's the rule. All the Medicaid health plans have achieved that. And they have some very special credentialing rules. So doulas have to

be followed, as well. So it's just important to keep those in mind as we look at all this.

They are very strict. They are geared toward protection of the consumers, which is a really important value that this Commission has.

At the same time, Commissioner Hartman's comments are well taken. This is a big provider abrasion issue. It is annoying and frustrating, all the different documents that you have to turn in. And then if you don't make it by a certain time period then you're told to start over. I mean, for small providers or ones that aren't used to dealing with managed care plans, like doulas, this can be overwhelming.

So there are many ways to help support providers through the process, and some health plans do that. They have a Provider Relations Department that will help guide people through the process, answer questions. You can't enroll for them in the PAVE process but you can certainly help them learn how to check status and see what's outstanding and help be their cheerleader. So there are some recommendations that might come from looking at those types of processes. Thanks.

CHAIR VERLON JOHNSON: Thank you. I really appreciate that, particularly as we think about access. So this is really good to understand. Doug.

COMMISSIONER DOUG BROWN: Thank you. Thank you both for the work on this. It is important work, and I appreciate it. I would be interested in understanding what you can find around provider enrollment around centers of excellence, especially related to cell and gene therapy treatment. Many of the new cell and gene therapies may be administered in three centers around the country, for example, in Boston or CHOP in Philadelphia or at Texas Children's. And then you have credentialing that has to go on or provider enrollment that's got to go on from 48 states, or 47 states, except for those three states.

My understanding is that within border states you likely already have those. Those centers are already participating with the states that surround that. I imagine that Boston has a relationship already with the New England states. But if you're in Idaho or Montana you may have to do a single case agreement or go through that provider enrollment piece if you're sending a child to Texas or sending someone to CHOP, for example. So I'd be

interested in that piece, please. Thank you.

CHAIR VERLON JOHNSON: Thank you, Doug. Jami.

COMMISSIONER JAMI SNYDER: I really appreciate your work on this today and I fully support continued work in this area, given the frustration level among providers when it comes to enrollment and credentialing, as expressed by April.

I too would love for us to take a closer look at the degree to which centralized credentialing reduces administrative burden for providers. Several states, I think as Carolyn mentioned, throughout the country have centralized credentialing verification organizations. There is a cost associated with standing a CVO up. And I would just like to better understand from stakeholders the degree to which they felt that that has been valuable.

CHAIR VERLON JOHNSON: Thank you, Jami. Tim, and then Adrienne.

COMMISSIONER TIMOTHY HILL: Thanks for the work here. I'm not going to pretend that I'm not having a little PTSD on this topic. In my career at CMS I had the opportunity to run a provider enrollment program for Medicare. It was a long time ago but it is a little, I

don't know if frustrating is the right word, to make the observation that some of the same issues that existed 10 years ago still exist. I guess I would frame my comments, one, as a substantive comment and the other a methodological comment.

The substantive one is obviously I think we should continue to keep doing this work. It's really important work for any number of reasons, both from the burden perspective on providers as well as the fiduciary role that provider enrollment plays for Medicare and Medicaid.

But teasing out the duplication and what is it that is preventing states from sharing with each other and the federal government from sharing with states and requiring some of that sharing, so that we don't have to do the same processes over and over again, in Medicare and Medicaid or across states. It's just incredibly frustrating, given that most of the data that's being collected is probably being collected multiple times, for the same provider.

And then methodologically, I mean, having April's comments being the first comments, I think they're so

important to hear. And I would really encourage us to think about a human-centered approach or one aspect of this to be user stories from a provider perspective. Because from the provider perspective, and I think April said it much better than I did, it's not a provider enrollment process. It's a how do I get paid by Medicaid process. And that could include, if you're in a nursing home you've got to get certified. If you're in a hospital you've got to get your accreditation. I think the NCQA issues for some managed care plans, as Sonja mentioned.

There's just more to it than just the sort of stovepiped rules that Medicaid requires to be enrolled. You know, you're in a lab and there are other things that have to be done.

So taking a provider's perspective and saying this is the road I have to go down to be able to get paid by a Medicaid program and maintain the fiscal integrity I think would be a really useful analysis to do and kind of pop out some of those inefficiencies.

CHAIR VERLON JOHNSON: Thank you, Tim. Adrienne.

COMMISSIONER ADRIENNE MCFADDEN: I have to say I was tempted to lower my hand after Jami and Tim's comments,

but I will weigh in, as well. One, thank you, Patrick and Melinda, for your work. April, thank you so much for your firsthand experience. As someone who didn't realize all of those complexities for a single or small practice provider, and a former rural health director, that really resonated with me.

I would actually like to see the different centralized credentialing models that you all laid out, and the experience that it has, particularly in rural communities for access, not just for the providers but understanding who the beneficiary choices will actually pan out to be. So with April's comment saying that it leads to providers just wanting to enroll or get credentialed once, with one MCO, that limits choices in access, as well, so I would like to see that experience.

And then to Carolyn's comments, with other providers like Indian Health Services, Patti I think mentioned the LTSS providers. So all of the sort of non-large health system providers, I'd like to understand those experiences.

CHAIR VERLON JOHNSON: Thank you. John.

COMMISSIONER JOHN MCCARTHY: From my experience

in doing this, one of the things that came up often, in discussing this with providers, is that we would get complaints about enrollment on the Medicaid side, so we were trying to streamline the process. And after I left, Ohio was able to do that.

However, for many providers they're also going through the commercial process too, and there is no streamlined enrollment for that. So also, for every health insurer in that state, enrolling with all of those.

So we run into this dichotomy of, well, on the Medicaid side let's make it streamlined but on the other side it's not. And I know then they usually comment back to me as, well, they pay more so then it justifies that. But there is this issue I still have of enrollment around that. I just wanted to get that comment on there.

