



PUBLIC MEETING

Hemisphere Room
Ronald Reagan Building and International Trade Center
1300 Pennsylvania Avenue NW
Washington, D.C. 20004

Thursday, December 12, 2024
10:32 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

Session 1: State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Organizations
 Allison Reynolds, Principal Analyst.....5
 Chris Park, Policy Director and Data Analytics Advisor.....n/a

Session 2: External Quality Review (EQR) Draft Recommendations
 Allison Reynolds, Principal Analyst.....47
 Chris Park, Policy Director and Data Analytics Advisor.....n/a

Public Comment.....86

Lunch.....89

Session 3: Transitions of Care for Children and Youth with Special Health Care Needs (CYSHCN): Policy Considerations and Options
 Ava Williams, Research Assistant.....90
 Linn Jennings, Senior Analyst.....96

Session 4: Potential Areas for Comment on CMS Proposed Rule on Medicare Advantage (MA) for CY2026
 Drew Gerber, Analyst.....130
 Chris Park, Policy Director and Data Analytics Advisor.....n/a

Public Comment.....160

Recess.....162

Session 5: Introduction to Self-Direction for Home- and Community-Based Services (HCBS)
 Brian O’Gara, Analyst.....163
 Gabby Ballweg, Research Assistant.....170

AGENDA

PAGE

Session 6: Panel on Self-Direction for Home- and Community-Based Services (HCBS)

Moderators:

- Gabby Ballweg, Research Assistant.....189
- Brian O’Gara, Analyst.....n/a

Panelists:

- Pamela Zotynia, Certified Supports Broker and Service Director, Values into Action.....190
- Robert Zotynia, Self-direction Participant.....190
- Mark Sciegaj, PhD, MPH, Professor of Health Policy and Administration, the Pennsylvania State University.....197
- Patricia Brennan, Director of the Office of Education on Self-Directed Services, Priority Waiting List, and Special Projects, New Jersey Division of Developmental Disabilities.....202

Public Comment.....260

Adjourn Day 1.....262

P R O C E E D I N G S

[10:32 a.m.]

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2
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CHAIR JOHNSON: Good morning, everybody. Welcome to the December MACPAC meeting. As always, we have a very packed agenda with some critical topics that align with our mission, of course, of improving Medicaid and CHIP.

I do want to thank you all in advance for your time and dedication for today, and with that, let's get started with our very first session. And this will be the first of a few focused on managed care. So the first is called "State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Organizations," and this will actually highlight some of the important work we're doing around accountability tools for Medicaid managed care organizations.

We'll hear from Allison Reynolds, who's our Principal Analyst, and Chris Park, our Policy Director and Data Analytics Advisor, about some federal and state-level approaches to ensure compliance with contractual obligations.

So, with that, I will turn it over to the two of you.

1 **### STATE AND FEDERAL TOOLS FOR ENSURING**
2 **ACCOUNTABILITY OF MEDICAID MANAGED CARE**
3 **ORGANIZATIONS**

4 * MS. REYNOLDS: Good morning, Commission. Thank
5 you.

6 Managed care is the predominant delivery system
7 in Medicaid, and the effective oversight of Medicaid
8 managed care programs is a priority for stakeholders.
9 Today we are introducing a new project on Medicaid managed
10 care accountability with a focus on the tools available to
11 federal and state regulators to oversee states' managed
12 care programs.

13 Specifically, how does CMS regulate state
14 Medicaid agencies and ensure compliance with federal
15 regulations, and how do state Medicaid agencies oversee
16 their contracted MCOs' performance and incentivize plans to
17 exceed contractual requirements and performance measures?

18 Additionally, what evidence can we identify that
19 these tools, both incentives and penalties, improve plan
20 performance over time?

21 Lastly, we want to understand how state Medicaid
22 agencies incorporate MCO performance from existing

1 contracts into their procurement process for new contracts.

2 This discussion of federal and state
3 accountability tools for Medicaid MCOs will be the first of
4 several over the next year and extend into the next
5 analytic cycle. The goal of this session is to provide a
6 foundation for our future work.

7 Today we will provide background on the use of
8 full-risk comprehensive MCO contracts to deliver Medicaid
9 benefits and place this new project in context with a brief
10 review of MACPAC's previous managed care accountability
11 work. We then provide an overview of federal policy
12 relevant to managed care procurement, state Medicaid agency
13 responsibilities when contracting with MCOs, and CMS's role
14 in providing direct oversight of MCO contracts.

15 We will present our initial findings from our 40-
16 state environmental scan conducted with our contractor,
17 Mathematica. The scan was a thorough review of
18 accountability tools found within recent MCO materials,
19 including requests for proposal or RFPs, MCO contracts, and
20 MCO performance information available on state websites.
21 Our focus was on accountability tools states utilize and
22 any potential impact MCO performance may have on

1 procurement opportunities.

2 In the second phase, we will conduct stakeholder
3 interviews with representatives of federal agencies, CMS,
4 OIG, and GAO; state Medicaid agencies; MCOs; Medicaid
5 managed care national experts; and beneficiary advocates.

6 Lastly, we will detail next steps in our work,
7 including areas of further inquiry based on the
8 Commission's feedback to the work presented today.

9 Under Medicaid managed care, states pay MCOs to
10 cover a defined benefits package through fixed periodic
11 payments referred to as capitation payments. States may
12 implement managed care for many reasons, including:
13 providing more control and predictability over future
14 costs; improving efforts to measure, report, and monitor
15 performance, access, and quality; allowing for greater
16 accountability for outcomes compared to fee-for-service;
17 and providing additional opportunities to improve care
18 management and care coordination.

19 Managed care is the predominant Medicaid delivery
20 system in most states, with 73 percent of beneficiaries
21 enrolled in a comprehensive full-risk MCO.

22 In fiscal year 2023, managed care capitation

1 payments accounted for 56 percent of Medicaid benefit
2 spending.

3 In recent years, MACPAC has focused on Medicaid
4 managed care accountability by studying managed care
5 policies regarding MCO procurement practices, external
6 quality review, or EQR, processes, and denials and appeals
7 in utilization management.

8 In 2022, MACPAC examined the procurement process,
9 wherein state Medicaid agencies select and contract with
10 MCOs. The study confirmed procurement is an area where CMS
11 defers to states but also found that opportunities exist
12 for CMS to assist states and MCOs with meeting contractual
13 requirements and program goals, including through the
14 federal readiness review process.

15 In 2022, MACPAC began a comprehensive study of
16 the EQR process, one of the few statutorily required tools
17 the federal government and states have to engage in
18 Medicaid managed care oversight.

19 After analyzing the study findings in the context
20 of the 2024 managed care rule, we identified gaps in how
21 the EQR process and findings are used to oversee MCOs and
22 improve quality. The Commission is currently evaluating

1 proposed recommendations to focus EQR activities on
2 meaningful outcomes over process and to improve the
3 usability of EQR findings through digestible, actionable,
4 and accessible reports for stakeholders. Those proposed
5 recommendations are the focus of our next session during
6 this morning's meeting.

7 In 2023, MACPAC examined the oversight of denials
8 and appeals in Medicaid managed care and the beneficiary
9 experience with the appeals process.

10 Our work concluded in 2024 with the Commission
11 making seven recommendations in our March report to
12 Congress to improve the appeals process and enhance
13 monitoring, oversight, and transparency efforts. These
14 recommendations included requiring external medical reviews
15 of denials, states conducting clinical audits of denials to
16 assess clinical appropriateness, and CMS and states making
17 denials and appeals data publicly available in accessible
18 formats.

19 CMS has issued three comprehensive updates to
20 Medicaid managed care rules in 2016, 2020, and 2024. In
21 totality, these rules reflected CMS's efforts to promote
22 state and MCO accountability for enrollees' access to care,

1 quality, and health outcomes while balancing appropriate
2 federal oversight with state flexibility.

3 Since 2021, CMS has supplemented this
4 increasingly complex regulatory framework with a series of
5 four annual informational bulletins to provide tools for
6 states and CMS to improve the monitoring and oversight of
7 managed care in Medicaid.

8 There are few federal rules governing the
9 Medicaid managed care purchasing process, and CMS's
10 involvement once contracts are awarded focuses largely on
11 state reporting requirements and providing technical
12 assistance to states.

13 States contract with MCOs, selecting them through
14 a competitive procurement process, RFPs, or a
15 noncompetitive application process. The procurement or
16 application documents establish the state's performance
17 expectations, which are then formally agreed to in the
18 contract between the state and its selected MCOs. Medicaid
19 managed care procurements are often among the largest
20 contracts awarded by states.

21 From our prior work, we found that the federal
22 government defers to states and their respective

1 procurement laws when selecting Medicaid managed care
2 plans. Therefore, states manage their own MCO
3 procurements, deciding whether to have a competitive or
4 noncompetitive selection process, the selection criteria,
5 the evaluation panel, how many MCOs to contract with, the
6 frequency of re-procurement, and the content of the
7 contract beyond the required federal provisions. States
8 may, but are not required by federal statute or regulation
9 to, incorporate MCO past performance in future procurement
10 cycles. These are decisions that can influence the success
11 of a managed care program, including MCO willingness to
12 contract, the responsiveness of participating MCOs,
13 provider participation, enrollee access, quality of care,
14 and continuity of care.

15 The uniform administrative requirements, cost
16 principles, and audit requirements for federal awards
17 implemented by the Office of Management and Budget, known
18 as "OMB's Uniform Guidance," does not apply to Medicaid
19 managed care procurements. The only aspect of federal
20 procurement guidance that states must apply when procuring
21 Medicaid MCOs is to establish conflict of interest
22 safeguards. Federal statute and regulations specify the

1 types of organizations with which states are allowed to
2 enter into comprehensive risk Medicaid contracts.

3 CMS verifies that each selected contractor meets
4 the definition of an MCO or is one of the other types of
5 entities as part of the annual contract review process. By
6 statute, an MCO must offer benefits to enrollees consistent
7 with that state's Medicaid fee-for-service program, have
8 adequate protections from insolvency, and enrollees are at
9 no risk for the debts of the MCO.

10 The managed care procurement process creates
11 enormous potential for state Medicaid agencies to improve
12 access, quality, and health outcomes for enrollees. States
13 require MCOs demonstrate innovative ideas to improve the
14 managed care program in their bids and often binds MCOs to
15 their commitments to make in RFP responses in the resulting
16 contracts.

17 However, achieving the goals articulated in the
18 procurement process depends on strong federal and state
19 oversight of MCOs' contractual obligations. While CMS
20 promulgates regulations to establish requirements that
21 govern how Medicaid managed care programs should operate,
22 CMS generally does not have a direct role in ensuring that

1 MCOs are complying with federal and state regulations or
2 other contractual terms because CMS is not a party to the
3 contract.

4 For the past eight years, CMS has supported
5 states' implementations of the managed care rules through
6 sub-regulatory guidance, technical assistance,
7 informational bulletins, and training.

8 Both the Social Security Act and implementing
9 regulations impose specific responsibilities on state
10 Medicaid agencies when they choose MCOs as their managed
11 care partners.

12 First, Section 1932 of the Act requires states to
13 develop and implement a Quality Assessment and Improvement
14 Strategy, or QAPI, that includes performance measures MCOs
15 must meet and monitoring procedures the state will
16 undertake.

17 Second, Section 1903 of the Act requires states
18 develop capitation rates that are actuarially sound. The
19 managed care regulations at 42 CFR 438 clarify that
20 soundness includes states ensuring that capitation rates
21 are adequate to meet MCO contractual requirements regarding
22 availability of services, assurance of adequate capacity

1 and services, and coordination and continuity of care.
2 These rates may cover special contract arrangements between
3 states and MCOs, including incentives, withholds, and risk-
4 sharing mechanisms. Total payments under the incentive
5 arrangement, for example, capitation rate plus incentive
6 payment, cannot exceed 105 percent of the approved
7 capitation payments.

8 Third, the Act provides that a state may not
9 enter into contracts with MCOs unless the state has
10 established intermediate sanctions that it may impose on an
11 MCO that fails to comply with specific requirements.
12 Medicaid managed care rules implement this requirement for
13 state Medicaid agencies to hold MCOs accountable for
14 performance on access, quality, and costs. However,
15 actually imposing the sanctions is entirely within the
16 state Medicaid agency's discretion.

17 Since 2023, CMS requires states submit Managed
18 Care Program Annual Reports, or MCPARs, including
19 information on sanctions and CAPs states imposed on their
20 MCOs the previous year.

21 States are required to post MCPARs on their state
22 Medicaid program website, and CMS has begun posting MCPARs

1 from states in a central repository on Medicaid.gov.

2 Federal regulations at 42 CFR 700-708 provide the
3 basis for states to establish sanctions and require states
4 to establish intermediate sanctions for specific instances
5 in which the MCO acts or fails to act.

6 States must include this intermediate sanctions
7 language in their MCO contracts, and CMS confirms this
8 language is included during the review of states' managed
9 care contracts as part of readiness review.

10 Federal regulations do provide CMS with direct
11 oversight and enforcement authority in specific instances.
12 For example, CMS must approve states' actuarial rate
13 certifications with MCOs. CMS must also review and approve
14 state Medicaid agency contracts with MCOs to ensure they
15 include all of the federal requirements specified in 42 CFR
16 438.

17 CMS has authority to deny federal match on state
18 capitation payments to an MCO that does not comply with the
19 applicable requirements of Section 1932 of the Social
20 Security Act.

21 Under Section 1903 of the Act, CMS may also deny
22 federal match for new enrollees of an MCO for the same six

1 reasons for which the state must establish intermediate
2 sanctions: failing substantially to provide medically
3 necessary services to an enrollee; improperly charging
4 enrollees for services; discriminating against enrollees
5 based on their health status or need for services;
6 providing false or misleading information to CMS or the
7 state; providing false or misleading information to
8 enrollees, potential enrollees, or providers; and failing
9 to comply with physician incentive plan requirements.

10 In the 2024 Managed Care Rule, CMS increased
11 managed care oversight through additional reporting
12 requirements, particularly around beneficiary access to
13 care. The rule requires states to submit and implement a
14 formal remedy plan for any of its managed care plans when
15 monitoring and oversight activities by the plans, states,
16 or CMS demonstrate a managed care plan needs improvement in
17 meeting required access to care standards. That part of
18 the rule is effective in 2028.

19 Traditionally, CAPs have been imposed and
20 monitored by state Medicaid agencies or their contracted
21 external quality review organizations, or EQROs, as part of
22 the annual EQR process.

1 Under this new requirement, states must submit a
2 remedy plan to CMS for approval within 90 calendar days of
3 the state becoming aware of a managed care plan's access
4 issue. The remedy plan must address the issue and improve
5 access within 12 months and must demonstrate those
6 improvements are measurable and sustainable.

7 States must submit quarterly progress reports to
8 CMS, and if the remedy plan does not result in improving
9 the access issues within one year, CMS may require changes
10 to the remedy plan and/or continuation of the remedy plan
11 for a second year.

12 CMS and states have made concerted efforts to
13 strengthen oversight of managed care programs, but little
14 is known about the accountability tools state Medicaid
15 agencies use to ensure MCOs comply with contractual
16 requirements and meet or exceed performance expectations.

17 States have a range of mechanisms, including
18 withholds and incentive payments, for achieving quality
19 standards, quality-based auto-assignment of enrollees,
20 fines for late or incomplete report submission, corrective
21 action plans or CAPs, and financial penalties, sometimes
22 called liquidated damages. Few studies have systematically

1 examined states' use of these mechanisms or their
2 effectiveness.

3 Working with Mathematica, we conducted a
4 systematic review of Medicaid MCO contracts executed
5 between 2021 and 2024 for 40 states operating comprehensive
6 risk-based managed care. Of the 40 states in the
7 environmental scan, we also reviewed 23 RFPs that were
8 publicly available.

9 Let's begin by taking a look at the key findings
10 from the 23 RFPs we reviewed. Our review found that all 23
11 state RFPs required bidding MCOs to provide past
12 performance information in their response. Of the eight
13 specified categories of performance issues states required
14 MCOs to disclose in RFP responses, the most frequently
15 required were non-renewal or early termination of
16 contracts, which were required by 17 states. Corrective
17 actions or CAPs were required by 16 states and monetary
18 penalties for 12.

19 In addition to the categories of past performance
20 states included in RFPs, we made several other initial
21 findings regarding procurement. In regards to disclosing
22 past performance issues, only two states did not specify a

1 look-back period. The other 21 states varied in their
2 look-back period requirements ranging from two to eleven
3 years. More than half of the states required MCOs disclose
4 issues occurring in the previous two through five years.
5 Seven states required between six and ten years, and one
6 state required MCOs to provide eleven years of past
7 performance issues.

8 States also took a range of approaches in the
9 specific information requested within these broad
10 categories of performance issues and how the information
11 may be ultimately used in awarding a contract.