Then three others. We always talk about that we're evidence based, so that's where I'm going to push you guys, is like where is our evidence on these things. One of it is how do states monitor the panel sizes? So like what April talked about, I totally agree with what she says, and you hear this all the time, and it comes up with contracting. And I will push even harder on that one, is

outside of the Medicaid part of that, if that provider also has a commercial contract with that plan, they may have to go through a whole separate division and credentialing for that plan, and they assign a full panel size too.

So how are states monitoring this? And I know states are looking at this, through their managed care plans. There is a way that some states are monitoring that.

Two, is there any evidence of states who use Medicare enrollment and/or other states' enrollment and fraud, waste, and abuse? If you use other states or Medicare, does fraud, waste, and abuse go up in that state? Go down? That type of thing.

And then the last one is I do want to see some analysis around any evidence we can get around your last point here. Do you see states that have more barriers or things like that, have lower fraud convictions for providers? Is there any correlation? Is there any correlation at all? If you just go out and look at all the prosecutions in a year for fraud in the Medicaid program and then lay that against how they do enrollment, is there any correlation? Just simple regression analysis on those

things, to see if we can find anything in there. I don't know what we would find in some of those areas, just to see what's going on, what were the barriers.

And I do want to say, lastly -- I know I said lastly before -- one more is that it is difficult, and I completely agree with the frustration that I hear, because you've got really, in my opinion we're doing this chapter at too high of a level. You really, really to break it down into very small levels. Because if we're looking at somebody like a large hospital system, they've got the staff to do these things. Yes, it's a pain for them. They're running through it. They're getting new people all the time. They can have delays in enrollment up to 60 days because they have the money to float those things.

But if it is a provider whose majority or is 100 percent Medicaid only provider, you can't wait 60 days to bill. They don't have the dollars in capital to do those things. So there is a discouragement in there. But at the same time, those are some of the providers where you have the most fraud, waste, and abuse. So how do you balance those things? And again, is there anything that we see in the data that shows some of those things?

When I saw that I mean like in the high areas of non-emergency transportation, right, people who are doing any type of in-home HCBS services, in-home services, and also durable medical equipment. Those are traditionally the three really high ones. So do we need even more scrutiny for provider enrollment in those areas versus other areas? I know HCBS is one of those that's really, really tough because it is an area where you have a shortage of people. Thanks.

CHAIR VERLON JOHNSON: Thank you, John. All right. So we will turn to, oh yes, April.

COMMISSIONER APRIL HARTMAN: Sorry. I have one more question. Also, can we look at what has been the impact of out-of-state telehealth services? Because we have a lot. I'm from Georgia. Atlanta school system has contracted with an out-of-state company to provide in-school services for the public school system. And I just would like to know what is the impact of that on services? Because more and more people are saying that these telehealth services are coming in and their patients, it's easy, you know. I'm at school. Let me just go get seen real quick. And it's impacting the ability to provide

quality care in the medical home. So maybe some look at that and how that's impacting things would be helpful.

CHAIR VERLON JOHNSON: Thank you. Anyone else? All right. I think this was a very robust discussion, and I'm looking forward to the chapter. Patrick and Melinda, anything else that you all need from us?

MELINDA BECKER ROACH: No. We just really appreciate all the great feedback, and we'll consider everyone's comments as we think about additional work.

CHAIR VERLON JOHNSON: I will turn it over to our Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman.

We've got Janice and Chris coming up next, an exciting opportunity to actually reflect back on some work that was done in 2017 around mandatory and optional enrollees and services in Medicaid. So with more recent data and new methodologies, they're going to share some of their findings, and from us, is there other information we're looking for and what feedback we'd like to give them on the issue brief.

So, with that, I will turn over. Who's leading

this? Is it Janice? All right. I'll turn over Janice. Thank you.

MANDATORY AND OPTIONAL ENROLLEES AND SERVICES IN MEDICAID

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

Today I'll be presenting our analysis on mandatory and optional enrollment and spending in Medicaid using fiscal year 2023 data. First, we'll cover some background information on mandatory and optional eligibility and benefits in Medicaid and then briefly describe our methodology for this analysis, including its limitations. Next, we'll highlight the findings from this analysis, first for enrollment and then for spending. We'll summarize some key takeaways, and then we'll conclude with next steps.

Federal statute and regulations mandate the coverage of certain populations and benefits and define the optional populations and services that states may cover. States make policy decisions regarding their program's parameters within these federal requirements to meet their specific needs and priorities.

States use various federal authorities, such as state plan amendments or waiver authorities, to design their Medicaid programs and to obtain approval from the Centers for Medicare and Medicaid Services, or CMS, for the populations and benefits that they propose to cover.

States can seek CMS approval to modify their Medicaid programs at any time, provided that these proposed changes remain within the federal framework that outlines mandatory and optional components of coverage.

States are federally required to cover individuals in certain low-income groups, referred to as mandatory eligibility groups, and states have the option to cover additional populations, referred to as optional eligibility groups, shown on this slide.

Mandatory groups include infants, children, and pregnant women up to specified income levels, low-income families, foster care children and youth, individuals who are either elderly or disabled and receive Supplemental Security Income, or SSI, and certain low-income Medicare enrollees.

Among the optional groups, this includes low-income children; pregnant enrollees, and individuals with

disabilities, and individuals age 65 and older with incomes above the federal minimum standard, as well as medically needy individuals, and low-income adults without dependent children.

Medicaid benefits are similar to eligibility in that there are mandatory and optional benefits. States have the flexibility to design their Medicaid benefit package so long as they align with these federal requirements. Federally mandated benefits include inpatient services, physician services, family planning services, and medical transportation. This isn't a comprehensive list, but for the sake of time.

For children under 21 in Medicaid, any medically necessary service is considered mandatory through the early and periodic screening, diagnostic, and treatment, or EPSDT, benefit.