12 For example, one state primarily used past
13 performance as a tiebreaker between similarly scored
14 proposals. Another had RFP language that would allow the
15 state to refuse to consider any proposal from a bidder that
16 had violated contract provisions. A third state not only
17 asked whether a bidder had a Medicaid managed care contract
18 terminated, it also requested information on whether
19 bidders voluntarily terminated a contract with a state
20 Medicaid agency, withdrew from a service area, or requested
21 a reduction in enrollment levels. A fourth state required
22 bidders to its 2023 RFP to explain how they will avoid

1 contract noncompliance in the future if awarded a contract,
2 even if the bidding MCO did not have any deficiencies from
3 the past three years to report. And in one of the rare
4 instances where procurement decision documents were
5 publicly available, one state specifically noted that a
6 bidder's disclosure of PHI breaches, as required in the
7 RFP, was a deciding factor in the state not awarding that
8 MCO a contract.

9 It is worth noting that state Medicaid agencies
10 allow bidding MCOs to submit disclosures of past
11 performance under the confidential and proprietary process
12 common to RFPs. Therefore, our line of sight into whether
13 MCO disclosures were a factor in the state's evaluation of,
14 scoring, or selection of MCOs will only be known to us if
15 publicly available evaluation documents specifically
16 reference the deficiencies identified for bidders, as in
17 the PHI example.

18 Our review of 40 contracts executed between state
19 Medicaid agencies and MCOs from 2021 to 2024 found
20 overwhelmingly that financial sanctions and incentives were
21 the most frequently cited accountability tools available to
22 states. States were also universal in citing deficiencies

1 in MCO performance, quality of services, and enrollee
2 access to services as reasons for sanctions.

3 The contracts we reviewed touched on potential
4 differences in how states could use similar tools but frame
5 their approaches differently. For example, some states
6 frame public reporting or auto-assignment as an incentive
7 or reward for high performance, while others frame these
8 tools as penalties.

9 We identified 11 different types of sanctions
10 that states may impose on MCOs: administrative corrective
11 actions, enhanced monitoring and oversight, CAPs,
12 enrollment penalties, capitation payment penalties,
13 monetary penalties, temporary management of a contractor,
14 contract termination, refusal to renew the contract,
15 referral for investigation, and public reporting.

16 And we identified three types of incentives state
17 Medicaid agencies included in their contracts with MCOs:
18 capitation payment bonuses to meet or exceed performance
19 standards or targets, auto-assignment of enrollees, and
20 public reporting of MCO performance.

21 All 40 state contracts we reviewed had some type
22 of sanctions provisions. At the high end, two states each

1 had nine sanction types included in their contracts.
2 Eighty percent of the states, 32 of the 40, included
3 between five and eight sanction types in their contracts.
4 One state, a non-competitive application state, had the
5 lowest number of sanctions provisions in its contract with
6 three.

7 The most common sanction types states included in
8 their MCO contracts were monetary penalties, present in all
9 40, CAPs and contract termination, present in 38,
10 administrative and corrective actions in 32, enrollment
11 penalties in 24 state contracts, and capitation payment
12 penalties in 21.

13 Our study found that the underlying reasons
14 states cited in contracts to impose sanctions included
15 issues with access to services, contractual noncompliance,
16 and operational deficiencies with an MCO as well as its
17 subcontractors, among other reasons.

18 All 40 state contracts we studied had language
19 allowing state Medicaid agencies to impose sanctions of
20 some type in response to identified deficiencies in
21 performance, quality of, or access to service requirements.
22 This broad category includes noncompliance with federal

1 requirements such as external quality review, provider
2 network adequacy, or delays in service authorization.

3 All but one of the 40 states included incentives
4 in their contracts to encourage MCOs to achieve or exceed
5 performance standards. Ninety percent, or 36 of the
6 states, had MCO contracts allowing for capitation payment
7 bonuses to meet or exceed performance standards or targets,
8 followed by 17 states providing incentives through the
9 auto-assignment of enrollees. Three states included
10 explicit contract language allowing the state to publicly
11 report individual MCO performance on quality measures and
12 other performance indicators.

13 States have wide latitude to develop incentive
14 strategies that encourage and reward MCOs for meeting and
15 exceeding performance measures and contractual
16 requirements. Our study revealed a variety of approaches
17 for each incentive type that demonstrate the considerable
18 flexibility state Medicaid agencies have in designing an
19 MCO accountability program that meets their state's
20 particular needs. For example, one state tied incentive
21 payments to increased access to preventative, early
22 intervention, and behavioral health services by school-

1 affiliated health care providers.

2 The second most common incentive we found in the
3 contracts we reviewed were provisions allowing state
4 Medicaid agencies to auto-assign enrollees to MCOs based on
5 performance.

6 Seventeen state contracts had auto-assignment
7 language to reward high-performing MCOs with greater
8 enrollment. These methodologies were frequently tied to
9 performance on quality metrics such as HEDIS scores or
10 beneficiary satisfaction surveys.

11 Public reporting was only explicitly stated in
12 three contracts reviewed. For example, one state had a
13 provision in which it could include quality and performance
14 indicators on materials developed to help beneficiaries
15 select a plan. While not explicitly stated in the
16 contract, we did find that many states do publish some MCO
17 performance indicators on their websites.

18 In the second phase of the project, MACPAC will
19 work with Mathematica to conduct stakeholder interviews
20 with representatives of six state Medicaid agencies, their
21 respective MCOs, as well as federal agencies, Medicaid
22 managed care national experts, and beneficiary advocates.

1 We will also review the MCPARS to see what information is
2 being reported by states to CMS.

3 At this meeting, we hope to get the Commission's
4 feedback on the project's direction and the initial
5 findings from the federal policy review and 40-state
6 environmental scan. We also welcome Commission feedback on
7 topics to explore through our interviews.

8 Thank you.

9 CHAIR JOHNSON: All right. Thank you so much. I
10 thought that was very helpful.

11 So, Commissioners, any thoughts or questions,
12 particularly around the direction we want this project to
13 go?

14 All right. Angelo.

15 COMMISSIONER GIARDINO: Thank you for that. That
16 was really informative.

17 One thing I'd be interested in understanding as
18 you think about your analytic framework is if there's a way
19 to think about tiering or stratification of those
20 sanctions, because clearly terminating the contract is like
21 a nuclear option. There must be some thought process to
22 more intermediate steps if there's a sense that the plan

1 can improve and how can you nudge them versus this plan is
2 near fraud and we have to get rid of them. So I would just
3 like to understand best practices and how people think
4 about that tiering.

5 Thank you.

6 CHAIR JOHNSON: Thanks, Angelo.

7 John?

8 COMMISSIONER NARDONE: This is one we could do
9 like the whole meeting on this, right? I mean, just one
10 hour. I could go on and on about the procurement and
11 different pieces like that.

12 So one of the things that I would like you to
13 look at, if possible, going back to measurement, is can we
14 do some type of regression analysis looking at how
15 sanctions are used? Is there anything that looks at
16 sanctions versus HEDIS measure outcomes?

17 It's kind of going to be the same thing on pay
18 for performance. If states use a withhold versus the bonus
19 methodology, do you see some type of better outcomes when
20 it comes to those things? Because this has always been the
21 issue.

22 Yes, states do these things, and we're in essence

1 talking about here's how they do oversight, but does the
2 oversight lead to better outcomes? I know the only way we
3 can do it is through HEDIS measures probably, and those
4 aren't outcomes. Those are measurements, but that's what
5 we have right now. So I'll leave it to that, if there's
6 any analysis you guys can do going forward, we can do any
7 type of regression analysis to predict some of those
8 things.

9 Thanks.

10 CHAIR JOHNSON: Thank you, John.

11 Tricia.

12 COMMISSIONER BROOKS: Thank you.

13 This is -- I can only imagine the amount of work
14 that went into reviewing all of these contracts and trying
15 to figure out what they did and didn't say. So thank you
16 for this.

17 I have a couple of things. First of all, on the
18 slide that summarized the -- go back, and I'll find it.
19 Whoa, whoa. No. Go down one more. It was -- there were
20 three things on the slide. I think it was at the end.
21 Yeah, this must be it.

22 Okay. The public reporting of MCO performance,

1 is that that the contract specifies for the MCO to publicly
2 report? Is that what that is?

3 MS. REYNOLDS: So these were incentive tools that
4 were included in contract language where the state Medicaid
5 agency was contractually permitted to publicize MCO
6 performance information. But we did find that even if it
7 wasn't included in contracts explicitly, that many states
8 are publicizing that information, even if they didn't
9 include a provision like that in the contract.

10 COMMISSIONER BROOKS: Got you.

11 And on this same slide, there's no mention of
12 withholds, and I heard John mention it. Where do withholds
13 come in?

14 MS. REYNOLDS: So they'd be captured in the
15 first, in the capitation payment bonuses.

16 COMMISSIONER BROOKS: And do you know the
17 breakout on that?

18 MS. REYNOLDS: I don't have it available, but I
19 can certainly look and see if the data broke that out.

20 COMMISSIONER BROOKS: Okay.

21 And then my last question is just it's one thing
22 to have these contract provisions, right, that say we're

1 going to do this or that if you don't. Do we have any
2 information on how often sanctions are applied or, you
3 know, their withholds? I mean, how often do states
4 actually take these provisions and use them as they're
5 intended to be used?

6 MS. REYNOLDS: Those are questions that we can
7 explore in our interviews with stakeholders.

8 MR. PARK: And also, we are trying to look at the
9 MCPAR reporting. It's fairly new, so we're not sure to
10 what extent it's fully complete. But, you know, we will
11 get some information about what states are reporting to CMS
12 on whether we actually applied a CAP or financial penalty
13 and for, like, broad reasons.

14 COMMISSIONER BROOKS: Yeah. Thank you. That's
15 helpful, because I really -- I have a sense, but it could
16 be wrong, that, yeah, the provisions are there, but is the
17 oversight and holding the feet to the fire actually being
18 used for accountability? So I'd be interested in any more
19 information we could get on that.

20 CHAIR JOHNSON: All right. Thank you, Tricia.

21 COMMISSIONER NARDONE: So just following up on
22 Tricia and John's points, I mean, I think we're coming to

1 the same point of, like, what -- okay, how often are these
2 tools used, and which ones are most effective in
3 accomplishing the results, and what are the results we're
4 trying to achieve? So I would just reinforce those
5 points.

6 I think one of the things that I'm really
7 interested in is what is the state infrastructure that
8 states have to actually manage the managed care process,
9 and I think I'd be interested in maybe some of the ways
10 states do this.

11 I just reflect on my time, and I'm sure some of
12 the former Medicaid directors around the table could also
13 reflect on this, is, you know, we had to put structures in
14 place where managed care plans are reporting on a regular
15 basis, and it was real -- more real-time. I mean, it was
16 somewhat real-time.

17 One of the challenges with some of the HEDIS data
18 is that it's so far past, in a way, that, you know, like,
19 right now we're getting data for 2023, right? So I think
20 having some feeling for that as how states, like, actually
21 put that in place, I think, would be helpful for people to
22 appreciate and understand.

1 And also, just given how strapped, you know, all
2 levels of government are, like, what -- you know, how are
3 they managing that is what I'd be interested in. I guess
4 it's kind of also following up on what you were saying,
5 Tricia, but it's also kind of understanding the real
6 resource constraints that, you know, federal/state
7 government is under.

8 And then I guess I just want to ask, in this
9 context, do -- and this is kind of a separate topic that
10 I'm particularly interested in. In terms of value-based
11 purchasing strategies, will that be -- is that part of this
12 analysis in terms of accountability around, you know,
13 achieving quality outcomes for beneficiaries? Which I
14 don't know if that's kind of taking us to a different
15 place, but it's something I'm interested in.

16 MR. PARK: Yeah, it wouldn't be specifically
17 included in this project unless that is, like, one of the
18 specific outcome measures that a state would have built
19 into their contract in terms of, like, you know, you need
20 so many VBP arrangements and we expect these types of
21 outcomes. If you don't, you know, maybe there's a penalty
22 or incentive attached to that, but we're not specifically

1 going to ask about VBP.

2 COMMISSIONER NARDONE: So I think that's what a
3 lot of the -- I think that's where a lot of the contracts
4 are headed, right, like, with threshold requirements around
5 how many contracts have to be in value-based purchasing
6 agreements. Are there particular models of VBP that states
7 have to be implementing?

8 And I think it all kind of goes back to what are
9 you trying to measure, and if you're trying to improve
10 performance and hold plans accountable for improvements in
11 maternal and child health, for instance, you know, a lot of
12 contracts will have actual models that have to be put in
13 place for those populations. So I'm just -- I think it's
14 got to be a little part of that. I'm not sure how -- I
15 know, as others have commented, this is, like, an
16 incredibly broad topic, right? And so I know there's a
17 need to kind of stay focused, but I think as contracts move
18 increasingly to more value-based payment arrangements, I
19 think it'd be interesting to kind of at least have
20 awareness or insights into that.

21 CHAIR JOHNSON: Yeah. Thanks, Mike.

22 And just kind of following back up on your

1 resource and constraints comment, it would be interesting
2 to know, like, what additional resources states may have in
3 terms of the ideas around how they can use these tools more
4 effectively, I think would be really helpful. And then
5 also, too, there are differences between more mature states
6 and smaller states or other demographics or other areas
7 that may be helpful to you as well.

8 All right. Adrienne.

9 COMMISSIONER McFADDEN: Yes. Thank you for the
10 work. I appreciate it. There's really not a state scan
11 that I have not appreciated. So I really enjoyed reading
12 through this.

13 So I have a general comment and then sort of an
14 area of curiosity, which I think thematically is very
15 consistent with the other Commissioners. So the general
16 comment is the past performance information that was in the
17 reading materials. I think just a little nuance there, it
18 comes both in the form of disclosures from the MCOs, but
19 also, there's this sort of underlying state reference,
20 whether it's official or unofficial. So I think that's
21 something that could come out as well as you're exploring
22 more.

1 So general curiosity, like everyone else, I think
2 the ultimate goal is to really optimize MCO performance,
3 and so I'm going to dissect your language a little bit more
4 and say I sort of looked at it in two ways. One, it's sort
5 of the consequences of the performance. So that may be the
6 auto-assignment that may be direct sort of financial
7 impacts, whether it's a penalty or a sanction or a bonus,
8 et cetera. And then sort of the approach that is taken by
9 the states, which is either the carrot or the stick
10 approach. And so I would really be curious as to sort of
11 what are the more effective consequences.

12 And then the second one would be what's the more
13 effective approach to the consequences, whether it's a
14 carrot or a stick.

15 And then to the resourcing sort of theme, really
16 understanding how much resourcing or the burden of
17 administering or executing these sort of tools actually
18 factored into how the state went about it.

19 CHAIR JOHNSON: Thank you, Adrienne.
20 Patti.

21 COMMISSIONER KILLINGSWORTH: I don't want to
22 sound like a broken record, but I do want to reinforce the

1 importance of really understanding the efficacy of the
2 various tools that are available. I just think it's very
3 difficult to make recommendation about the use of tools if
4 we don't really understand which ones are having the
5 desired impact.

6 And I think John said it well. You know, does it
7 lead to better outcomes? I would add and/or improve
8 performance. I think there are aspects of performance that
9 may not sort of get to the level of HEDIS outcomes, but
10 they're really important from a performance perspective.
11 And so I would just encourage us to really focus on that as
12 we do this work.

13 The other thing I would just mention that I think
14 is kind of important is just kind of bearing in mind the
15 CMS oversight and making sure that we continue to honor the
16 fact that CMS oversight is really to the state, which is
17 the CMS contractor, if you will, and then the state is
18 responsible for overseeing the plans. And so when we think
19 about CMS's oversight, I just want to be sure that we kind
20 of keep in mind that CMS should be overseeing how the state
21 oversees the health plans and not kind of put -- not sort
22 of renegotiate that relationship, if you will, and put CMS

1 in a different position when they really don't have that
2 contractual responsibility over health plans.

3 Thank you.

4 CHAIR JOHNSON: Thank you, Patti.

5 Dennis.

6 COMMISSIONER HEAPHY: Thanks.

7 So my question is really about transparency and
8 the procurement, the reporting, like what CAPs are in place
9 and overall performance, because transparency is key to, I
10 think, the performance of a plan. It would be helpful to
11 understand why certain states, if it was three, actually
12 have that public reporting, and why do they do that?
13 What's the purpose of it, and what's the outcome that they
14 get from that?

15 And then other states, why aren't they more
16 transparent about the entire process? And especially for
17 consumers, for folks who are going to be joining or
18 assigned to a plan, that they should know what the quality
19 of the plans are. So the lack of transparency is really a
20 big issue for me.

21 And then network adequacy, the states have
22 different definitions of network adequacy, because some

1 states may require more restrictive time, time and
2 distance, or they may have accessibility requirements that
3 the plan needs to show that the X number of providers in
4 that area have such specialties or just accessible, like,
5 disability ADA requirements.

6 The other question I have is, given the variation
7 in the state definition of performance, it would be
8 helpful, I think, to understand where the common
9 requirements are for performance or where performance
10 outcomes vary. Does that make sense?

11 MS. REYNOLDS: Yes.

12 COMMISSIONER HEAPHY: Okay, thanks.

13 CHAIR JOHNSON: Thank you, Dennis.

14 Heidi.

15 COMMISSIONER ALLEN: Thank you for this work. A
16 lot of the things that I had on my list, other
17 Commissioners have already mentioned, so I'll try not to be
18 too redundant.

19 I was really intrigued by the levers that were
20 used both as incentives and sanctions and, like,
21 particularly auto-assignment. Is auto-assignment something
22 that when you're new into the market that that benefits

1 you, but when you've been there for a long time, it doesn't
2 because you would prefer for people to be able to just
3 directly select? I just would love to understand that
4 more.

5 And building off of Dennis's question about
6 public reporting, I'm curious about the differences when
7 it's used as an incentive versus used as a sanction. Are
8 there different ways of reporting? Like, are the
9 incentives more consumer friendly? So, you know, you go on
10 the website, and you're like, this is the one that the
11 state thinks is doing really well and, therefore, I want to
12 apply. And are sanctions hidden in some report somewhere
13 on a website that the consumer would never see? I'm kind
14 of interested in that relationship.

15 And then, you know, what many people have said is
16 it's all about trying to make meaning on these tools in
17 terms of how they impact behavior, and it seems like
18 monetary penalties are a really big one, and I just would
19 love to kind of get an understanding of the scope of the
20 penalty relative to the financial benefit for the behavior
21 that was being penalized.

22 So, you know, sometimes you'll hear about, oh,

1 this company was fined a million dollars for doing X, Y,
2 and Z. But then you're like, oh, well, they made \$75
3 million doing X, Y, and Z. So, really, it isn't going to
4 drive behavior change because it was still in their
5 benefit.

6 And related to that, I'm interested in the
7 concept of, like, too big to fail. Are there managed care
8 organizations that are so important for provider networks
9 or so well established that these levers are kind of
10 weakened because states really can't say, "I'm not going to
11 work with you anymore," or is that just not something that
12 exists?

13 And thinking, like, particularly like Oregon and
14 the CCO model, how has a model like that, which has really
15 fully tried to get the managed care organizations in deep
16 contractual relationships with their providers -- how would
17 you negotiate that, you know, like being able to pick
18 somebody else who doesn't have these kind of already
19 established relationships?

20 It's pretty complicated, but I'm curious as
21 states are trying to do these innovative things to
22 restructure the delivery system and the relationship

1 between the managed care companies and the delivery
2 systems, like, how that changes the contractual process and
3 procurement.

4 And that's it for me.

5 CHAIR JOHNSON: Thank you, Heidi.

6 Carolyn?

7 COMMISSIONER INGRAM: Well, thank you so much for
8 starting this work, and I think I agree with my fellow
9 Commissioners that this could be a lot. So I'm going to
10 just go down my list of things and happy to talk if
11 clarification is needed.

12 One of the questions I had is if you found any
13 states providing for consumers' report cards or dashboards.
14 I'm familiar with what TennCare does or Tennessee does, but
15 wanting to know if there's something that's more consumer
16 friendly. That goes off of some of our other work that
17 we're talking about later today.

18 The other piece that I'm wondering about is the
19 number of members who are auto-assigned versus actually
20 choosing. So in your work, a lot of the states, it looks
21 like, use auto-assignment as a way to award managed care
22 companies, but I'm curious if that's really a reward or are

1 most of the members assigned already, are they really
2 actually choosing, and what the variance is on that piece.

3 I think Heidi raises a good point about
4 recognition for outcomes, and John raises this as well. In
5 the performance oversight, are managed care companies ever
6 recognized for the extra things they may do? Oregon is a
7 good example, but there's a lot of states now that have
8 approvals, or if they don't have approval, encourage their
9 managed care companies to do something around social
10 drivers of health, such as providing supportive housing,
11 meals, work training. And I'm wondering if there's
12 anything ever done in terms of measurement to look at
13 outcomes with those types of services and some of the
14 unique things that managed care companies bring to the
15 table.

16 Commissioner McFadden brought up the issue around
17 background checks and reference checks being used in
18 procurements. I'm curious if in any of your data, you
19 found how many states are actually willing to do those
20 reference checks anymore.

21 Back when I was Medicaid director, you know, it
22 was common usually to get calls from other states off the

1 cuff and not in a formal process to respond to an RFP, and
2 I think one of the things we're finding is that due to
3 these procurements being protested so much, there's a
4 caution around the legality of providing references that
5 could be scored, and so states are now deterred from
6 actually providing those. So I'm wondering if you've found
7 in your research any states willing to still share that
8 reference information actually on the record, or if they're
9 now doing it in a different format or a different way that,
10 again, consumers won't openly see.

11 And then lastly, I think Dennis's point on common
12 performance measures would be really helpful to see. So I
13 just want to back up his question there, how much we're
14 looking at common measurement tools so there can be some
15 comparisons for consumers to be able to look at in terms of
16 outcomes.

17 CHAIR JOHNSON: Thank you, Carolyn.

18 COMMISSIONER INGRAM: Thank you.

19 CHAIR JOHNSON: Jami.

20 COMMISSIONER SNYDER: Allison, Chris, thanks so
21 much for digging into this really important and really
22 complex topic.

1 I've had the opportunity to work in a couple of
2 states, and what I can tell you -- and you alluded to this
3 throughout your presentation -- that there's tremendous
4 variability in terms of what states review, the frequency
5 with which they review various performance measures, and
6 the magnitude of penalties and incentives.

7 So I'm going to echo the sentiments of many of my
8 colleagues just to really dig in as you conduct your
9 interviews and try to identify best practices that really
10 contribute to improved performance and improved outcomes.

11 The other thing that I did want to mention, as we
12 all know, with the managed care regulation that was
13 finalized earlier this year, by 2028 states will be
14 required to post the performance of health plans via the
15 quality rating system report card, I guess you could call
16 it, but I think there are a host of measures, 16 or 17
17 measures that they've identified, that states will be
18 required to report on and post the information on their
19 websites. That might be an important monitoring tool to
20 note that's upcoming in the future.

21 CHAIR JOHNSON: Thank you, Jami.

22 Doug?

1 COMMISSIONER BROWN: Like other Commissioners
2 have said, thank you both for the detailed report here
3 today.

4 One comment that I want to make here is that I
5 think as we talk about ensuring accountability, we're
6 focusing on kind of the negative. What are the penalties
7 in place that spur action upon the MCOs to do better?

8 I want to make sure that we're looking at this as
9 a bell curve, because I think there's some MCOs that are
10 performing very well, securing bonuses, or in states where
11 they only have penalties, you're focused on one penalty
12 associated with one MCO. But if they have five MCOs, four
13 MCOs are not getting penalties. And so it goes to the
14 totality of the state and the plans in those states and how
15 well those plans are operating. And I don't just want it
16 to look like -- you know, I'd like to make sure that we're
17 kind of accounting for the fact that penalties only occur
18 in certain instances versus all instances.

19 Thanks.

20 CHAIR JOHNSON: Thank you, Doug.

21 Jenny?

22 COMMISSIONER GERSTORFF: I have a few things
that

1 I think would be worthwhile to look into. One is to what
2 extent sanctions or incentives affect risk margin
3 assumptions and capitation rate setting and then variation
4 in planned financial performance and how that might be
5 correlated to assessed penalties or incentive payments and
6 then state oversight of penalties and incentives when MCOs
7 delegate a significant portion of their business to another
8 entity, subcontractor.

9 And then are we considering incentives that are
10 incorporated into risk mitigation arrangements, so like
11 outside of the capitation rates? There could be some that
12 are more inherent there.

13 CHAIR JOHNSON: Thank you, Jenny.

14 And then Dennis.

15 COMMISSIONER HEAPHY: To Doug's comment, I really
16 appreciate that. I think it would be helpful to
17 understand, like, on what basis states actually provide
18 incentives to the plans that have done really well. And
19 there's no more criteria that states to do that.

20 But I also want to comment on Heidi's statement
21 about too big to fail. I see that as a big concern for
22 folks in the community. There are plans that may have a

1 disproportionate share of the population, Medicaid
2 population, and therefore, it would be too difficult for
3 the state to do away with them.

4 And so I guess the question to ask folks is, is
5 there a concern about a David and Goliath sort of situation
6 where states have challenges? We're asking states or
7 stakeholders why underperforming plans are permitted to
8 maintain their contracts. Like, what are the reasons
9 they're permitted to do that? You can word it whatever way
10 you want, but it would be helpful to get at that sort of
11 ability of these plans to continue to perform as
12 underperforming in states over time.

13 Thanks.

14 CHAIR JOHNSON: Thank you, Dennis.

15 Any other Commissioners?

16 [No response.]

17 CHAIR JOHNSON: So, Allison, I think you can tell
18 there's a lot of interest here. So I think we're going to
19 be looking forward to a lot of different conversations
20 around this. So thank you again for your efforts. All
21 right.

22 MS. REYNOLDS: Thank you so much for all the

1 thoughtful feedback.

2 CHAIR JOHNSON: Thank you.

3 All right. So you are all staying right there.

4 We are going to go to our next session here, and Allison

5 and Chris will help us to continue our discussion on

6 potential improvements to the EQR process.

7 Are we doing public session now? You have that

8 up. Okay. Just making sure. Making sure. Okay.

9 So I'll turn it over to both of you to get the
10 conversation started around the draft recommendations that
11 we have.

12 [Pause.]

13 **### EXTERNAL QUALITY REVIEW (EQR) DRAFT**

14 RECOMMENDATIONS

15 * MS. REYNOLDS: Good morning, Commissioners,

16 again.

17 Today we will continue our discussion of Medicaid

18 Managed Care External Quality Review, or EQR, from the

19 September and October MACPAC public meetings.

20 At the October meeting, Commissioners expressed

21 interest in moving forward with potential recommendations

22 to improve the managed care EQR process. These proposed

1 recommendations are intended to build on MACPAC's ongoing
2 work examining effective oversight of Medicaid managed care
3 programs to ensure beneficiaries have appropriate access to
4 needed services, work that continues, as you heard from
5 this morning's earlier presentation.

6 We will begin with a brief overview of key
7 elements of the current EQR process, including those
8 impacted by the 2024 Medicaid Managed Care Final Rule.
9 Next, we will recap the five limitations and challenges
10 with the current process identified by our study. We will
11 then spend the majority of our time this morning presenting
12 three proposed recommendations for the Commission's
13 consideration, intended to address those limitations. We
14 will conclude with next steps, including a decision by the
15 Commission to advance any of the proposed recommendations
16 to a vote at our January 2025 public meeting.

17 Let's briefly review the key elements of the
18 current EQR process relevant to our study findings and
19 proposed recommendations.

20 As of 2024, Medicaid agencies in 45 states and
21 the District of Columbia contract with managed care plans
22 that are subject to the EQR process. These state Medicaid

1 agencies are required to contract with qualified
2 independent entities, referred to as EQROs, to conduct
3 periodic reviews of the quality, timeliness, and access to
4 care provided by the managed care plans operating in their
5 state.

6 Federal rules describe four mandatory quality
7 review activities that EQROs must conduct and report on as
8 well as seven optional activities that the state can choose
9 to have their contracted EQRO conduct.

10 CMS provides technical assistance to states,
11 EQROs, and managed care plans with EQR protocols for each
12 mandatory and optional activity. Section 1932 of the
13 Social Security Act requires CMS coordinate with the
14 National Governors Association and to contract with an
15 independent entity, such as the National Committee on
16 Quality Assurance, or NCQA, to develop the protocols.

17 Once the EQRO has completed the mandatory and any
18 optional activities for a state Medicaid agency within a
19 calendar year, the EQRO produces an annual technical
20 report, or ATR, summarizing those activities, each plan's
21 performance, and the state's managed care program overall.

22 The 2024 Medicaid Managed Care Rule requires the

1 ATR include outcomes data for three of the four mandatory
2 EQR activities but not for the triennial compliance review.
3 States are required to publish the ATR on their individual
4 state websites and provide the reports to CMS.

5 Now that we've reviewed the key elements of the
6 current EQR process, we'll recap the limitations and
7 challenges with that process revealed by our previous study
8 and our analysis of the 2024 Medicaid Managed Care Final
9 Rule.

10 As we detailed for the Commission at the
11 September 2024 public meeting, our in-depth study conducted
12 from 2022 through 2024 included 18 interviews with more
13 than 60 stakeholders representing five state Medicaid
14 agencies, three external quality review organizations,
15 three managed care plans, four consumer advocacy
16 organizations, as well as NCQA and CMS.

17 We've identified five gaps in how the current EQR
18 process and findings from EQR activities are used to
19 oversee managed care plans and improve quality. First, the
20 EQR process and state quality strategies are not always
21 aligned. Second, the EQR process and the protocols used
22 for EQR activities do not focus on outcomes. Three, states

1 vary on their enforcement of EQR findings. Four, the
2 annual technical reports recapping EQR activities are not
3 always accessible and the findings within them are hard for
4 stakeholders to use; and five, CMS oversight of the EQR
5 process appears limited.

6 At MACPAC's October 2024 meeting, Commissioners
7 expressed interest in moving forward with potential
8 recommendations to improve the managed care EQR process.
9 Commissioner feedback during the September and October '24
10 public meetings shaped the proposed recommendations.

11 The three proposed recommendations seek to shift
12 the focus of EQR activities from process and compliance to
13 meaningful outcomes and actionable data and to improve the
14 usability of that data through reporting standardization
15 and summarization. These proposed recommendations are
16 intended to build on MACPAC's prior and ongoing work
17 examining effective oversight of Medicaid managed care
18 programs to ensure beneficiaries have appropriate access to
19 needed services.

20 Our first recommendation is the Secretary of the
21 U.S. Department of Health and Human Services should direct
22 the Centers for Medicare and Medicaid Services to amend 42

1 CFR 438.364(a)(2)(iii) to require the external quality
2 review annual technical report include outcomes data and
3 results from quantitative assessments collected and
4 reviewed as part of the compliance review mandatory
5 activity specified at 42 CFR 438.358(b)(1)(iii).

6 Our first proposed recommendation is regarding
7 the triennial compliance review, a mandatory EQR activity
8 to determine the extent to which states' managed care plans
9 policies and procedures are in compliance with 14 federal
10 standards detailed in 42 CFR 438, including standards
11 related to access, coverage and authorization of services,
12 and care coordination.

13 The triennial compliance review is the most
14 comprehensive EQR activity required by CMS, assessing each
15 plan's core operational areas - from health information
16 systems, through coverage and authorization of services, to
17 grievance and appeal systems.

18 Many stakeholders we interviewed, including state
19 officials and managed care plan representatives, identified
20 the compliance review as the most important EQR activity
21 and detailed the extensive time and resources devoted to
22 preparing for, executing, and responding to the review.

1 Despite this view of the activity by
2 stakeholders, the triennial compliance review was the only
3 mandatory activity left out of the 2024 Managed Care Final
4 Rule requiring outcomes data be reported in the annual
5 technical report. Therefore, this first proposed
6 recommendation closes that gap.

7 In the preamble of the rule, CMS stated that the
8 new requirement for reporting outcomes data would result in
9 more meaningful ATRs. Consequently, the ATR would become a
10 more effective tool for states to use in quality
11 improvement and managed care plan oversight.

12 MACPAC and other stakeholders noted in their
13 comments to the proposed rule that this change to require
14 outcomes data and quantitative assessments for EQR
15 activities may help place a greater emphasis on performance
16 outcomes and comparability.

17 In its commentary, CMS did not explain why the
18 triennial compliance review activity was not included in
19 this new requirement to report outcomes data and results
20 from quantitative assessments. In discussions with CMS
21 after the release of the 2024 Managed Care Rule, they did
22 not identify a specific rationale for excluding the

1 triennial compliance review from this new requirement.

2 In addition to closing the gap in the 2024
3 Managed Care Final Rule, this recommendation also builds
4 upon the existing EQR protocol for the triennial compliance
5 review and carries outcomes data gathered into the annual
6 technical report.

7 The existing protocol already includes suggested
8 questions the EQRO ask plan representatives and suggested
9 reports the EQR gather, such as on service availability and
10 accessibility, data on enrollee grievance and appeals, data
11 on claims denials, and performance measures.

12 If the EQRO is required to include in the ATR any
13 outcomes data and the results from quantitative assessments
14 reviewed or generated as part of the triennial compliance
15 review activity, it could demonstrate the outcomes
16 associated with the plans, policies, and procedures,
17 particularly around the availability and furnishing of
18 services and timely access that would not necessarily be
19 captured in other mandatory EQR activities.

20 Finally, we want to make clear that this
21 recommendation is not intended to create new measures or
22 mandate specific data be collected and reported, but rather

1 to report information that EQROs are already reviewing as
2 part of the compliance review.

3 In evaluating the impact of this first proposed
4 recommendation on key stakeholders, we do not anticipate
5 that it would require fundamental changes to the triennial
6 compliance review EQR protocol issued by CMS nor
7 preparations for this activity by state Medicaid agencies
8 or managed care plans. We will get an official score for
9 any recommendations from the Congressional Budget Office,
10 but we do not anticipate this recommendation increasing
11 federal spending.