Many of the Medicaid benefits are considered optional, which include prescription drugs, clinic services, dental services, intermediate care facilities for individuals with intellectual disabilities, and certain non-institutional long-term services and supports, or LTSS, like home- and community-based services, or HCBS.

Next, we'll describe the methodology we used for this analysis.

We analyzed fiscal year 2023 enrollment, utilization, and spending data from the Transformed Medicaid Statistical Information System, or T-MSIS, and we also used spending data as reported by states from the CMS-64 net financial management report.

In 2017, MACPAC published a June chapter in the report to Congress on mandatory and optional enrollment and spending. This current analysis is an update to that study. For that study, we used fiscal year 2013 data from the Medicaid Statistical Information System, or MSIS, which was the predecessor to T-MSIS.

In addition to using a different data source for this analysis, we also used an updated and improved methodology for classifying enrollment and spending as mandatory or optional.

We adjusted spending from T-MSIS to match benefit spending reported in the CMS-64. This means that, for example, if we calculated $100 billion in state spending according to T-MSIS, but the state reported $150 billion in spending in the CMS-64, we adjusted spending up to match

that total.

To classify enrollees as mandatory or optional, we used several enrollee characteristics, which were enrollee age, eligibility group, dual eligibility status, and their benefits code.

Additionally, we classified claims into MACStats service categories based on service type and eligibility information. The service categories are acute hospital, acute other, institutional LTSS, non-institutional LTSS, and prescription drugs.

Under each service category, we also created subcategories, which were used for classifying services as mandatory or optional. For example, under the non-institutional LTSS service category, the subcategories included home health, which was classified as mandatory, and personal care services and HCBS, which were classified as optional.

After identifying the distribution of mandatory and optional spending within each service category, we applied the distribution from encounter data to managed care capitation payments.

As with any analysis, there are several data

limitations to keep in mind as we review the results today. Due to changes in the data source and methodology, findings from this analysis are not directly comparable to the previous analysis.

Regarding the data source used, compared to MSIS, which was used for the previous analysis, T-MSIS data, which was used for this analysis, contain more granular eligibility and comprehensive managed care data.

In the previous analysis, which used fiscal year 2013 data, the new adult group was not included, because states had not yet adopted or implemented the Medicaid expansion. For this updated analysis, we incorporated the new adult group, and we refined the methodology by applying the mandatory/optional distribution to capitation payments using encounter data.

T-MSIS does not have a reliable data element that specifies mandatory or optional services, and because service types in T-MSIS and the CMS-64 data do not align one-to-one, services were aggregated into broad categories for comparability.

As a result, we developed an algorithm based on MACStats service categories, subcategories, and eligibility

characteristics for mandatory or optional classification. But the data elements used for classifying services may have limitations in clearly defining each claim as one specific service category and subcategory.

In addition, because spending is reported at broad service category levels on the CMS-64, when we adjusted T-MSIS spending to match the CMS-64, the adjustment factor was applied at broad service category level, regardless of the classification of the subcategories.

And lastly, T-MSIS encounter data may exclude certain managed care payments, such as supplemental payments and state directed payments. Therefore, this analysis does not account for how these payments may be allocated differently across mandatory and optional services.

Now we'll review the findings, starting with mandatory and optional enrollment.

First, we'll look at the distribution of mandatory and optional enrollment in total and by eligibility group. In fiscal year 2023, a total of 103.1 million individuals were enrolled in Medicaid, 61.5 percent

of which were enrolled via mandatory eligibility pathways.

Among enrollees that were mandatory, children made up over half of that population, over 20 percent were other adults, and almost 12 percent were blind or disabled. Among enrollees that were optional, the new adult group made up almost two-thirds of that population.

The share of enrollees eligible under mandatory and optional pathways varied by eligibility group, shown on this slide. Children and pregnant enrollees had the largest share of mandatory enrollees. Of the children that were optional, most qualified through the medically needy option for children under 18, and the new adult group had the largest share of optional enrollees with 99.1 percent.

The small share, or less than 1 percent of enrollees in this group that were considered mandatory, were those eligible for limited benefits through emergency Medicaid or they were partial benefit, dually eligible enrollees.

Among enrollees age 65 and older, 37.2 percent were considered optional, which was the group with the largest share of optional enrollees after the new adult group. This may be because enrollees age 65 and older are

more likely to need long-term care and HCBS, which may be the basis for Medicaid eligibility through optional pathways.

Taking a look at the distribution of mandatory and optional enrollees by state and expansion status, we see that among expansion states, South Dakota had the largest share of mandatory enrollees with over 80 percent, and Oregon had the largest share of optional enrollees with 62 percent. And among the non-expansion states, Georgia had -- nearly all enrollees in Georgia were mandatory with over 90 percent, and Florida had the largest share of optional enrollees with 57 percent.

Expansion states had a larger share of optional enrollees compared to non-expansion states, likely because these states expanded Medicaid eligibility to adults without dependent children, which is considered an optional eligibility group.

Now we'll review our findings related to spending on mandatory and optional services in Medicaid.

Here, we have the distribution of mandatory and optional spending in total and by service category. In fiscal year 2023, Medicaid spending totaled $823.1 billion,

most of which, or 61.2 percent, was for mandatory services. Of mandatory services, spending on acute hospital and acute other services represented the largest share, and of optional services, half of spending was on non-institutional LTSS, which includes HCBS, and about a quarter was on prescription drugs.

The distribution of mandatory and optional spending also varied across service categories. Overall, most Medicaid spending was for acute hospital services and other acute services. Spending on acute hospital services was nearly all mandatory, and other acute spending was 82 percent mandatory. The vast majority, or 96.0 percent, of non-institutional LTSS spending was optional, and this is likely because HCBS are optional benefits.