12 There could be increased administrative effort on
13 CMS, but this could be reduced by leveraging efficiencies
14 and consistencies across all four mandatory EQR activities.
15 Nor do we anticipate an increase in state spending or
16 administrative effort for state Medicaid agencies or
17 managed plans.

18 Finally, states, managed care plans, and
19 enrollees could benefit from new insights generated by the
20 outcomes data being reported in the annual technical report
21 that could improve Medicaid managed care quality and access
22 to care.

1 Our second proposed recommendation is the
2 Secretary of the U.S. Department of Health and Human
3 Services should direct the Centers for Medicare and
4 Medicaid Services to issue guidance and external quality
5 review (EQR) protocols that include more prescriptive and
6 consistent standards for reporting on EQR activities to
7 improve the usefulness of report content and alignment of
8 the EQR process with the overall federal quality and
9 oversight strategy.

10 Our second proposed recommendation is in response
11 to feedback voiced by stakeholders and the Commission
12 regarding the need for the EQR process to be streamlined as
13 federal managed care quality and oversight requirements
14 become increasingly complex and for EQR activities to be
15 aligned with other federal requirements to reduce states'
16 burden to provide duplicative information.

17 In our interviews, both state Medicaid agencies
18 and plans valued the flexibility CMS has given states to
19 design their EQR process but think this flexibility can be
20 better balanced with standardization and consistency to
21 help stakeholders find, interpret, and align EQR findings
22 and bring efficiency to the EQR process.

1 Stakeholders we spoke to reported that
2 flexibilities in the implementation of EQR protocols can
3 lead to inconsistent interpretation and reporting across
4 states, programs, and EQROs.

5 Additionally, inconsistent reporting makes it
6 difficult for stakeholders, including state and federal
7 officials, to extract key findings from the annual
8 technical report, place EQR findings in context, or
9 synthesize EQR findings with other required quality and
10 oversight activities.

11 MACPAC's review found that ATRs are lengthy,
12 detailed, and often hard for audiences to comprehend. The
13 vast majority of ATRs are hundreds of pages long, often
14 with additional appendices or attachments.

15 Additionally, our review found states used
16 different approaches for evaluating plan performance,
17 making it difficult for individuals to clearly determine
18 the extent to which a plan was compliant or the extent to
19 which a plan's non-compliance was significant.

20 A more standardized structure for summarizing and
21 reporting EQR activities, results, or actions taken by the
22 state Medicaid agency in response to findings would make it

1 easier for interested stakeholders to review these reports
2 and glean the key takeaways on plan performance.

3 As part of our second recommendation, we suggest
4 CMS should consider the following design considerations
5 when providing guidance and updating the EQR protocols.
6 First, reduce EQR reporting requirements that are
7 duplicative of information included in other federally
8 required reports. Second, develop a standardized template
9 that synthesizes and summarizes key findings and
10 recommendations; for example, an executive summary. Third,
11 establish a clear link between EQR processes and the state
12 managed care quality strategy. Four, identify key
13 indicators of plan performance based on stakeholder input,
14 which should be consistently reported in the template in
15 order to track performance across plans and states over
16 time. And finally, require additional information that
17 clearly identifies a plan's level of compliance and puts
18 its performance into more context; for example, through
19 comparison to national benchmarks.

20 We do not anticipate the second recommendation
21 would increase federal spending. There could be some
22 increased administrative effort for both CMS and state

1 Medicaid agencies initially, but this could be offset by
2 alignment between EQR processes and other federal quality
3 and oversight reporting requirements. We anticipate
4 managed care plans could benefit from efficiencies gained
5 through standardized EQR activities. Finally, enrollees
6 could benefit from increased transparency and accessibility
7 to managed care plan information.

8 Our third proposed recommendation is the
9 Secretary of the U.S. Department of Health and Human
10 Services should direct the Centers for Medicare and
11 Medicaid Services, CMS, to require states to publish
12 external quality review, EQR, annual technical reports in a
13 508-compliant format and for CMS to publicly post all state
14 EQR reports in a central repository on the CMS website.

15 While there are federal requirements for states
16 to post their annual technical reports publicly, our
17 project found that the most recent reports can oftentimes
18 be hard to find. Given that EQR is an important statutory
19 oversight mechanism related to managed care, the lack of
20 accessibility of some reports can hinder the ability of
21 stakeholders to monitor health plan performance.

22 CMS could improve transparency by developing a

1 central repository for these ATRs on the Medicaid.gov
2 website, similar to the way they began posting the Managed
3 Care Program Annual Reports, or MCPARS.

4 This recommendation addresses a gap in the
5 current process, which is that CMS publishes summary tables
6 based on the ATRs on Medicaid.gov, but the summary tables
7 do not include any findings from the ATRs. As such,
8 stakeholders are not able to use these summary tables to
9 assess plan performance.

10 Officials at CMS indicated that it was
11 challenging to post the ATRs on the Medicaid.gov website
12 due to issues with 508 compliance. CMS has been able to
13 post other reports, such as MCPARS, because there is a
14 standardized template. To address these issues, CMS should
15 require states and their EQRO provide the EQR technical
16 reports in a 508-compliant format.

17 Alternatively, CMS could require a standardized
18 executive summary in a 508-compliant format in addition to
19 the entire report. This executive summary would simplify
20 the process of making the EQR findings 508-compliant so
21 that CMS could post these summaries in a central location
22 and provide stakeholders easier access to the key EQR

1 findings across states.

2 We do not anticipate the recommendation as
3 increasing federal spending. There could be some increased
4 administrative effort for CMS, state Medicaid agencies, and
5 managed care plans to initially create and report using the
6 508-compliant template, but this would diminish over time
7 and across states due to standardization.

8 Finally, enrollees could benefit from increased
9 transparency and accessibility to managed care plan
10 information in one central location.

11 During this meeting, we look forward to the
12 Commission's feedback to the three proposed recommendations
13 and the rationale for each. If the Commission decides to
14 move forward with any of the three proposed
15 recommendations, then we will be back in January 2025 for
16 the Commission to vote on those recommendations and to
17 review a draft of the chapter to be included in MACPAC's
18 March 2025 report to Congress.

19 Once again, here are the three proposed
20 recommendations for the Commission to consider. We look
21 forward to your feedback. Thank you.

22 CHAIR JOHNSON: Thank you so much. That was very

1 helpful.

2 So let's go ahead and get your feedback. I know
3 you've all read this and digested this information, and
4 Allison's presentation was very helpful. Let's go ahead,
5 and let's do it by each of the different recommendations.
6 So let's start with Recommendation 1, if you have any
7 particular feedback.

8 Sonja.

9 COMMISSIONER BJORK: Well, 1 seems very logical,
10 and isn't that great that it doesn't cause any additional
11 budgetary impacts or administrative impacts? So I'll save
12 the rest of my comments for the other recommendations.

13 Thanks.

14 CHAIR JOHNSON: Okay. Anyone on Recommendation
15 1?

16 Jami.

17 COMMISSIONER SNYDER: I have one quick comment on
18 Recommendation 1. I'm totally in agreement with the
19 recommendation and support it. I wonder if it would be
20 helpful, because you do mention in the memo supplied to
21 Commissioners, that our real interest when it comes to
22 outcomes is around the availability and timely access to

1 services. Would it be helpful to include that language in
2 the actual recommendation as an example of outcome data
3 that we'd like to see included in the reporting?

4 MR. PARK: Well, there's always kind of this
5 tricky balance between how much we include in the actual
6 recommendation language versus, like, the rationale,
7 because we don't also want to suggest that's the only area
8 where, you know, we would want the data. So, certainly, we
9 can think about, you know, maybe ways to reinforce, you
10 know, the importance of that. But, we also don't want to -
11 - you know, this got into some of the comments from the
12 Commission about to what extent should there be required
13 measures or outcomes to be reported versus the state
14 flexibility and, like, how they design their EQR, you know,
15 what measures they have implemented, where they are
16 actually collecting data versus process, you know,
17 measures.

18 So, you know, we can certainly think if you do
19 want to include more specifics in the actual recommendation
20 language, but that's always a tricky balance as to kind of,
21 like, what's there versus in the rationale.

22 COMMISSIONER SNYDER: Yeah, it may be the case

1 that it would be just as impactful to just include some
2 additional detail when we talk about the availability and
3 timely access to services in the chapter, so we're giving
4 states some examples of the kind of information that we'd
5 like to see included in the reports, if that makes sense.

6 MR. PARK: Yeah, yeah.

7 CHAIR JOHNSON: Thank you, Jami.

8 Mike?

9 COMMISSIONER NARDONE: This is a question in
10 terms of all the data elements that are part of the
11 triennial review. Will some of those overlap with
12 information that's provided in MCPARS and the access
13 reporting? I'm just trying to figure out, like, we're
14 trying to make a requirement, right, that isn't
15 duplicative, kind of streamlining this. So we're getting
16 the necessary information, but we're not kind of creating
17 different reports that maybe even conflict with one
18 another. So I'm just curious, is there overlap? And I
19 guess that's a point we would make in the chapter, right,
20 around that we want to minimize the duplication.

21 But just for my own information, I don't know all
22 the different items that are in both sources.

1 MS. REYNOLDS: Sure. So given the breadth of the
2 triennial compliance review and the 14 standards that are
3 evaluated, it does evaluate sort of the whole operational
4 organization, and there is some aspects. Its focus is
5 mostly on the policies and procedures.

6 So, for example, care management is evaluated,
7 but often it's asking the plan to share their
8 stratification formula and their care management process
9 and not really the numbers, if you will, whereas some of
10 the other EQR activities, HEDIS measures, other -- the
11 performance measure validations, et cetera, have very
12 specific measures and targets, et cetera, whereas the
13 compliance review focuses more on the process. But there
14 is the data component that naturally comes about and the
15 opportunity in this recommendation to link those two
16 together.

17 MR. PARK: And what I would say is some of the
18 duplication, potential duplication of reporting is more
19 addressed in Recommendation 2 versus this specific
20 recommendation.

21 CHAIR JOHNSON: Thank you. That was a good
22 segue.

1 Let's go to Recommendation 2, proposed
2 Recommendation 2.

3 All right. Patti.

4 COMMISSIONER KILLINGSWORTH: I'm actually backing
5 up to 1 for just a second and want to ask if I'm thinking
6 about this in the right way.

7 So to the extent that we would duplicate some
8 reporting that's available in the annual reports, wouldn't
9 sort of doing -- including those in the triennial, give us
10 an opportunity to actually look at trends, if you will, and
11 improvement or not over time? Some of the things that
12 we've been thinking about, could you do that on your own by
13 going and getting all that information and putting it
14 together? Yes, but maybe that's a way of thinking about
15 some of the value of including it in this report as well.
16 It's kind of putting it all in one place in a longitudinal
17 way, at least for a short period of time.

18 As it relates to Recommendation 2, I think where
19 I get a little anxious -- and we've had these conversations
20 before -- is when we start to talk about prescriptive and
21 consistent standards, and we kind of begin prioritizing, if
22 you will, for states what they are focused on in their

1 quality strategies.

2 And maybe some things should sort of be
3 universal, but then states also need flexibility because
4 programs are different, and objectives and goals are
5 different. And so I would hate for this to all become a
6 very structured, standardized process where we kind of lose
7 sight of some of the very innovative things that states are
8 trying to accomplish through their programs.

9 I also worry, quite frankly, if the kinds of data
10 that we have available really reflect the true outcomes,
11 and I'll give you an example of that. Like, we can measure
12 denied claims, but that doesn't necessarily -- it doesn't
13 tell us why the claims were denied, right? We can measure
14 the services that require prior authorization, but
15 requiring prior authorization isn't necessarily a bad thing
16 for certain kinds of services where we want to be sure that
17 they're kind of not the default inpatient being one of
18 those.

19 And so I want us to proceed with great caution as
20 it relates to beginning to be really prescriptive about
21 what gets measured, at least in total in these reports.

22 CHAIR JOHNSON: Thank you, Patti.

1 Sonja?

2 COMMISSIONER BJORK: So I also appreciate the
3 need for consistency and the ability to compare, but I want
4 to touch on something that Patti brought up last time,
5 which is it's really difficult to compare for access
6 between really urban places and rural places. There's
7 never going to be certain kinds of specialists in a really
8 small town in rural Northern California, but you can still
9 measure access. Does the health plan offer telehealth
10 opportunities? Do they cover transportation if a person
11 needs to go in person all the way to San Francisco and have
12 a visit there?

13 And so when we're looking at the reporting, how
14 do we have an overlay or a category or a data element that
15 accounts for rural and really shows the true picture
16 instead of looking at an urban setting and saying, "Wow,
17 they have great access," and then look at a rural setting
18 and say, "Oh, that's a terrible health plan. They don't
19 have access there"? So we just have to pay very close
20 attention to rural considerations when we set up the data
21 reporting.

22 Thanks.

1 CHAIR JOHNSON: Thank you, Sonja. Good point.
2 John?

3 COMMISSIONER McCARTHY: I just don't agree with
4 this recommendation, and it kind of gets to what Patti and
5 Sonja just said.

6 Having worked in -- Medicaid director in two
7 states, well, the District and a state and then worked with
8 a bunch of states, the purpose of the EQR is to measure
9 what's going on in that state and what's particular about
10 that state. So I get nervous when we're doing
11 recommendations to standardize things nationally, because
12 that's not, in my opinion, the purpose of these reports.
13 It was more of a deep dive into that state.

14 And so to try to use this to do comparisons
15 across, I don't think that's the reason for the EQR
16 reports. That's the reason we've got the MCPAR that has
17 come out. That's the way to compare things across
18 different states. So on this one, I'm concerned that as we
19 standardize things, we'll be measuring the wrong things or
20 we'll be comparing apples to oranges.

21 MR. PARK: So just to clarify -- and maybe this
22 requires some tweaking to the recommendation language, but

1 we are not necessarily saying access would be measured by a
2 particular standard. But when the state is, they are
3 currently assessing whatever it is that they're reporting
4 in the EQR, that they should be clearly identifying that
5 information in the report. So it wouldn't necessarily
6 standardize to say all states must measure urban and rural
7 in a specific way, but when they report their findings and
8 assess the plan's compliance with those access standards,
9 they need to be clearly highlighted, maybe like an
10 executive summary or some way to really make that
11 information more transparent and accessible but also
12 provide some more information about why they think the plan
13 is compliant or non-compliant.

14 So instead of just providing, saying like 70
15 percent of X is the outcome, well, is that compliant or
16 non-compliant? Is that a range? Provide some more
17 information about is that 70 percent -- like, if the
18 national benchmark is 50 percent, then that's good. If
19 it's 90 percent, maybe it's bad. Just providing a little
20 bit more of that context to make the report a little bit
21 more usable, but it wouldn't necessarily require states to
22 report all the information in the same way, collect the

1 exact same outcomes data. It's more about trying to make
2 that information and synthesizing the results more clearly
3 in the report and reporting it so that it's a little easier
4 to find and providing some more of that context about the
5 nuance of the different numbers that might be reported.

6 COMMISSIONER McCARTHY: I understand what you're
7 saying, Chris, but I still, even at that level -- so two
8 things.

9 Number one, I think Mike is going to talk next,
10 and he has some new language that he's going to propose is
11 my understanding around fixing that.

12 COMMISSIONER NARDONE: I don't know if it answers
13 your --

14 COMMISSIONER McCARTHY: But even with what you're
15 saying, it is a slippery slope on those different pieces
16 because we do say standardized.

17 And then the second part of it is like when you
18 said there are examples of, oh, and there would be a
19 measure and you say if it's compliant or not compliant,
20 well, sometimes the EQR is doing things that's not about
21 compliance. You're just trying to find out information in
22 there. So that's what's in there.

1 So I think I hear what you're saying, and I think
2 the recommendation as we have it written now doesn't get to
3 that. So if that is the direction we want to go, we
4 probably have to work on it a little bit. I still have to
5 decide whether I agree with it or not.

6 COMMISSIONER NARDONE: So, you know, for me, the
7 key points around what I think is important in this
8 recommendation is that it's summarized and that it's
9 information that is helpful to stakeholders. Right now,
10 I'm not sure that the EQRO report is really presented in a
11 way that's particularly helpful, and I think kind of what
12 came out in my mind when we were talking about this the
13 last couple of meetings was it would be helpful to have a
14 more user friendly document that had some standardized
15 aspects and kind of summarized what was in the EQR report.

16 And I think it's also important that we're not --
17 to the extent that we're providing this report, that it's
18 not duplicative or it minimizes duplication with other
19 reporting that's out there.

20 So, you know, I know I was kind of put on the
21 spot to develop language, right? But actually, I think
22 that you may have already provided it. I mean, for me, the

1 key pieces were a more standardized structure for
2 summarizing and reporting EQR activities, results, or
3 action taken by the state Medicaid agency to help make it
4 easier for interested stakeholders to review these reports
5 and glean key takeaways on planned performance.