Most spending on prescription drugs was optional, and 20.2 percent was mandatory. The drug spending that was considered mandatory was largely for children due to the EPSDT benefit.

Spending for mandatory and optional services also varied by eligibility group. Total spending was highest for enrollees in the blind or disabled eligibility group and lowest for pregnant eligible enrollees. Nearly all of

spending for enrollees in the pregnancy-related and child eligibility groups was for mandatory services. Most spending for pregnant eligible enrollees was for inpatient services and physician services, and spending for children largely included acute care services, drugs, and institutional LTSS.

All of the optional spending for children was for HCBS and for state personal care services. By comparison, optional spending represented a substantially larger share of total spending for some other eligibility groups. Optional spending accounted for 60.2 percent of total spending among enrollees age 65 and older, and it comprised 55.6 percent among enrollees in the blind or disabled eligibility group. Institutional LTSS and non-institutional LTSS made up the largest shares of spending for these two groups.

Now turning to the distribution of mandatory and optional spending by state and expansion status, we do see some variation, although the differences are less pronounced than what we observed for enrollment. Among expansion states, Alaska had the largest share of spending on mandatory services with almost 80 percent, and Minnesota

had the largest share of spending on optional services with 58.1 percent.

Among non-expansion states, Alabama had the largest share of spending on mandatory services with 81.6 percent, and Kansas had the largest share of optional spending with 37.4 percent.

In summary, looking at both spending and enrollment, the largest share of Medicaid spending, with just over one-third, was for mandatory services provided to mandatory eligibility groups. By comparison, spending on optional services for optional eligibility groups accounted for a smaller share of total spending at approximately 18 percent.

Here are some key takeaways from our analysis. In fiscal year 2023, most spending and enrollment in Medicaid was for mandatory populations and services.

Focusing on enrollment first, our analysis found that mandatory eligibility groups accounted for the majority of Medicaid enrollment, children represented the largest share of mandatory enrollees with 53.6 percent, and the new adult group represented the largest share of optional enrollees with 66.6 percent.

When we looked at spending, we found that most spending was for mandatory services. Most mandatory spending was for acute hospital services with 44 percent and other acute services with 36.9 percent.

Non-institutional LTSS accounted for half of optional spending, and drugs accounted for about a quarter.

For our next steps, we will publish this analysis in an upcoming issue brief, and we welcome Commissioner questions or comments on the findings that we've shared today, specifically if there are any questions about the data or the methodology and whether there are any additional findings that we should include as a key takeaway.

And, with that, I'll pass it back to Bob. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Janice. I appreciate it.

I found it interesting when reading the chapter, particularly thinking about the time frame of the data going through COVID and that piece to see that. So I appreciate the work in that.

With that, I'll open it up. Anne, John, Heidi,

Doug, and then Adrienne.

COMMISSIONER ANNE KARL: Thank you so much for this. I think this is just such interesting and helpful and really timely work.

One question that I had is, it feels like the new adult group throws such a wrench in any analysis of optional services, because the new adult group has to receive the alternative benefit plan, and the alternative benefit plan has to cover the essential health benefits, and the essential health benefits have to cover drugs. So, when you look at it, it's easy to say, like, well, drugs are an optional category, but they're not for the new adult group. So how did you handle that when you were doing your analysis?

JANICE LLANOS-VELAZQUEZ: That's a really good question.

It's something that we came to realize as we were classifying the services. For this analysis, we did classify drugs as optional for the new adult group as well, but it is something that is also considered a limitation. I don't know if it would be helpful to also include that in the issue brief.

COMMISSIONER ANNE KARL: I think so, because it even applies to things like physical therapy. There's a whole bunch of services that, you know, before expansion would have been considered truly optional services.

Again, prescription drugs, most states are going to want to continue to cover prescription drugs, but then because of the requirement to cover the EHB for that expansion population, it just sort of complicates things.

So I think just acknowledging that is helpful, but it also does just really cloud the analysis if a state is thinking about, like, truly what are optional services that we could pare back.

JANICE LLANOS-VELAZQUEZ: Yeah. And another limitation that I forgot to note during the presentation was that we didn't account for drug rebates in this analysis. So that is also something else to consider.

CHRIS PARK: Just to clarify on that, we do account for drug rebates in the sense that the fee-for-service drug dollars were adjusted downward and the managed care capitation amounts were adjusted downwards, but when we used the encounter data to allocate dollars into mandatory and optional to apply to the capitation payments,

we did not individually adjust each state by the drug rebate amounts. So that distribution, you know, is a little bit off.

VICE CHAIR ROBERT DUNCAN: Is your mic on, Doug? Okay.

COMMISSIONER DOUG BROWN: I didn't want to jump in line, but I'm going to ask the question.

So, in the 24 percent, does it include or exclude?

CHRIS PARK: It excludes.

COMMISSIONER DOUG BROWN: It's just gross?

CHRIS PARK: Yeah. Well --

COMMISSIONER DOUG BROWN: Gross spend on pharmacy or gross --

CHRIS PARK: It gets complicated because it's net for fee-for-service but gross for managed care.

COMMISSIONER DOUG BROWN: Okay.

CHRIS PARK: You know, we started to try to go down the path, but then it got super complicated to try to apply rebate amounts to individual claims for different populations under managed care. So the total managed care dollars do reflect a discount for drug rebates, but the

distribution of mandatory and optional services within managed care do not.

VICE CHAIR ROBERT DUNCAN: Thank you, Chris.

All right. John, then Heidi, then Adrienne.

COMMISSIONER JOHN McCARTHY: So, guys, I'm going to ask you this question, if you can do a little more work around this, because we are in this era right now of a big spotlight on fraud, waste, and abuse. So I am a little concerned of what this chapter looks like and how some of the figures can be used.