6 You don't have to use all those words, right?
7 But I think that's where I was trying to get to when we
8 talked about this recommendation. I don't know if that
9 helps with, you know, John's concerns, or maybe I'm kind of
10 not -- maybe I don't represent what other Commissioners are
11 thinking, right? So that's where I was -- wanted us to go
12 with this recommendation, and that was my -- that's my two
13 cents and my best effort to give you some language to work
14 with.

15 CHAIR JOHNSON: All right. Thank you, Mike.
16 Dennis.

17 COMMISSIONER HEAPHY: My comment actually echoes
18 what Patti has been putting in the chat, and that is the
19 recommendation doesn't really match what you seem to be
20 trying to accomplish as it's written, because I was viewing
21 it as a standardization of reporting requirements across
22 all the EQROs in different states as opposed to

1 standardization within reports of how information is going
2 to be reported out. And I think that's what Mike is trying
3 to get at is standardization within the reports, so there's
4 consistency in how they can be read.

5 And I also just put forward that -- I don't know
6 how you put this in language, but putting a plain language
7 format that supports the ability of stakeholders to read
8 the report. I don't know if that needs to be in the
9 recommendation itself, but so in the chapter. To me it is
10 about accessibility and usability by stakeholders.

11 Thanks.

12 CHAIR JOHNSON: Thank you, Dennis.

13 Heidi.

14 COMMISSIONER ALLEN: So I disagree with John.
15 Not the first time, probably won't be the last time. But I
16 do like you very much.

17 I think that we need more opportunities to
18 utilize the function of state policymaking as a laboratory.
19 We talk all the time about how states are supposed to learn
20 from each other, but then we lose all these opportunities
21 to be able to compare apples to apples. And it's part of
22 transparency. And many of these managed care companies

1 operate in multiple states. Why do they perform
2 differently in one state or another? I mean, I think these
3 are important things that consumers and CMS and its role of
4 oversight should be able to look at.

5 And so I'm not saying that it has to be entirely
6 prescriptive and everybody needs to do the exact same
7 thing, but I think some -- I think that, like, data without
8 context is meaningless. And we see this all the time in
9 MACPAC when we're reading these reports and we see that
10 there's variation, but we don't know what it means. We're
11 constantly like, well, what does it mean that 7 states do
12 that and 15 states do that and 13 states do that? I mean,
13 like, we need to be able to connect data to, like, meaning.
14 And so often we collect the data, but then we miss the
15 opportunity to make the meaning.

16 And so, yes, it would be nice if the reports are
17 standardized in the same way so that they look alike, and
18 you can know which section to look at to find this
19 information and the executive summary. Like, that is
20 indeed useful. But to me, what's more useful is to
21 understand across states, which have really different
22 policy environments and are using these levers and

1 strategic ways to get these outcomes, what levers are more
2 effective than others to achieve the outcomes that we care
3 about? And the only way to do that is through the
4 reporting that goes to CMS from states, and so any effort
5 to make that reporting more useful for CMS and more useful
6 for states to understand why things are happening that look
7 different in their areas.

8 Yes, populations are different, but partly what's
9 different are the policy levers that our states are using.
10 And one way of evaluating those policy levers is to be able
11 to compare apples to apples. That's my perspective. So I
12 support the recommendation as written.

13 COMMISSIONER ALLEN: Thank you, Heidi.

14 Angelo.

15 COMMISSIONER GIARDINO: I support the concept
16 that's in here, and I like Michael's conceptual overlay.
17 So I'm sure you all will be able to word this correctly.

18 But I do say, fundamentally, I think it's
19 wonderful that Medicaid is a joint federal/state program
20 and there's some variation in the states, but I'm not
21 willing to say all the variation is perfect, we don't need
22 to look at it, everybody in the states knows what they're

1 doing, so we don't have to ask. That, to me, just is not a
2 viable option.

3 This is a jointly funded federal/state program,
4 and we should be able to compare apples to apples across
5 states. And if there's some unique element to that state,
6 I suspect there's a footnote in this standard report, and
7 that can be explained. I have never heard anyone who's
8 interested in quality say that benchmarking is not helpful,
9 And the way you do benchmarking is by having standard
10 definitions and a shared understanding.

11 That's why HEDIS is valuable. No one's arguing
12 that HEDIS should be 50 different measures. We all figure
13 out what the vaccines are, and you report them.

14 So I think from a quality perspective, providing
15 guidance so that standard language is used and you can find
16 what you're looking for in a very easy, simplified way is
17 the way that stakeholders hold states and the federal
18 government accountable.

19 So I support this recommendation with Michael's
20 suggestions.

21 CHAIR JOHNSON: Thank you, Angelo.

22 Carolyn.

1 COMMISSIONER INGRAM: A lot of discussion on
2 this, which is good, I think, and healthy for the
3 commission, And I support the direction Mike was going with
4 doing some rewriting to get to the goal of what Chris was
5 talking about. I don't think the language quite gets
6 there. So if we could rewrite it and come back and
7 consider it, I think that'd be great.

8 Just to address Heidi's question about the
9 differences between states, it takes, just for some
10 background, over six hours to drive across New Mexico, And
11 we've got some really rural communities and most Tribes, I
12 think, with lots of different health disparities and
13 issues, and it's very different to provide care there than
14 it is in New York, for example. A lot of rural areas where
15 we don't have any providers. We have more cows than people
16 in some areas and no maternity care, so very different than
17 providing care in New York. So that's what I think John
18 was trying to get to, is there's differences between
19 states.

20 But I think if we rewrite this and we're trying
21 to get out some standardization so we can start to look at
22 the data, that's what we're trying to get to. It is just

1 being able to see the data reported in a standardized way
2 and have that transparency. I think that's what we're
3 trying to get to.

4 So anyway, I support working on the language and
5 coming up with something better. Thank you.

6 CHAIR JOHNSON: All right. We'll go to Tricia
7 and then Heidi.

8 COMMISSIONER BROOKS: We needed more time for the
9 sessions.

10 CHAIR JOHNSON: I'm realizing that. Your lunch
11 is a little bit shorter, unfortunately.

12 COMMISSIONER BROOKS: So I'm in Mike's camp in
13 terms of tailoring the language a little bit.

14 I also react to the word "prescriptive" in a
15 different way than I react to "specific," and I think
16 they're trying to get at the same thing, but "prescriptive"
17 sounds harsher, like we're trying to be punitive or
18 something, so just a comment there.

19 But I am definitely in Heidi's camp in terms of
20 being able to compare what we can compare. Those EQR
21 reports are very dense, very complex, and if we could
22 highlight key findings, I think it's important.

1 And one of the things that we're missing here in
2 the discussion is that it's helpful for identifying who's
3 doing something well, right? Because isn't that what
4 comparability is all about? Yeah, let's weed out the bad,
5 but let's also see who's doing things well and learn from
6 whatever it is that they're doing that we can implement
7 elsewhere. So I'm all for this recommendation with some
8 edits.

9 CHAIR JOHNSON: Heidi and Dennis, and then we're
10 going to go ahead and go to Recommendation 3.

11 COMMISSIONER ALLEN: Great. I totally get that
12 New Mexico is different than New York City. I grew up in
13 Idaho. That's very, also different from New York City.
14 But I think that it would be nice to be able to compare
15 Oklahoma and New Mexico, places that have big Tribe
16 enrollments. And so ideally, if you do have that
17 comparability, you can start making more specific
18 comparisons that allow you to understand context and think
19 about the policy.

20 But my question is, Mike, I didn't quite
21 understand if your edits were to get at the report
22 consistency or measure consistency, and that's why it's

1 hard for me to know when people say they support the edit,
2 which one you're talking about, because I think that I
3 would support both of those things, consistency of what the
4 reporting looks like so that people can know where to look
5 in the different sections or consistency in how things are
6 measured and some consistency across what is measured.

7 COMMISSIONER NARDONE: I guess I was focusing
8 more on some sort of summarization of some of the key
9 findings and having those so that the findings could be
10 usable for people and easier to understand.

11 The EQRO report in Pennsylvania is probably like
12 250 pages long. And I guess the question is, can we take
13 away from that certain key things? Like, if you have a
14 performance in -- you know, I'm not exactly sure I know
15 specifically, but maybe performance improvement projects
16 that states are engaged in, and what are the results of
17 those performance improvement projects? That's a possible
18 suggestion, but, I mean, I think kind of distilling, trying
19 to distill some of the key elements that would be helpful
20 in kind of assessment of how the managed care plans are
21 working in the state. Because I think having the
22 variability in the EQRO report, you could still have all

1 that information, that, you know, if you're a Medicaid
2 staff and you want to really dig into that, you can do
3 that. You have the EQRO report.

4 But I think really making it more understandable
5 and having the key findings summarized, to me at least, is
6 what I would like to see. Even as a Medicaid director,
7 when I would look at EQRO reports, it would have been
8 helpful to know like, okay, what are the takeaway messages
9 I should have from these 250-page documents? So that's
10 where I was going. That was my reaction. I thought that's
11 where this recommendation was going, and I didn't -- it's
12 in the language if you read it really carefully, but I
13 don't think it's stressed, for me anyway.

14 COMMISSIONER SNYDER: Heidi's question was
15 exactly my question. I think what you're advocating for,
16 Mike, is consistency in the summary reporting, right? Not
17 in the measurement, right? Okay.

18 CHAIR JOHNSON: All right. Thank you. We'll go
19 ahead. Let's flip to Recommendation 3, but I think Dennis
20 -- and then, Jami, do you have some more comments around
21 recommendation -- okay. So Dennis.

22 COMMISSIONER HEAPHY: I'm wondering, they're

1 still going to have multiple, different reports. If we're
2 going to hunt around, I'd have to hunt around to find out
3 similarities and differences in the outcomes in different
4 states. So is it possible to have a synthesized report
5 that's put out by CMS that shows what's actually happening
6 in different states if there are similar outcomes or
7 reporting measures, the EQROs? Does that make sense? I
8 just think there's got to be -- otherwise, we're going to
9 be hunting and packing in different states to find out what
10 the data is. So there's got to be somewhere to centralize
11 it, at least key elements of it.

12 MR. PARK: Yeah. I think -- and this gets to
13 some of the other comments and part of the recommendation
14 is that there may be greater alignment in certain reporting
15 elements within, like, the quality rating system or these
16 network -- I don't remember the exact, like, what it stands
17 for, but, you know, as part of the new access requirements,
18 you know, there's going to be a little bit more information
19 coming from, like, satisfaction surveys and other things
20 like that in terms of -- or, like, minimum wait time
21 standards in this network, like NAAAR, N-A-A-A-R, report
22 that's going to -- you know, that's required.

1 And so, you know, I think part of the
2 recommendation is for CMS to really think about where
3 certain things should be reported, where there might be
4 overlap, and, you know, what's the best vehicle for that to
5 be reported. And so, some of the outcome measures may be
6 more useful in the quality rating system because that will
7 be -- it's supposed to be designed to be a little bit more
8 beneficiary-friendly where they can compare plans on these
9 outcome measures. And so is that the best place for that
10 to reside versus, like, trying to make that part of the EQR
11 report when it's also part of the quality rating system?

12 COMMISSIONER HEAPHY: I think I'll dispel some of
13 that in the chat.

14 COMMISSIONER NARDONE: Yeah.

15 CHAIR JOHNSON: All right. So even more
16 important than your lunch are the public comments. So what
17 I'd like to do is go to Recommendation 3, and if you all
18 could let us know if there's any comments around that. So
19 let's see. Looking at all the Commissioners. I see
20 shaking heads. Everyone is in agreement with the way it
21 stands, it sounds like.

22 Okay. All right. Perfect. All right. Well,

1 thank you so much.

2 Do you need anything else from us?

3 [No response.]

4 CHAIR JOHNSON: You have -- definitely, I think,
5 Recommendation 2, you are going to do some rewriting, it
6 sounds like.

7 MS. REYNOLDS: Stronger readers.

8 CHAIR JOHNSON: There we go. There we go. Thank
9 you so much, both of you, for your efforts on this. We
10 appreciate it.

11 All right. So with that, let's go ahead and go
12 to public comments, and, you know, we invite people in the
13 audience to raise your hand if you would like to offer
14 comments. Please make sure you introduce yourself and the
15 organization that you do represent, and we do ask that you
16 keep your comments to three minutes or less. That'd be
17 very helpful for us. So let's see who we have.

18 We have one. Arvind?

19 **### PUBLIC COMMENT**

20 * MR. GOYAL: Can you hear me, all?

21 CHAIR JOHNSON: We can hear you. Thank you.

22 MR. GOYAL: My name is Arvind Goyal, G-O-Y-A-L.

1 I'm the Medical Director for the State Medicaid Agency in
2 Illinois.

3 A couple of years ago, I was also the Chair of
4 the Medicaid Medical Directors Network, and with that
5 perspective, I submit to you that this discussion has been
6 extremely educational, extremely helpful. And I'm so glad
7 that Commissioners are so engaged.

8 I want to say that there are three reasons why
9 MCOs came into being somewhere between 15 to 20 years ago,
10 depending on which state you're in, and so one was access.
11 The second was quality, and I add to it outcomes. I would
12 not separate them because quality is definitely tied to
13 outcomes. With bad outcomes, quality, you can't measure.
14 And the third part is the cost savings that should go with
15 an MCO. I'll give you examples of each, and then I have
16 two small comments.

17 As far as the access is concerned, I am sure
18 you've heard recently about ghost networks being published
19 and some legislative remedies, both at the federal level
20 and some states who want to fix it. But access is as much
21 an issue or more as it was with fee-for-service. I just
22 want to put that on the table.

1 As far as quality and outcomes are concerned,
2 one, I think the emphasis on NCQA in your reporting and
3 also on HEDIS measures is misplaced. You're also shutting
4 out innovation by other organizations. There are multiple
5 other organizations in this space, and I won't waste my
6 three minutes on this.

7 However, think about it this way. HEDIS measures
8 are not performance-based. For the most part, they are
9 process-based. It was important when they came out because
10 at the time, medical community, clinical community wasn't
11 really doing those things. And I used an example at one of
12 your previous meetings, like measuring hemoglobin A1c for
13 diabetes is a HEDIS measure. But if you don't pay
14 attention to it or you don't look at the result or you
15 don't improve diabetic control, then you haven't done
16 anything. Same thing for opioids. If you do MAT, but your
17 mortality and morbidity rate due to opioid overdoses is
18 going up, you haven't made a difference. So that is the
19 example of quality and outcomes.

20 I also want to say that as far as the cost part
21 is concerned, think this way. The cost is not only to the
22 state agency, to write the contracts, to monitor them, to

1 take whatever actions you need to take if they don't
2 comply. Cost to the MCO itself -- and that's a third party
3 -- taking away Medicaid money, both federal and state, to
4 be able to organize and have an army of people help it.

5 And then think about the provider stress and cost
6 to them, both in time and money, and beneficiaries, the
7 last thing, very, very important.

8 Having said that, I also want to say that 30 to
9 40 percent of patients in many states do not have any
10 claims during the year. However, you're paying for them.
11 So they're not getting any service. And if it was fee-for-
12 service, you would save that money, but because it's an MCO
13 per member per month or whatever your metric is, you're not
14 saving any money.

15 So I say this to you, that our reporting needs to
16 hold their feet to the fire, and I do believe that as of
17 this time, the report does touch some important points.

18 I'm especially troubled by some regulation that
19 will become effective in 2028. In the meantime, how many
20 beneficiaries, how many providers could be affected? Why
21 not 2025? Why not earlier than later?

22 So I would stop at my comments. I remain

1 available for stakeholder interviews when they come. But
2 again, please don't limit or diminish your participation in
3 this process. I'm thoroughly impressed that you're looking
4 at it.

5 Thank you.

6 CHAIR JOHNSON: Thank you so much for your
7 comments.

8 Any other comments?

9 [No response.]

10 CHAIR JOHNSON: All right. Seeing none, I just
11 want to remind everyone that if you do have some additional
12 comments later, you can submit those comments on our MACPAC
13 website.

14 And with that, I want to thank you for your
15 engagement this morning, and we will be back from lunch at
16 1 p.m. Eastern. We will see you then. Thank you.

17 * [Whereupon, at 12:17 p.m., the meeting was
18 recessed, to reconvene at 1:00 p.m., this same day.]

1 AFTERNOON SESSION

2 [1:00 p.m.]

3 CHAIR JOHNSON: All right, everyone. Welcome
4 back from lunch. We're going to go ahead and get started.

5 We are going to hear from Linn Jennings, our
6 Senior Analyst, and Ava Williams on the transitions of care
7 for children and youth with special health care needs, some
8 policy considerations and options. And last time was a
9 robust conversation. So I have no doubt this will happen
10 again today. So let's turn it over to both of you.

11 **### TRANSITIONS OF CARE FOR CHILDREN AND YOUTH WITH**
12 **SPECIAL HEALTH CARE NEEDS (CYSHCN): POLICY**
13 **CONSIDERATIONS AND OPTIONS**

14 * MS. WILLIAMS: Thank you, and good afternoon,
15 Commissioners.

16 Today Linn and I will be presenting policy
17 considerations and options for our work on children and
18 youth with special health care needs, transitions of care.

19 I will start by giving a brief recap of our
20 findings we presented in our previous meeting in October.
21 I will then start our discussion of policy options before
22 turning it over to Linn to continue discussion of policy

1 options before ending with next steps and questions for
2 Commissioners.

3 As a reminder, our objective for this project was
4 to examine how state Medicaid programs and MCOs
5 operationalize their transition of care policies for
6 children and youth with special health care needs, how
7 beneficiaries and their families experience transitions,
8 and to identify barriers to transitions that can be
9 addressed in federal policy.

10 During the course of this project, we have
11 completed a literature review, a federal and state policy
12 scan, stakeholder interviews, and beneficiary and caregiver
13 focus groups.

14 As a reminder, for this work, we narrowed our
15 definition of children and youth with special health care
16 needs to those covered by Medicaid under an SSI pathway
17 under the Tax Equity and Fiscal Responsibility Act, also
18 known as TEFRA, and Katie Beckett authorities.

19 Next, I will present a recap of the stakeholder
20 interview and beneficiary focus group findings.

21 There is no federal requirement for states, and
22 states often do not develop a transition of care approach

1 for children and youth with special health care needs and
2 publicly document or communicate this approach. Some
3 states have developed or require their MCOs to develop
4 transition of care approaches. However, these approaches
5 are not publicly documented, which makes it difficult for
6 beneficiaries and their families to find information
7 related to the expectations around the transition from
8 pediatric to adult care.

9 Additionally, not all children and youth with
10 special health care needs receive a transition of care
11 plan, and of those who do, the plan is not always useful
12 because it does not address key components of the
13 transition approach. These key components can include a
14 readiness assessment, connecting with adult providers, or
15 designating a care coordinator or transition specialist to
16 support the beneficiary and their family through
17 transition.

18 There are no federal restrictions on covering
19 services to support transitions of care for children and
20 youth with special health care needs, and some states cover
21 these services through existing state plan or waiver
22 authorities, such as MCO contracts, TCM, or CPT codes.

1 However, some states may be unaware of how these different
2 authorities can be used to cover transition-related
3 services.

4 Additionally, transition-related CPT codes may
5 not cover all aspects of transition needs, such as warm
6 handoffs between pediatric and adult providers.

7 An additional finding is that state Medicaid
8 agencies are not required to, and often do not, measure the
9 experiences of children and youth with special health care
10 needs transitions of care, and their outcomes. There is a
11 lack of commonly used measures to assess children and youth
12 with special health care needs, their transitions of care,
13 and their health outcomes because of this population's wide
14 range of health conditions and needs.

15 The lack of data collection limits states' and
16 researchers' understanding of children and youth with
17 special health care needs experiences with and needs during
18 the transition from pediatric to adult care.

19 State Medicaid and Title V agencies are required
20 to coordinate with each other on their overlapping children
21 and youth with special health care needs population but not
22 on their transitions of care, and we found that many state

1 agencies do not coordinate on this population's
2 transitions. The lack of coordination can lead to a lost
3 opportunity for sharing experiences and needs of children
4 and youth with special health care needs. State officials
5 have shared interest in increased coordination between the
6 agencies because it would be helpful in supporting children
7 and youth with special health care needs during their
8 transitions.

9 Next, I will start the discussion of the policy
10 options that address the challenges we have identified.

11 Here are the identified challenges, what
12 objectives we are trying to accomplish, and the policy
13 options we developed to address these challenges.

14 In the following slides, we'll discuss each of
15 these policy options. Our first policy option states that
16 Congress should direct states to develop an approach for
17 transitions of care for children and youth with special
18 health care needs. The population for this recommendation
19 would include, but not be limited to, children and youth
20 with special health care needs enrolled in Medicaid through
21 SSI-related eligibility pathways, those eligible under
22 TEFRA and Katie Beckett authorities. This option requires

1 states to specify their transition of care approach that
2 would include an individualized transition of care plan.

3 Beneficiaries, families, caregivers, and family
4 advocates have indicated that beneficiaries and their
5 families have difficulties with finding information on
6 their state's transition of care approach and do not feel
7 supported by the state Medicaid agency during their
8 transitions. Findings from the course of this project have
9 indicated that a structured transition approach that
10 includes an individualized care plan can improve transition
11 outcomes for children and youth with special health care
12 needs.

13 For example, a meta-analysis of 43 studies and a
14 meta-analysis from the Agency of Healthcare Research and
15 Quality found that children and youth with special health
16 care needs who had an individualized transition of care
17 plan experienced better outcomes, such as greater
18 transition readiness, reduced anxiety related to their
19 health, decreased hospital visits, and increased primary
20 and specialist visits.

21 However, despite the evidence indicating the need
22 for these transition of care plans, findings from the 2022

1 National Survey of Children's Health showed that only 42
2 percent of children have worked with their provider to
3 create a transition plan.

4 Our findings from the state policy scan show that
5 some states have developed or require MCOs to develop a
6 transition of care plan for individual children and youth
7 with special health care needs, but based on our findings
8 from interviews and focus groups, these transition of care
9 plans may be missing some key components that are important
10 for supporting the beneficiary during the transition; for
11 example, the steps needed to transition, roles and
12 responsibilities of those involved in the beneficiary's
13 transition, available services to facilitate the
14 transition, and questions that youth and family can ask
15 providers, service, and care coordinators.

16 * MX. JENNINGS: So moving on to Policy Option 2,
17 we developed this policy option to address barriers related
18 to the lack of guidance to states on covering services to
19 support transitions of care, and so this recommendation
20 directs CMS to issue guidance to states on the existing
21 authorities to cover services to support transitions of
22 care for children and youth with special health care needs.

1 And we use the minimum definition, as Ava defined, also
2 with Policy Option 1, and so this would be minimum related
3 to children enrolled in Medicaid through SSI-related
4 eligibility pathways and those eligible for Medicaid under
5 TEFRA or Katie Beckett authorities.

6 So there are no federal restrictions on states
7 covering services to support transitions of care. CMS has
8 not issued guidance on how to use existing authorities to
9 cover these services.

10 Findings from our work indicate that although
11 some states do use these existing authorities to provide
12 these services, other states may not be aware. And given
13 these findings, states need clarity on the use of existing
14 authorities for paying for transition of care services, and
15 stakeholders identified four areas where CMS may need to
16 provide guidance on the applicability to transitions from
17 pediatric to adult care.

18 And these include targeted case management.
19 Nothing precludes states' Medicaid programs from providing
20 transition of care services as part of TCM, but CMS has not
21 provided guidance on how this benefit could be used for
22 transitions.

1 There are also no federal restrictions on
2 covering transition of care-related CPT codes, but many
3 states do not include these codes in their Medicaid fee
4 schedule, and they may be unaware of which services may be
5 already covered using existing CPT codes.

6 Additionally, states with managed care should
7 ensure that transition-related services are included in
8 their MCO capitation rates.

9 Related to payment for interprofessional
10 consultation, in 2023, CMS published a state health
11 official letter and provided states with guidance for
12 reimbursing for clinical consultation and discusses the
13 importance of warm handoffs and same day appointment or
14 services in the context of behavioral health for youth but
15 does not discuss these types of services in the context of
16 pediatric to adult care transitions.

17 And finally, payment for transitions of care
18 covered through EPSDT. The 2024 guidance to states on
19 EPSDT indicates that care coordination and case management
20 can be used to facilitate the development of a plan and to
21 outline the transition of care process, but doesn't provide
22 specific details on how this would be done.

1 And for Policy Option 3, we developed this to
2 address barriers related to measuring transitions of care
3 for children and youth with special health care needs. And
4 with this, the Commission recommendation would direct CMS
5 to design, develop, and require states to measure and
6 collect data on transitions of care, and these measures
7 should be developed with input of beneficiaries and their
8 families and caregivers.

9 There are no federal Medicaid transition of care
10 measurement requirements, and so states are not required to
11 collect or report these types of data. And in general,
12 from our findings, we learned that the majority of states
13 are not collecting or monitoring these populations.

14 The literature does indicate that there are a few
15 available data sources that do measure the experiences of
16 youth with special health care needs with the transition of
17 care process, and this includes the National Survey of
18 Children's Health. But there aren't standardized outcome
19 measures. And designing health outcome measures, in
20 particular, is challenging, given the varying health
21 conditions and needs of this population.

22 And so based on our findings, data collection is

1 needed to understand who is transitioning and when, to
2 understand their process and their services and whether
3 they are accessing services that are related to their
4 transition of care plan and their health outcomes and also
5 to evaluate whether there are gaps in their access to those
6 services.

7 And for Policy Option 4, we developed this policy
8 option to require that state Medicaid agency IAAs, or
9 interagency agreements, with state Title V agencies specify
10 roles and responsibilities for supporting children and
11 youth with special health care needs and their transitions
12 from pediatric to adult care.

13 Just as a reminder, that Title V programs are
14 required to use 30 percent of their funds towards children
15 and youth with special health care needs, and these funds
16 can be used for direct services, but they often are also
17 used by Title V agencies to partner with or fund other
18 organizations that support this population. And this can
19 be for educational purposes or to help them enroll in
20 Medicaid coverage, and this can also be used for
21 transitions of care.

22 Medicaid and Title V programs are required to

1 have an interagency agreement, and in this, they outline
2 roles and responsibilities related to providing services
3 for this population and their overlapping children and
4 youth with special health care needs. But there are no
5 federal Medicaid IAA requirements related to transitions of
6 care in ensuring that Medicaid-covered children and youth
7 with special health care needs do transition to adult care.

8 So findings from our review of state IAAs and
9 stakeholder interviews indicate that very few states
10 coordinate on transitions of care for this population, and
11 stakeholders indicated that the lack of coordination can
12 also be a barrier to cross-agency information sharing on
13 beneficiary challenges with this process and a barrier to
14 collaborating to ensure that children do transition to
15 adult care.

16 And so based on our findings, state Medicaid and
17 Title V agency IAAs should specify the roles and
18 responsibilities for these agencies to ensure that the
19 transition of care process is transparent and
20 understandable to the beneficiary and their family and to
21 identify which agencies should be providing direct
22 services, should be providing training and educational

1 information and resources for plans, providers, the
2 beneficiaries and their families, and which agencies are
3 providing other supports to facilitate the transition of
4 care.

5 So moving on to our next steps and discussion
6 questions. Today we'd appreciate your feedback on the
7 policy options and which of these you would like to advance
8 to the June report to Congress. The four policy areas are
9 viewed as complementary efforts to improve children and
10 youth with special health care needs transitions of care,
11 and we could combine these options into one recommendation
12 package.

13 We've also included the discussion questions on
14 this slide, which are also in your materials, and I'll
15 leave this figure up to guide discussion. And I'll turn it
16 back to the Chair.

17 CHAIR JOHNSON: Thank you so much, Linn and Ava.
18 That was very helpful.

19 So let's go ahead and get the Commissioners'
20 reactions to the policy options that were presented. You
21 did have a couple of questions in there that I'll continue
22 to draw out, but let's go ahead and get started.

1 And Bob, Bob is up first.

2 VICE CHAIR DUNCAN: Well, again, Linn and Ava,
3 thank you so much for this amazing work. I appreciate it.

4 And I'm actually in favor of all four options
5 that you have put on the table, because I think it takes a
6 holistic look at addressing those children that are
7 transitioning to the adulthood. So I just want to throw my
8 support and say thank you.

9 CHAIR JOHNSON: Thank you, Bob.

10 Tricia.

11 COMMISSIONER BROOKS: So Bob certainly has lived
12 experiences with this, and so I would certainly defer to
13 his thoughts on it. But I had a couple of questions.

14 So in the recommendation to Congress, it would
15 appear that what we're asking for is a mandatory
16 requirement for states. Is that what we're getting at?

17 MX. JENNINGS: Yes.

18 COMMISSIONER BROOKS: Okay. And just so people
19 are clear, we're, you know, adding a mandatory benefit, I
20 guess you'd call it, or service to the plan, which is not
21 necessarily a bad thing, but I just wanted to make sure we
22 were on the record there.

1 And also, you limit it to SSI kids or kids on
2 Katie Beckett or a waiver, and yet there are a lot of
3 children with special health care needs that don't qualify
4 for either of those pathways of eligibility. Is there a
5 reason that we're limiting the recommendations at this
6 point in time to those pathways?

7 MX. JENNINGS: So we initially kind of scoped out
8 this work looking at a broader definition, but then limited
9 it to a narrow scope to have higher needs, but also to
10 allow for a little bit more comparability across states.
11 And so our thinking behind limiting it is that really our
12 evidence that we've collected is related to this narrowed
13 scope population, but then by recognizing in our
14 recommendations that it's a minimum population.

15 So a state, it doesn't preclude a state from
16 using a broader definition or using a definition that they
17 already use, but it allows for kind of setting a minimum
18 population.

19 COMMISSIONER BROOKS: So that would be the
20 mandatory group, whereas it would be optional otherwise.

21 And then on Recommendation 3, about the
22 transition of care measures, I had -- you know, I play with

1 this concept of measures because I think about quality
2 measures. There are national performance measures that are
3 developed by HRSA that Title V agencies have to adopt a
4 certain number of them. I don't know a lot about the
5 interaction or the collaboration between Title V and
6 Medicaid, but I just think we need to clarify that what
7 types of measures or data that we're asking for here. I
8 mean, even if there's a way to define transition of care
9 measures such as kind of thing, that would just be a point
10 that I would make here.

11 But no, this is important work. It's a
12 population that struggles throughout life, but this is a
13 period of time when the struggles are even more significant
14 for not only the kids, but their families as well. So
15 thanks for the work.

16 EXECUTIVE DIRECTOR MASSEY: So, Tricia, can I
17 just respond to your first comment in terms of what Policy
18 Option 1 is intended to do?

19 COMMISSIONER BROOKS: Okay.

20 EXECUTIVE DIRECTOR MASSEY: Because I think your
21 characterization of it was as a new mandatory benefit, and
22 I think from our perspective, we were looking at it as

1 states being required to articulate or codify an existing
2 policy and make that public and transparent.

3 But, Linn, did you want to add and maybe kind of
4 spend a little bit of time talking about what the intention
5 is of Policy Option No. 1?

6 MX. JENNINGS: Sure. Thank you.

7 So our intention with the first policy option is
8 that many states already have maybe some approach for
9 transitions of care, but to ensure that that is made public
10 and transparent. And since one of the key things we heard
11 from focus group participants and advocates that there's
12 just really no -- they don't know where to find that
13 information and understand the process. So the intention
14 isn't really to have that it creates a new benefit. In
15 many cases, an approach exists, but to make it public and
16 then leaving that approach and kind of the design of that
17 approach up to the state, but including an individualized
18 transition of care plan within that approach.

19 COMMISSIONER BROOKS: Do you have any examples of
20 statutory language that talks about requiring an approach
21 to something? I guess it seems a little not in my
22 vernacular that I would see this in statutory language.

1 MX. JENNINGS: I would have to get -- I would
2 have to come back with that, and we can look into that a
3 little bit more.

4 COMMISSIONER BROOKS: Yeah, I think it'd be
5 helpful to know how such a statutory provision might be
6 crafted. What would it say, or do we have other things in
7 statute that are similar to that, that we can point to and
8 say this is what we have in mind? That would be very
9 helpful.

10 Thank you.

11 CHAIR JOHNSON: Thank you, Linn. Thank you,
12 Tricia. That was a good call-out.

13 All right. Patti.

14 COMMISSIONER KILLINGSWORTH: Just a couple of
15 quick comments. One, with regard to the applicable groups,
16 I think I've raised this before. I'm going to raise it
17 again. I would encourage us to think about including all
18 children who meet institutional level of care requirements,
19 whether by virtue of 435.217 participation in a 1915 CHCBS
20 waiver or any equivalent sort of authority that might be
21 provided under an 1115 demonstration or, as much as I hate
22 to admit it, kids who might actually be institutionalized,

1 right? So I think any child that we know is either
2 institutionalized or significantly at risk of
3 institutionalization probably needs a transition of care
4 process. I think that's really important.

5 And the other thing would say with respect to --
6 I think it is the third -- no, it is the -- which measure
7 is it? It's the third measure on sort of measuring
8 transition of care data. I would caution us against
9 becoming too focused on services as kind of the measure. I
10 think it's important for there to be flexibility to deliver
11 this kind of transition support as a service and to provide
12 reimbursement for it, but I think there's a lot of ways of
13 handling it also through care coordination processes that
14 may fall within the purview of a managed care
15 organization's responsibility pursuant to a state contract.
16 And so I would just -- I'd hate for us to sort of look at,
17 is it being paid for as a service as kind of our measure of
18 the process.

19 CHAIR JOHNSON: All right. Thank you.

20 Heidi.

21 COMMISSIONER ALLEN: Thank you for this. I love
22 that we're moving into the policy option stage of the work.

1 That's always exciting.

2 I agree with Patti. I think it's worth
3 considering expanding to all kids that would meet the
4 institutional level of care requirements, and I wonder if
5 that would also -- I think often of like foster kids too,
6 which as they age out, they also probably need transition
7 of care. And I know that we're very specific to special
8 health care needs, but many of those kids have special
9 health care needs too.