So, for instance, on Figure 7, where you show the total spending for optional mandatory services, the figure is correct. Nothing wrong with that figure, but I think it would be very helpful if you'd made a Figure 7B -- or 7A, 7A and 7B and broke it out.

Then the second one, take out the non-institutional LTSS spending and the drugs, because then that optional percentage goes way down -- or have some way to show that, because it really looks like optional. I know it's less than the majority, but it's really not 38.8 percent if you take those two out.

And I think what people then -- this is the next

part of what I was going to ask. What people really are interested in is when you hear the discussions, at least the discussions I'm in around on optional services, is that very small there, acute other that you have in there, the 12.7 percent. You can put a chart in there that breaks that out into what those services are in dollar amounts with those, so the dental services, chiropractic, those other things. I think that is one of those things I get questions on all the time. Well, can't we just get rid of all these optional services and save trillions and trillions of dollars? And the answer is no, because it's just not there. But what happens is people will see this chart and say, oh, look, it's 38 percent of our total spending and just use that number.

So thank you very much.

VICE CHAIR ROBERT DUNCAN: Good points. Thank you, John.

Heidi, then Adrienne.

COMMISSIONER HEIDI ALLEN: Thank you so much, Chris. I loved reading this. It was so helpful in understanding the way that programs have evolved. I love the timeline.

I had a couple -- my first question is I wasn't sure how you treated the postpartum expansions. Are they considered optional?

JANICE LLANOS-VELAZQUEZ: So the postpartum expansion for the purposes of this analysis would be included in the pregnancy eligibility group if the state is expanding the enrollment for that specific group. So their services would be considered mandatory.

So there wasn't -- if you're asking, like, if we looked at, like, postpartum services, we didn't necessarily look at it that way.

COMMISSIONER HEIDI ALLEN: Yeah. Okay. But it does seem like that should be included in the optional eligibility, right? Because it is optional, and, you know, well, almost, I think, all but one state has decided to do it. It is not mandatory. So I'm just curious about that.

The second question I had or some nuance I think would be helpful is I think about, like, the all or nothing of some of these categories. So, like, prescription drugs with the Medicaid drug rebate program, if you cover prescription drugs, you have to cover all the drugs that participate in the drug rebate program, even though, you

know, you can use utilization management techniques.

There's some nuance there of like when you're thinking of -- if we're trying to give snapshots of, like, states' options of addressing optional services, do we really want them to use a hammer, or do we want them to use a chisel? To me, there may be some policy options that we could consider that would allow states to have more of a chisel approach, which they do have with, like, you know, the optional eligibility, because they all kind of, you know, go up and down the FPL according to the budget that they think they have.

But the services are a little bit more unique than that because they have less of that ability to kind of widen -- or at least it seems like they have less of that ability, and so trying to bring out some of that kind of nuance would be really helpful.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Heidi.

Chris, looks like you wanted to say something.

CHRIS PARK: Oh, just on the comment about the postpartum expansions, we had talked about this, and ultimately, because it's kind of an expansion of the time

they're eligible within a particular pathway, we left them as either mandatory or optional based on that eligibility code. So, you know, the postpartum expansion just kind of expands their time they're eligible within kind of like that mandatory pregnancy pathway.

COMMISSIONER HEIDI ALLEN: Yeah, I think you could still put it on the timeline or at least have a sentence about it.

CHRIS PARK: Yeah.

COMMISSIONER HEIDI ALLEN: Yeah.

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

Adrienne.

COMMISSIONER ADRIENNE McFADDEN: Admitted soapbox issue, but I'm just curious where dental benefits are falling in these graphics. Is it really truly under acute other? And I know that it's mandatory for children and optional for adults, but just trying to figure out where it's captured and if there's enough spend that we could actually break it out to see what the dental spend is.

CHRIS PARK: Yeah, dental would be in acute other. We would have to -- I mean, we certainly looked at

certain categories of services, like, individually because they would be optional. So I do think we probably have that number on dental.

You know, again, like for simplicity purposes, we kind of did not want to show every single service within this issue brief, but certainly, we can take a look at what that particular number might be.

VICE CHAIR ROBERT DUNCAN: Thank you, Adrienne. Thank you, Chris.

Jenny, then John.

COMMISSIONER JENNIFER GERSTORFF: I think it would be interesting to see average duration of enrollment by these different groups, and maybe then as we look over time, like, for example, with the pregnancy group, seeing their average enrollment increased and maybe other interesting patterns for other groups as well.

VICE CHAIR ROBERT DUNCAN: Thank you, Jenny.

John.

COMMISSIONER JOHN McCARTHY: Adrienne brought up the dental issue. I was like, oh, that is a good point. So how did you classify kids' services that are covered under EPSDT? That's my first question. Would that be in

the mandatory or in the optional?

JANICE LLANOS-VELAZQUEZ: Yeah, for children, all services were considered mandatory except for HCBS, which is the only service for kids that we treated as optional.

COMMISSIONER JOHN McCARTHY: Okay.

JANICE LLANOS-VELAZQUEZ: So dental would be mandatory.

COMMISSIONER JOHN McCARTHY: And then back to my other comment before, in the one chart that you -- the reason I bring this up around breaking some services out is because that chart where you show services by eligibility group specifically, there's the bar graph that shows age, blind, and disabled and -- yeah, on this chart here. And, you know, it's 62 percent optional services, but if we took away most of those services, not all, but a huge chunk of that is HCBS services, waiver services. If we took that away, the mandatory service is nursing home, and so you would just see a shift in that.

This is why I'm bringing this up, because in the other services, if you took it away, there's a shift but not at the same levels that you would see. So, you know, I just want to make sure that, again, we're breaking those

things out in anywhere -- if, like, you can pull some of that out for pharmacy and HCBS services, I think it would be helpful on these charts.

VICE CHAIR ROBERT DUNCAN: Thanks, John.

Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: All right. Janice, Chris, you feel like you've got what you need for the issue? All right.