10 But the thing that I wanted -- my most -- the
11 comment I really feel the most strongly about is in
12 Recommendation 3, when we're trying to understand
13 beneficiary experience. I think it's also important to
14 center caregiver experience. When you think of kids aging
15 out and being able to stay in the community, the health and
16 well-being and ability of their parental caregivers often
17 and then maybe sometimes sibling caregivers, is really,
18 really important. And if undue stress and pressure is put
19 on that system, it can have really significant implications
20 for the young adult, and so I'd love us to be able to bring
21 that forward as well.

22 CHAIR JOHNSON: Thank you, Heidi.

1 Dennis.

2 COMMISSIONER HEAPHY: Thanks.

3 Can we go to the slide for the Recommendation 4,
4 the one after? I think that's it. Yes. So for me, I
5 guess my concern is that these kids and their families are
6 losing all the supports that were available to them under
7 Title V once they turn 22. And so it seems like there's
8 still a siloing in the recommendation and not a recognition
9 that there needs to actually be a transition from Title V
10 too as part of the kids are receiving their occupational
11 therapy, their physical therapy, all these different
12 therapies in school. So much of what they've done, what's
13 being done in school, and that will no longer be there.
14 All those things will be moving on.

15 Also, care coordination is done in the school.
16 And so how is the care coordination going to transition to
17 the adult world once those supports are gone? And I think
18 it's not just about medical, but also the HCBS side of it.
19 So much of the HCBS really is developed in coordination
20 with the school and Title V.

21 So as I look at this, I'm thinking, how can this
22 really be strengthened? I'm sorry I don't have language.

1 But how can we strengthen this to show that Medicaid really
2 has an obligation to ensure that the state Medicaid offices
3 have the capacity and the responsibility to ensure that
4 these folks, they transition and their families, and they
5 get the support they need so that they're not just -- those
6 supports under Title V don't just disappear, but there's
7 someone there at the adult side to catch them.

8 CHAIR JOHNSON: Thank you, Dennis.

9 John?

10 COMMISSIONER McCARTHY: So a couple of things.
11 Number one, I'm a little confused, and maybe I just missed
12 this, because our third -- we always say we make
13 recommendations based on evidence. But our third
14 recommendation is to measure things in order so we could
15 have evidence.

16 So then is our first couple of recommendations
17 based just on the interviews of what we heard from people?
18 Because it kind of gets to my second piece, which is,
19 shouldn't we do the third recommendation first of try to
20 get measurement to see what's working in these different
21 areas before we make recommendations on what to do around
22 telling states what to do around transitions? That's my

1 first question and second question.

2 MS. WILLIAMS: The evidence for the first two
3 policy options come from the state policy scan and federal
4 policy scan interviews and focus groups, as well as
5 literature, and from the literature, we found literature on
6 all the things. There's not many approaches that state
7 Medicaid agencies are doing, and because of this and
8 because of what we heard from focus groups and what we
9 heard from beneficiary advocates and the literature, it's
10 important and helpful for these beneficiaries to at least
11 have some sort of approach.

12 COMMISSIONER McCARTHY: I assume that's what it
13 would be, and I agree with that. It should be documented,
14 and there should be some things, but I just want to make
15 sure we're following what we've said in other places.

16 The other piece is on the third recommendation
17 from CMS. One of those issues is we talk about having CMS
18 give guidance around payment structures and what can be
19 paid for. We talked about this last time a little bit, and
20 I hadn't thought of it then, and when I was reading through
21 the memo this time I did. But in our memo, one of the
22 things is state Medicaid payments for transitions -- and

1 CMS should talk to states about that, of how to use those,
2 but I think we probably need to look into that a little bit
3 more, because if you cover some of those CPT codes and
4 you're doing it through a state plan, I don't know if you
5 can necessarily limit it to just this population we'd be
6 talking about. And I am not a CPT code expert, okay? But
7 having set rates and been in Medicaid, those are things
8 that sometimes why those codes don't get covered, because
9 yes, you want to pay for this, but if you added that code,
10 it wouldn't just be for this population. It would be for a
11 much larger population, so it would cost you additional
12 dollars maybe you don't have. So that would just be one of
13 those things I'd want us to look into before we necessarily
14 make that recommendation, making sure that it would align
15 with exactly what we're talking about. We're limiting it
16 to the population we're talking about, whether it's the
17 narrower definition which you guys have proposed or the
18 expanded definition that Patti and Tricia talked about.

19 Thanks.

20 CHAIR JOHNSON: Thanks, John.

21 Patti?

22 COMMISSIONER KILLINGSWORTH: Let's circle back on

1 just a couple of comments. So one, with respect to Heidi's
2 comment, wholeheartedly support modifying Policy Option 3
3 to include not just the experience of beneficiaries, but
4 also the experience of families and caregivers, which I
5 think is critically important.

6 A couple of responses to John's comments. I love
7 that John always holds us accountable for consistency to
8 our own commitments. I do think that there is sufficient
9 evidence to warrant adjustments, even while we're trying to
10 develop better measurement processes, right, so that we
11 have more consistent and reliable access to information.
12 But I would hate for us to wait to take steps to improve
13 the experience for these beneficiaries while we kind of
14 collect information to sort of bear out what we already
15 have some evidence to tell us is problematic.

16 And then kind of on the third point, with respect
17 to making the benefit available, I wonder, John, if in
18 practice, this wouldn't be a point of medical necessity,
19 right? You would only kind of provide reimbursement for
20 transition services when there's a need for them, right, by
21 virtue of the child's level of challenge in navigating
22 transition and really the importance of doing that. So

1 maybe that would help to kind of mitigate any concern over
2 utilization of that.

3 I think as a practical matter, it's already
4 there, right? It's already covered. We're just kind of
5 articulating what's already available under the EPSDT
6 program currently for these kiddos, but correct me if I'm
7 wrong.

8 CHAIR JOHNSON: Do you want to respond?

9 [No response.]

10 CHAIR JOHNSON: All right. Thank you. Thank
11 you, Patti.

12 Carolyn?

13 COMMISSIONER INGRAM: Thank you, and thanks for
14 putting these great ideas forward so we could start to
15 consider them.

16 If we could go to No. 3. In your work and your
17 interviews, did you gather any information on how folks
18 envision carrying this recommendation out that's worth
19 sharing back with us? When I review it -- and I think
20 Tricia brought up a point about focusing on services when
21 we're really looking at focusing on outcomes, and so I was
22 sitting here looking and thinking, if I were the Medicaid

1 director of Medicaid agency, how would I put this into
2 practice? So did you all gather any information about
3 that, about what people envision?

4 MX. JENNINGS: I think one thing we really heard
5 in our state interviews is that although -- and I think we
6 will do a better job, I think, of strengthening this in our
7 rationale for next time since there may -- there was some
8 confusion over what specifically we would be measuring.
9 But I think one of the things that we really are lacking in
10 is just understanding who this population is, who is kind
11 of at this transition of care age and are they getting --
12 like, if they have a plan -- like, do they, like, do they
13 have a plan? What does that plan look like?

14 And so our understanding from state interviews is
15 states often actually have this information potentially but
16 have never looked into it. They couldn't tell us who was
17 transitioning, but said it might be possible. It's just
18 not an area that they're -- like, it's not on their
19 dashboard of measures that they're looking at. And so I
20 think some of these measure -- and maybe measures aren't --
21 maybe isn't the right -- but some of this data collection
22 is there. It's just a matter of kind of finding those data

1 and maybe having specific -- I guess, we can continue to
2 use measures, but it's having some measures that kind of
3 point to those specific data points to help states
4 understand what they could be looking at.

5 COMMISSIONER INGRAM: Maybe we could dig into
6 that a little bit more to address the question about what
7 we are trying to get to in terms of outcomes.

8 I struggle a little bit with just putting this
9 kind of blanket thing out there and then states are
10 supposed to figure out what folks mean by that, and I
11 suppose that's the job we're telling CMS to do in this
12 policy option, but maybe focusing more on outcomes instead
13 of just the access to the services.

14 Folks have, as you mentioned in your research --
15 they've got the access to the services. It's whether or
16 not people are carrying them out appropriately to get the
17 outcomes, right? And they're not helping this population
18 the way we should be. So that's what it sounds like. So I
19 think trying to focus on the outcomes maybe more is what
20 we're trying to get at.

21 Anyway, I struggle with that one a little bit.
22 We got to -- I think we need to refine it a little bit

1 more.

2 Thank you.

3 CHAIR JOHNSON: Thank you, Carolyn.

4 Doug and then Mike.

5 COMMISSIONER BROWN: Thank you.

6 As I read the chapter and the pre-read and then
7 sat here, the one thing that kind of keeps running through
8 my mind -- and some folks have mentioned here -- is EPSDT.
9 And you're checking for kids and testing them along the way
10 early on. It seems to me like if you could test them at
11 the end before they get ready to leave the program,
12 somewhere between age 16 1/2 and 18, you could work a
13 transition plan in at that point. Not that that's the
14 answer here, but it could be a start.

15 I see the recommendations. It seems like between
16 Title V and Medicaid, there's programs here, there's
17 funding. It's just kind of closing the loop in some degree
18 here, and I don't know if EPSDT is one way to help close
19 that loop. Just a general question for the group.

20 CHAIR JOHNSON: All right. Thank you, Doug.

21 Mike.

22 COMMISSIONER NARDONE: I was going to respond to

1 John's comment, and I guess I was wondering if -- and I
2 don't know if this is what you all were thinking about --
3 is some of the things and clarity that John was looking
4 for, I assume, would be something that would actually be
5 covered in the CMS guidance, right, like around how
6 different authorities could be used to support transitions.
7 At least that's the way I was interpreting that.

8 So, I mean, I think -- to John's point, I think
9 it'd be good -- you know, you always -- lots of times, you
10 want to know kind of what the answer is before you, like,
11 put a recommendation up. But I mean, I think it does seem
12 like that that's something that CMS could help flesh out as
13 part of the guidance that they were providing. So that was
14 my comment on 2.

15 I guess on 3, I assume -- and maybe this is
16 something you would -- and maybe others who have more
17 familiarity with this topic than I do, it doesn't sound
18 like we have measures, right, like, that we have to develop
19 them. And I assume that's a process that wouldn't just be
20 CMS, that it would be a process that involved a lot of
21 stakeholders in the development of that. And I guess
22 that's assumed, and maybe that's something you would cover

1 in the chapter. But I wouldn't want CMS just to go off and
2 design, even though I worked at CMS. But I'm assuming that
3 there would be that sort of input.

4 And then in Title IV -- not Title IV -- in terms
5 of the fourth recommendation and Title V, I'm probably not
6 as familiar with the Title V requirements. And so I'm just
7 wondering, do we have some good examples of agreements and
8 how they're structured to kind of integrate with Medicaid?
9 It's not something I'm familiar with. So I'm wondering if
10 there are some examples around that that might be helpful
11 to just kind of talk about.

12 And I guess I also kind of reflect that -- are
13 there good examples of kind of putting forward, like, what
14 are -- are there good examples also of good transition
15 planning that states are engaged in? Are there some models
16 that we should be looking to?

17 CHAIR JOHNSON: Thank you, Mike.

18 Patti and then Tricia and then Sonja.

19 COMMISSIONER KILLINGSWORTH: Just a quick comment
20 about Carolyn's and now Mike's comments about measures. I
21 do think there are some ready things that we could mention
22 as examples if we're inclined to do so. We've talked about

1 the public availability of information, about the
2 transition of care process, making sure there are clearly
3 defined responsibilities in the state for who will -- who's
4 responsible for transitions of care. We could measure
5 whether transition meetings actually occur timely, whether
6 there's a transition of care plan. We could look at
7 continuity of services and providers and then finally
8 develop processes to measure beneficiary experience, and
9 those are just examples, right?

10 But I always think that perfect is the enemy of
11 good, and sometimes we don't measure things because we
12 don't have the perfect measures that are available yet to
13 start measuring. But we have to start somewhere, and so
14 even if we start with some process measures and some
15 experience measures, I think those bring value, even while
16 there may be a more rigorous process to develop HEDIS
17 measures going forward.

18 CHAIR JOHNSON: Thank you, Patti. Couldn't agree
19 with you more.

20 And I think I'm going to skip over Angelo.

21 COMMISSIONER GIARDINO: Thank you.

22 Once again, thank you for taking this work on. I

1 know it's a heavy lift.

2 I just want to make a couple comments. I think
3 the first one is that there's ample evidence that a
4 systematic approach to the transition from pediatric to
5 adult care is helpful in terms of the management of either
6 the physical or the mental condition of that child who's
7 now becoming an adolescent and young adult. I don't think
8 there's any evidence that an unplanned transition is
9 beneficial, and in fact, there's ample evidence that
10 unplanned transitions, particularly for children that have
11 heart disease, kidney disease, neurologic problems -- and
12 the list goes on -- if it's unplanned, that transition
13 leads to unplanned hospital visits to the emergency
14 department, fragmented care. And some of those conditions,
15 if you don't manage it consistently, there's end-organ
16 damage.

17 So I think the evidence is absolutely available
18 for the need for planned transition, because there's a lot
19 of evidence for unplanned transition that ends up with kids
20 as they become adults ending up in the emergency room and
21 getting care in a fragmented way.

22 So I don't think we're actually unanchored or

1 unmoored from an evidence perspective. There's ample
2 evidence.

3 Second, I would say there has been at least 20
4 years of national centers, the National Center on
5 Transition -- and now the current one is Got Transition.
6 And they have decades of work in terms of the approaches.
7 And as you had said in some of your briefing materials last
8 time, there's really two major approaches. The American
9 Academy of Pediatrics has a policy statement, and Got
10 Transition has the six core fundamentals.

11 So it is not -- if you're talking to people who
12 are doing this care, they're not at a loss for what the
13 basic approach is, and they're all the same. There's an
14 assessment of readiness. There's partnering with the child
15 and family, and then there's getting the pediatric provider
16 connected to the adult provider.

17 So, again, we're not unmoored here. We have
18 approaches. I would just encourage you to look at -- HRSA
19 for about 10 years had -- I think it's called the "D70
20 program." So they funded all 50 states to do some type of
21 demonstration project in transition. So there's going to
22 be some models that emerge as best practices. So I think

1 there could be some information there.

2 And then finally, I guess I'm operating under the
3 assumption -- and you can correct me if I'm wrong, but when
4 we ask CMS to develop a guidance, that they, in fact, would
5 do some work to think about what information would be
6 helpful. So some of the concerns that John has, I assume
7 that's going to be in the guidance. I don't think we have
8 to write the guidance before we approve a recommendation to
9 have a guidance. So I'm assuming they would talk about the
10 CPT codes, and that they would say this is the appropriate
11 guidance around using that CPT code. So I don't think we
12 have to know the wording of the guidance before we propose
13 a guidance, because I think then CMS works on what is
14 appropriate for the stakeholders.

15 So I'm in full support of your moving forward
16 with this. Thank you.

17 CHAIR JOHNSON: Thank you, Angelo. I'm sorry
18 about missing you.

19 All right, Tricia.

20 COMMISSIONER BROOKS: Thank you.

21 I just wanted to point out, I was interested in
22 Doug's comment about doing some kind of EPSDT screening at

1 that stage, and we have examples of that for former foster
2 youth and justice-involved youth that is coming online as
3 of January 2025, that they have to have an EPSDT screening
4 within 30 days of release or aging out. And they have to
5 be set up with prescription drugs and referrals and other
6 things that they need. I think these transitions of care
7 would have to be more robust, but there is, you know,
8 something happening in this world that is similar to that.

9 And just to Mike's point, there are very specific
10 requirements for interagency collaboration between HRSA
11 and, you know, the Title V agency and CMS on both sides.
12 But this is not an area I concentrate in on our work at
13 CCF. But I don't ever recall seeing one of those
14 agreements, right? So, I mean, then the starting point is
15 that they have to enter into an interagency agreement and
16 to have certain components, and I would just be interested
17 to know what we can gain by a review of those and seeing
18 what they do and don't say about this relationship. I
19 think it would end up being broader than children with
20 special health care needs, but I thought I'd raise it at
21 this point, just because it's important.

22 I mean, if 30 percent of Title V money is

1 supposed to go to special needs kids, that's important, and
2 they're boosting, you know, maternal access and, you know,
3 other things that are closely knitted with Medicaid. So
4 understanding that relationship would be helpful.

5 MX. JENNINGS: So for our state policy scan, we
6 did review all IAAs, and I believe I'd have to go back, but
7 I think only about four or five mentioned transitions of
8 care for this population. And it isn't a requirement to
9 include it in the IAAs. So I think, in general, states are
10 not including it there.

11 Although from our interviews and from our scan
12 and from other sources, it does seem like there are states
13 that are collaborating, even if it isn't in the IAA. But
14 very little is included in those.

15 COMMISSIONER BROOKS: Maybe that's an idea is
16 that it should be included in those interagency agreements
17 as one way to trickle it out from perhaps Congress talking
18 about the approach.