JANICE LLANOS-VELAZQUEZ: Yes. Thank you. This is helpful.

VICE CHAIR ROBERT DUNCAN: Thank you.

Madam Chairwoman, I'll turn it back over to you to bring us home.

CHAIR VERLON JOHNSON: Thank you. Thank you. I know Chris will stay. We'll wait on Caroline to get here. But we're going to turn to MACStats, probably the most exciting thing I think that we all -- we always love this, right. So every year this session is really important to us. It really reminds us why our data discipline really matters. We get to see all the trends around enrollment, spending, delivery systems, and such.

As we listen to the highlights, and of course as we've read the materials, let's think about things we want to do a little bit deeper, based on what we're hearing and learning.

So with that, I'll turn it over to our team.

HIGHLIGHTS FROM THE 2025 EDITION OF MACSTATS

* CAROLINE O'NEIL: Good afternoon, Commissioners. Today I will be providing a high-level overview of this year's findings from the February 2026 edition of MACStats, our Medicaid and CHIP data book. MACStats is usually published in December, but it was delayed this cycle. For members of the public, we will have MACStats both compiled as the published book as well as separated into individual tables on our website. Most of the tables have both Excel and PDF versions for your convenience.

MACStats is a regularly updated end-of-year publication that compiles a broad range of Medicaid and CHIP statistics from multiple data sources, including census, enrollment, survey, and national and state level administrative data. Listed on this slide are the six sections of MACStats.

Key statistics of this year's MACStats shows

similar results to last year. These key statistics focus on Medicaid and CHIP enrollment spending compared to other payers, Medicaid's share of state budgets, and more.

In fiscal year 2024, over 31 percent of the United States population was enrolled in Medicaid or CHIP at some point during the year. Looking at the state-funded portion of state budgets, Medicaid was a smaller proportion compared to elementary and secondary education, and additionally, Medicaid and CHIP combined were a smaller share of national health expenditures when compared with Medicare.

Moving on to the trends in Medicaid and CHIP enrollment over time, we can see the impact of policy responses and the unwinding. Note that enrollment figures are point-in-time estimates that do not capture all individuals enrolled at any time during the year, and are generally lower. Compared to July 2013, Medicaid and CHIP enrollment was around 36 percent higher in July 2025. Most of the increase happened during the initial years after the bulk of the Affordable Care Act expansion. Enrollment in Medicaid and CHIP had peaked during the continuous coverage requirement.

Most recently, as states began to redetermine eligibility for beneficiaries following the end of the continuous enrollment requirement, the number of Medicaid and CHIP enrollees has declined. From July 2023 to July 2024, enrollment in Medicaid and CHIP decreased by about 13 percent, or over 12 million enrollees. Enrollment continued to decrease in the most recent year, although at a smaller rate, by approximately 3 percent, or 2.2 million enrollees, from July 2024 to July 2025.

Looking further into growth trends, this graph shows growth trends in Medicaid enrollment and spending. Overall, spending and enrollment have had complementary trends, both rising and falling in tandem. The trends reflect policy changes and economic conditions such as economic recessions and policies to expand and preserve Medicaid coverage.

In this graph, spending for health programs are compared with spending for other components of the federal budget for fiscal years 1965 through 2024. In general, the share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965, and Medicaid spending continues to account for a

smaller share of the federal budget than Medicare.

In fiscal year 2024, the share of federal spending on Medicaid and CHIP decreased from the prior fiscal year. This recent reduction reflects a decrease in federal Medicaid spending from Medicaid unwinding and the end of the provisions of the Families First Coronavirus Response Act.

We also looked at various characteristics of program enrollment and spending. In fiscal year 2023, nearly three-quarters of enrollees were enrolled in comprehensive managed care, and managed care spending accounted for over 50 percent of Medicaid benefit spending. We also saw that in fiscal year 2023, the new adult group, which applies to states that have expanded Medicaid, accounted for about 26 percent of Medicaid enrollees and 23 percent of spending.

In fiscal year 2024, drug rebates reduced gross drug spending by about 55 percent. We also saw that in fiscal year 2024, disproportionate share hospital, upper payment limit and other types of supplemental payments, such as those made under Section 1115 waiver authority, accounted for over half of fee-for-service payments to

hospitals.

In fiscal year 2023, total spending for full-year-equivalent enrollees across all service categories ranged from $4,040 for children to $27,361 for the disabled eligibility group. Spending for managed care capitation payments was the largest service category across all eligibility groups. Managed care was between 70 and 74 percent of spending for children and adults, and a little over 40 percent for the aged and disabled groups.

Long-term services and supports users represented only 6.6 percent of Medicaid enrollees but almost 39 percent of all Medicaid spending. That is, $329 billion was spent on services for these 6.6 million enrollees. Note that this estimate includes enrollees using at least one LTSS service during the year, and starting with this year's edition we accounted for enrollees who received LTSS throughout a managed care plan or fee-for-service. These numbers may not be directly comparable to prior MACStats data books, where we only included those receiving LTSS under a fee-for-service arrangement.

In 2024, 36 percent of Medicaid enrollees had annual incomes less than 100 percent of the federal poverty

level, and 52 percent had incomes below 138 percent of the federal poverty level. As of July 2025, 40 states and the District of Columbia have expanded Medicaid and now cover the new adult group.

MACStats also reports on beneficiary health, service use, and access to care using survey data from the National Health Interview Survey and the Medical Expenditure Panel Survey. In 2024, children and adults with Medicaid or CHIP coverage were less likely to be in excellent or very good health than those who have private coverage. Children with Medicaid or CHIP coverage were as likely to report seeing a doctor or having a wellness visit within the past year as those with private coverage, and more likely than those who were uninsured.

While most children with Medicaid or CHIP coverage had a usual source of care, they were less likely to have one compared to children with private insurance.

Finally, children and adults with Medicaid or CHIP coverage are as likely to report no difficulty reaching their usual medical care provider by phone during business hours as those covered by private insurance.

And I will take questions.

CHAIR VERLON JOHNSON: All right. Thank you so much. That was very helpful, very data rich. It's what we love here. So Commissioners, any comments, thoughts, insights that you'd like to share? Doug.

COMMISSIONER DOUG BROWN: Thank you. Thank you for the great work here. I appreciate it. I do have some comments relative to the federal rebate estimate that you've got in the report. I look back at the report, I think it's Figure 28 is where you're getting the data from, and I know it's on collections, state collections of the federal rebate and what states actually collect. And I know, Chris, you and I have spoken a little bit about this, and I understand the limitations in some of the data from that collection, and that rebate invoices go out on a quarterly basis and payments come in from several quarters at the same time, and therefore you get the fluctuations in state collections.

When you're kind of averaging or trying to figure out where your rebate collections average, 55 is pretty close to what I see in some data I've seen, net of federal and supplemental rebates, somewhere between 50 and 55 percent is probably the neighborhood of where that is.

When we look at the data in this chart and you add a percentage to it, it fluctuates by states, from as low as 7 percent up to 117 percent, which really doesn't give us an accurate picture of what's happening to federal rebates across states or across the Medicaid program.

What would be helpful here is to bring in the invoiced amount on an annual basis and actually look at it over a five-year period. So I've done that. After I downloaded the Excel of this, I looked at the past five years and where the trends have gone. And what I'm not seeing in the collections trend, that you would expect to see in the trends of invoiced amounts, is a decline in federal rebates over the past five years, driven by the inflation, which suppresses the inflation penalty component of the federal rebate, which drives the federal rebate down, and then the cost of drugs up.

And so the other piece of that is an increase in supplemental rebates that accompanies that for those drugs that states can put under contract.

So overall you see a decline there. And then in 2024, we had AMP cap repeal, which also, for a number of reasons, lowered the federal rebate and caused an increase

in the cost of drugs.

So if we look at invoiced amounts here against the total drugs, I think we can see some trends that then we can see some actions on, and we can go back and say at a point in time certain legislation did certain things to the federal rebate and kind of track where that's going. And maybe there are some policy recommendations that might come out of that. Thank you.

CHAIR VERLON JOHNSON: Thank you, Doug. John, and then Angelo.

COMMISSIONER JOHN MCCARTHY: Okay. Now I sound like a broken record but I've got to ask. MACStats really has never, in the past, neither this one or in the past, looked at collections. I'll stick with the collection theme from Doug, on fraud, waste, and abuse. So Chris, is that because we're using T-MSIS data in here and just T-MSIS data, and there's not other ways to get it? I know in the past we haven't done it. Is there any chance of doing that going forward?

CHRIS PARK: Yeah, so it's not shown here, but on one of the exhibits, I think it's 17, we do break out what's reported on CMS 64 in terms of various service

categories. And one category is collections. So the total amount of collection is shown in MACStats. We've never taken a close look at exactly what's reported there. I've seen other sources saying there are certain state reporting anomalies where I think one state kind of reports all of their claim adjustments as collections. So there might be a couple of places where it looks anomalous. But that's not something we've typically reported in MACStats, but we can certainly try to look at the various reports within the CMS 64 to see if there is any more information there.

COMMISSIONER JOHN MCCARTHY: Thanks. Yeah, I'm looking at 17 now and I didn't realize that's what that collections was for. So that's helpful. Thanks.

CHAIR VERLON JOHNSON: Thank you. Angelo.

COMMISSIONER ANGELO GIARDINO: Yeah, I just wanted to thank you for the analysis, the tables displayed. It's really helpful.

I'm in a glass-half-full optimistic phase today. So when I look at MACStats over the years, I'm often struck by how large the enrollee numbers are for kids, and then how cost effective it is to invest in the children. So I was just hoping in the future if we could just make that

point stronger and stronger in the data displays.

Because as Medicaid comes under the microscope more and more, I just would like to really help policymakers understand just what a tremendously good investment it is to invest a small number of dollars into the health and well-being of children, because children are the future of the nation, and they will inherit this great nation. So when you have like 37 percent of the kids in America on Medicaid, those are the people that will take over this great nation in 20 or 30 years. So we want them to be healthy.

So I would love to really use MACStats to help people see the good part of Medicaid, which is there are a lot of kids that get health care, and it's not that expensive, and it really then allows us to turn the country over to a healthy group of adults.

CHAIR VERLON JOHNSON: Thank you, Angelo. Great point. Mike.

COMMISSIONER MICHAEL NARDONE: I was going to say maybe something that's similar to what Angelo is saying, was that I just want to thank you for this work as well as the work on the previous panel around optional versus

mandatory services, because I think it really does help us to tell the story about who is served by Medicaid. The chart in there around the spending distribution was something that I always had hanging up on my wall in the Medicaid office around who is served by Medicaid and where does the funding really go. You know, we serve the aging, disabled population significantly, but also kids and adults, and what is the cost.

Also, that line chart that shows kind of expenditures versus eligibility, I think it tells the story around how, you know, the thing that's driving Medicaid expenditures is more people getting covered under the Medicaid program, not necessarily inflation in provider payments, which I think sometimes is maybe kind of an interpretation of what's happening in Medicaid, when you hear comments that Medicaid spending is out of control.

But also the whole notion with John's edits around optional services. You know, what is really optional? I can't tell you how many times I've had to go through that exercise of saying, well, what are the optional services in Medicaid? And having to explain to people that pharmacy and IDD, ICF service and HCBS are,

quote/unquote, "optional" services.

So I just really wanted to make that comment because as I read both the last section and this particular MACStats presentation, it really helped tell the story, and I think that's important for us to do, particularly, and just echoing what you said, Angelo, that as we go into a period of, I think, potentially difficult fiscal times for state Medicaid programs that it's really important to kind of keep this top of mind, top of attention, in helping educate people about who Medicaid serves and the services that we provide.

So thank you, Chris and team and Caroline.

CHAIR VERLON JOHNSON: Thank you so much, Mike. Doug?

COMMISSIONER DOUG BROWN: Thank you. One quick one here. The T-MSIS data that you look at, if there are elements that are missing in that data, if, as MACPAC, if we can make recommendations that CMS ask states to include additional data elements to make things clearer, or to remove elements that nobody uses in that report, so we don't put extra burden on the state, I would be in favor of trying to help with that. Or if you could come to us and

say we'd love to have these particular data elements in the T-MSIS data so we could look at it and be more robust in our reporting and more transparent in the way the program operates, I think that would be helpful, and I think we could take action on that. Thank you.

CHAIR VERLON JOHNSON: Thank you so much. Anyone else? All right. Again, thank you so much for the work that you all did on this. Obviously, and I think Mike and Angelo said it best in terms of how this really helps to tell the story of Medicaid, and not just for us here at MACPAC but also for our listeners and everyone else who loves Medicaid and CHIP as much as us. So if you don't already have a copy of it, you heard it from the beginning. Go to MACPAC.gov and get yours today.

That sounded like a commercial, but it was a really good one, wasn't it?

CHAIR VERLON JOHNSON: All right. So with that let's go now to public comments. This is the one where we're asking our listeners, we invite them to provide any comments from the discussion today, or even yesterday. So we do invite you to raise your hand if you'd like to offer comments. We do request that you introduce yourself and

the organization that you represent. And we also ask that you keep your comments to three minutes or less.

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

[Pause.]

CHAIR VERLON JOHNSON: All right. We have one. Is it An Danh? The floor is yours.

PUBLIC COMMENT

* AN DANH: Hi. Can you all hear me? My name is An Danh.

CHAIR VERLON JOHNSON: We can hear you. Thank you.

AN DANH: Hello?

CHAIR VERLON JOHNSON: We can hear you. Go ahead with your comment.

AN DANH: Hello?

CHAIR VERLON JOHNSON: Can you hear us? Is it An Danh? You can go ahead with your comment.

AN DANH: Hello?

CHAIR VERLON JOHNSON: All right. Might be some technology difficulties. So let's go ahead and move on to Lynn Lewis.

LYNN LEWIS: Yes, this is Lynn Lewis. I'm an

independent consultant.

My comments to previous Commissioner's statement regarding how the contractual agreement has assigned with different NGOs as well as assigning Medicare patient, I believe CMS is making modifications on the ACL module moving away from a fee-for-service module, which is more focusing on the outcome of the health care for the patients instead of going by the numbers.

Every space from the providers to the carriers and insurance companies, we all face the huge challenge in terms of health care expenditure as well as how to make them more affordable as well as understanding how the fee-for-service structure is not a sustainable and successful module.

So CMS has RFIs to make the proposition for 2027 as well as other legislation so we can all participate and work together.

One roadblock right now is I don't believe American Hospital Association is in the position to support price transparency based on the regulation insurance companies must provide transparency data.

On the other hand, there's a discrepancy if a

provider is -- belong to a hospital system instead of independent clinic. There's the EHR system roadblocks to move the initiative forward so anyone can make a proposition to improve the current system would be a winning proposition for all of us.

Thank you.

CHAIR VERLON JOHNSON: Thank you so much for your comment.

All right. We'll try An Danh again. A-n -- there we go -- D-a-n-h.

AN DANH: Hi. Can you all hear me now?

CHAIR VERLON JOHNSON: We can hear you now. Thank you. Go ahead with your comment.

AN DANH: Sorry about the audio issue earlier.

My name is An Danh. I'm an actuary. I'm the president and founder of HDI.

My comment relates to Puerto Rico. As you all may be aware, Puerto Rico is facing a Medicaid fiscal cliff after September 30, '27. The current funding in Puerto Rico right now is around $4 billion per year under the Consolidated Appropriations Act of '23 with the FMAP set at 76 percent. My expectation is that that's going to go down

to $475 million starting in federal fiscal year '28, and the FMAP is going to drop down to 55 percent.

So the current funding levels right now, it's not even sufficient to cover nursing facility services, and that is a mandatory Medicaid service. Imagine the funding level dropping down to $475 million. Puerto Rico won't be able to cover other mandatory services.

Furthermore, the FMAP, even though it's 55 percent under federal statute, if Puerto Rico has to cover any federal shortfalls with local funds, that's going to be even lower than 55 percent.

And just to give you all an example of the disparity in Puerto Rico versus the mainland, the average hourly wage for health care workers in hospitals is about $20 per hour based on Medicare cost reports, and on the mainland, it's about $60 per hour, so a three times' difference.

So my ask is that MACPAC encourage Congress to continue the funding levels under the Consolidated Appropriations Act of '23, adjusted for CPIU for federal fiscal year '28 and beyond, or possibly make it open-ended like other states, because when Medicaid was originally

passed in 1965, the funding for territories were open-ended.

I would also ask that the FMAP be set at 83 percent permanently like the other territories in the nation and also consider additional funding for long-term care for Puerto Rico since there's no funding for that right now.

Thank you.

CHAIR VERLON JOHNSON: Thank you so much for your comment.

Give it a second for any other comments.

[No response.]

CHAIR VERLON JOHNSON: Okay. Well, thank you so much. If you do have comments later, we do encourage you to submit those comments to our MACPAC website.

So, with that, our 2026 meeting for March is adjourned. We hope to see you on April 9th and 10th for our next meeting. Thank you, and have a great weekend.

* [Whereupon, at 11:39 a.m., the meeting was adjourned.]