19 CHAIR JOHNSON: Thank you, Tricia. Thank you,
20 Linn.

21 Sonja?

22 COMMISSIONER BJORK: For Policy No. 3, I do like

1 it when we offer up some suggestions or examples. So we
2 could not act like this is an all-inclusive list of what
3 the measures should be, but, you know, for example. And
4 when we do that, we often turn to experts, right? So we
5 can check in with beneficiaries and their family members as
6 well as some of the agencies that serve them as we come up
7 with these.

8 So Patti already mentioned, you know, was there a
9 transition of care plan developed? You can check yes or no
10 on that for outcome measure, right? And then you can check
11 things like, was a primary care -- was a new primary care
12 provider assigned after they turned 22? Now, that's kind
13 of a yes or no. You can also look and see, did the person
14 have any visits with anybody that first quarter after they,
15 you know, got to age 22? That's not hard to find out,
16 because if someone who has really serious and special needs
17 hasn't gone to the doctor or gotten any prescriptions
18 filled or gotten any labs, it's a cause for concern.

19 So I know we're looking back, but you can see
20 what happened during a certain period of time after they
21 reached a certain age. That's not that hard to measure.
22 So I would like it if we came up with some examples to

1 offer up when we do this policy.

2 And also, I'm glad that what John raised, but I
3 don't want to wait until we have a huge amount of data to
4 move forward with the first two policy options. I get so
5 impatient. I want to charge ahead. So I appreciate John
6 bringing up, you know, do we need more evidence? But I
7 really thought you did a great job with the literature
8 review and the scan and all of that. So I feel like we're
9 rolling. We're moving forward.

10 That's it for me.

11 CHAIR JOHNSON: Thank you, Sonja. Appreciate
12 that.

13 Jami?

14 COMMISSIONER SNYDER: I just wanted to go back
15 really briefly to the issue of definition. I, too, want to
16 be able to move forward with the policy recommendations.
17 I'm fully supportive and supportive of the narrower
18 definition that you've developed for the purpose of the
19 policy recommendations that we have in front of us.

20 I do think it would be helpful in the chapter to
21 just articulate that it's really a baseline and that states
22 can extend the framework that we're recommending to a

1 broader population.

2 CHAIR JOHNSON: Thank you.

3 Any other Commissioners have comments before we
4 wrap up?

5 [No response.]

6 CHAIR JOHNSON: All right. So, Linn and Ava, do
7 you think you have what you need? I know you had a lot of
8 questions. You were able to answer many of them. You're
9 going to go back and do a little bit more of a deeper dive
10 on some issues. There were some other factors that
11 Commissioners had brought up that it sounds like you all
12 are going to put into this as well. But anything else from
13 us that you need?

14 MX. JENNINGS: No, this was very helpful, and
15 thank you.

16 CHAIR JOHNSON: Thank you. Great job. We
17 appreciate it.

18 All right. So we are going to switch gears a
19 little bit, and we're going to go to the CMS proposed rule
20 on Medicare Advantage for 2026. We're going to welcome
21 Drew Gerber as our analyst and welcoming back Chris Park.

22 I feel like you've been up here a lot this go-

1 around. We need to work on that and give you a break a
2 little bit more. Of course, our Policy Director and Data
3 Analytics Advisor.

4 They're going to present key aspects of the
5 proposed CMS rule for Medicare Advantage and Medicaid, and
6 normally, we would not necessarily have comments on MA
7 rules, but we did want to make sure that we were shaping a
8 MACPAC response on the issues that really affect eligible.

9 So, with that, I'll turn it back over to Drew and
10 Chris.

11 **### POTENTIAL AREAS FOR COMMENT ON CMS PROPOSED RULE**
12 **ON MEDICARE ADVANTAGE (MA) FOR CY2026**

13 * MR. GERBER: Thank you, and good afternoon,
14 Commissioners. Chris and I will be providing an update on
15 the contract year 2026 Medicare Advantage and Part D
16 proposed rule.

17 We, the staff, regularly review this annual rule
18 for its implications for dually eligible individuals and
19 for the Medicaid program. This presentation will also
20 identify potential areas of the proposed rule on which the
21 Commission may wish to comment.

22 CMS published a notice of proposed rulemaking

1 earlier this week for Medicare Advantage (MA) and Part D
2 for contract year 2026. We've grouped the relevant
3 provisions of this rule into three areas for potential
4 comment: mandatory coverage of anti-obesity medications,
5 or AOMs, such as the new class of glucagon-like peptide-1,
6 or GLP-1, medications like Wegovy; integrated care for
7 dually eligible individuals; and access to cost-sharing
8 tools.

9 Finally, we'll turn the conversation back to the
10 Commission to provide staff with feedback on where, if at
11 all, the Commission would like to make comment.

12 So beginning with mandatory coverage of AOMs, in
13 the Medicare title, the definition of a Medicare Part D-
14 covered drug is tied to the definition of a covered
15 outpatient drug under the Medicaid Drug Rebate Program in
16 Title XIX of the Act. The Medicaid Drug Rebate Program, in
17 Section 1927, excludes coverage of agents for anorexia,
18 weight loss, or weight gain, which means that these drugs
19 are currently excluded from coverage under Part D.

20 AOMs are not covered under Medicare when
21 prescribed for weight loss. While states may optionally
22 cover them under Medicaid, it is important to note that

1 AOMs that are prescribed for other medically accepted
2 indications, such as for diabetes, do receive coverage
3 under Part D and Medicaid.

4 CMS proposes to reinterpret this statutory
5 exclusion to allow coverage of AOMs for obesity. The
6 agency pointed to growing consensus around obesity as a
7 chronic disease in its own right, and it said that such an
8 interpretation would mirror its previous interpretation of
9 the statute to allow for coverage of certain drugs related
10 to weight gain for diseases such as wasting syndrome and
11 AIDS.

12 The proposed rule distinguishes obesity from
13 overweight, which is not recognized as a disease, although
14 some states do currently cover AOMs prescribed to those
15 with overweight.

16 As the statutory reinterpretation revolves around
17 Section 1927, the proposed decision to mandate coverage of
18 AOMs for obesity would apply to both Medicaid as well as
19 Medicare. Should the rule become final, statute also
20 creates the potential for a gap in the applicability dates
21 of the mandated coverage between the programs.

22 Medicare's statute prohibits significant changes

1 to Part D except at the start of a calendar year, while the
2 Medicaid program has no such prohibition.

3 CMS notes that coverage would become mandatory in
4 Medicaid on the effective date of the final rule, which is
5 typically 60 days after publication in the Federal
6 Register. This means that there could be a period of time
7 in which Medicaid is required to cover and pay for AOMs for
8 duly eligible beneficiaries, which we'll discuss.

9 Over a 10-year window, CMS estimates that
10 mandating coverage of AOMs will cost \$11 billion to federal
11 Medicaid and \$3.8 billion to state Medicaid programs,
12 although it's unclear whether this estimate accounts for
13 the amount states may have to pay for duly eligible
14 beneficiaries should there be a gap in the applicability
15 dates.

16 In the proposed rule, CMS noted that states would
17 still have access to cost-control tools that it currently
18 has, such as preferred drug lists and prior authorization.
19 For states that currently cover AOMs for weight loss, a KFF
20 survey found that nearly all require prior auth or had body
21 mass index, or BMI, requirements to receive coverage.

22 There are several comments that the Commission

1 could make on mandatory coverage that are supported by our
2 prior work. First, the Commission could ask CMS to issue
3 guidance on what it would consider allowable prior auth
4 criteria for coverage of these drugs in Medicaid. In the
5 proposed rule, CMS declined to define obesity, instead
6 allowing Part D sponsors to develop their own definitions
7 for prior auth purposes, so long as the criteria were not
8 more restrictive than the drug's label. However, CMS also
9 noted that labels for AOMs have removed reference to
10 specific BMIs in certain cases. Without a definition of
11 obesity, there may be uncertainty as to whether a drug
12 should be covered for a specific beneficiary and whether
13 that beneficiary would be considered overweight or obese.

14 The Commission's June 2019 report to Congress
15 highlighted some of these challenges that states face in
16 developing their drug coverage policies, especially as it
17 relates to Part D.

18 The Commission could also ask CMS to link the
19 Medicare and Medicaid effective dates for mandatory
20 coverage to avoid the potential for any cost shifting to
21 Medicaid program. However, if the agency moves forward
22 with an earlier applicability date, CMS could or should

1 issue guidance on its expectations for Medicaid coverage of
2 AOMs, especially as it relates to duly eligible
3 individuals. In statute, the Medicaid exclusion of
4 coverage for Part D drugs or cost sharing is actually tied
5 to the definition of a Part D-eligible individual, not to
6 the definition of a Part D-covered drug.

7 Moving on to integrated care for dually eligible
8 individuals, the proposed rule also includes a number of
9 new requirements and technical changes related to
10 integrated care. Two of these provisions would apply to
11 applicable integrated plans, or AIPs. AIPs, if you
12 remember from our prior work on integrated care, are a
13 category of MA dual eligible special needs plans, or D-
14 SNPs, with exclusively aligned enrollment, which means the
15 D-SNP only enrolls individuals enrolled in the affiliated
16 Medicaid managed care plan.

17 Other provisions would apply to all MA special
18 needs plans, or SNPs.

19 CMS proposes to require that AIPs issue
20 integrated member ID cards. The IDs would have to meet
21 existing ID requirements for both programs, and most
22 states, with a few exceptions, already require their AIPs

1 to do this. CMS also proposes to require AIPs to use a
2 health risk assessment, or HRA, an assessment conducted by
3 SNPs, combined with similar Medicaid assessments for
4 functional need.

5 The flexibility to align these assessments
6 already exists, and combining assessments can reduce
7 duplication and burden on beneficiaries faced with repeated
8 intensive questions.

9 Finally, CMS also proposes to codify for all SNPs
10 timelines for conducting HRAs and developing integrated
11 care plans, or ICPs, which are informed by the HRA.

12 The proposed rule would put into regulation the
13 requirement that HRAs be completed at least 90 days before
14 or after enrollment, add a requirement that ICPs be
15 completed within 30 days of the HRA, or the effective date
16 of enrollment, whichever is later, and also sets some
17 specific requirements for plans to conduct and document
18 their outreach to enrollees about the HRA and ICP.

19 At several places in the Commission's body of
20 work on integrated care, we've noted how exclusively
21 aligned enrollment can be a tool to increase integration,
22 including through allowing for integrated member materials

1 like an ID, which beneficiaries have expressed satisfaction
2 with.

3 The Commission might choose to voice support for
4 the new proposed requirement, as recent CMS rulemaking that
5 we presented on back in December 2023 is likely to increase
6 the number of AIPs by 2030, including among states that may
7 not already require an integrated ID.

8 Similarly, the Commission's recent report on
9 state Medicaid agency contracts, or SMACs, highlighted how
10 timely HRA and ICPs are important in advancing state goals
11 for integration and D-SNPs for dually eligible individuals.

12 Separately, CMS did request comment in the
13 proposed rule about whether the agency should publicly post
14 SMACs, noting that CMS is not party to those contracts
15 between states and plans. While our prior work underscored
16 the challenges states face in developing and retaining D-
17 SNP expertise -- and the Commission's heard from panelists
18 previously about state interest in peer-to-peer learning --
19 this question fell outside the scope of our work at the
20 time, and therefore, we don't have information on the
21 amount of potentially confidential or proprietary
22 information that may be in these contracts that would be a

1 consideration for publicly posting them.

2 And then finally, I'll discuss some access to
3 cost-sharing tool provisions. The proposed rule would
4 require MA agents and brokers to discuss with beneficiaries
5 their potential eligibility for cost-sharing supports.
6 These include the Medicare Part D Low-Income Subsidy; the
7 Medicare Savings Programs, or MSPs, for partial- and full-
8 benefit dually eligible individuals; and supplemental
9 Medigap insurance.

10 CMS proposes that these brokers and agents would
11 also need to provide a pause to allow beneficiaries to ask
12 questions about what they've heard, and they must offer to
13 connect beneficiaries with the state to learn more about
14 programs such as the MSPs.

15 MA plans are also able to offer supplemental
16 benefits, a category that includes benefits beyond what
17 Medicare fee-for-service offers, such as dental, as well as
18 benefits that enhance existing fee-for-service benefits.

19 Increasingly, CMS says in the proposed rule that
20 plans are offering these supplemental benefits, including
21 reduced cost-sharing through debit cards, also known
22 colloquially as flex or cash cards. In light of some

1 concerns from stakeholders over their use and beneficiary
2 confusion about these debit cards, CMS proposes to codify
3 existing requirements dictating plan processes for
4 administering benefits via debit cards and further require
5 plans to provide enrollees with instructions and access to
6 customer service for using the cards.

7 After reviewing a number of MA plan
8 advertisements focused on the debit card dollar value or
9 without directly connecting the debit card to actual
10 covered plan benefits, CMS proposes to also prohibit plans
11 from advertising this way.

12 So MACPAC has monitored enrollment in the MSPs
13 for several years, initially identifying some issues with
14 enrollment and recommending changes, which CMS did
15 implement in part. In the Commission's June 2024 report to
16 Congress, MACPAC found enrollment in MSPs had improved,
17 although millions eligible for the programs still remain
18 unenrolled. Therefore, the Commission might support
19 requirements intended to raise awareness of the MSPs and to
20 facilitate connections with the state for individuals to
21 potentially enroll.

22 And now, while regulations governing debit cards

1 and MA are a Medicare issue, dually eligible individuals
2 may be drawn away from integrated care models that the
3 Commission feels are better suited to providing care by
4 attractive debit card offers.

5 We would note that we've heard from stakeholders
6 and read in evaluations of the integrated Medicare-Medicaid
7 plans under the Financial Alignment Initiative that
8 competition from MA plans has been a persistent challenge
9 for enrollment in these integrated models. The Commission
10 may then choose to voice support for the proposed
11 prohibition on prominently advertising these debit cards to
12 consumers.

13 Next steps. Comments are due on the proposed
14 rule by January 27, 2025. If the Commission decides to
15 comment, we'll take back the comments we hear in your
16 discussion today and draft a letter for your review.

17 And I'll turn it back to the Chairwoman for this
18 discussion.

19 CHAIR JOHNSON: All right. Thank you so much,
20 Drew.

21 All right. So I am assuming that people want to
22 comment, but if not, then definitely let us know in your

1 remarks. And then also, if you can group them into three
2 areas that Drew outlined, too, in terms of where you think
3 we should comment and what we should comment about, that'd
4 be really helpful.

5 So, with that, let's see if we have any
6 Commissioners.

7 Adrienne.

8 COMMISSIONER McFADDEN: So I am supportive of the
9 comment. My comments here today will just be around the
10 anti-obesity medications.

11 As a physician, I think there's a very
12 prescriptive sort of language around individuals with
13 obesity having these medications. The medications are
14 effective. They fall below the threshold on the BMI scale
15 of being obese, and therefore, some might argue they should
16 then come off the medications, but there's a large subset
17 of individuals who need to stay on these medications for
18 potentially lifelong to maintain the healthy weight as well
19 as the other health benefits there.

20 So I think the comment for the Medicaid side of
21 the house is making sure that the estimated cost to
22 Medicaid contemplates sort of the lifelong coverage of the

1 anti-obesity medications.

2 CHAIR JOHNSON: Thank you.

3 Carolyn.

4 COMMISSIONER INGRAM: So I think I would say,
5 yes, we do need to comment in these areas, and it just is
6 another example of why we need to do a better job of
7 integrating Medicare and Medicaid back together for people
8 who have complex needs on the ground. All of these things
9 that are raised in here are just examples of the issues
10 that hit members on the ground and providers when they're
11 trying to coordinate care better for people out there.

12 I'd be interested in what some of the other
13 Commissioners, especially Doug, feel about the drug
14 coverage and the drug recommendations, to hear some of
15 their feedback. I have to say I would agree with the
16 frustrations enrollees have about not having one card or
17 having to be screened several times through an HRA process
18 by different entities. It just doesn't make sense. So I
19 think some of these recommendations are kind of no-
20 brainers, even if they are things that might take time to
21 operationalize on the ground.

22 Along with the SMAC agreements being publicly

1 posted, I don't know what would be in them that is
2 proprietary. A lot of organizations gather those and get
3 them and look at them. So I don't quite see the harm in
4 that, but I'd be open to if some of the other Commissioners
5 are able to share their feelings or thoughts on that.

6 My understanding is that because it's signed by a
7 public entity and the health plan, they are public
8 documents, and they should be shared as such, in my
9 opinion.

10 And then the last is just the instructions on the
11 debit cards and the use for those. I echo the concerns
12 that it can be confusing to consumers when they get those,
13 and it would be helpful to have that clarity and
14 transparency for people out there. And I'd be interested
15 in if Dennis has any feedback on those pieces.

16 So, anyway, I'll turn it back over to you, and
17 maybe some of my colleagues would have comments on there
18 that they could share from their own lived experiences.

19 CHAIR JOHNSON: Oh, great. Thank you, Carolyn.
20 Good points, and definitely respond to some of the
21 questions that Carolyn raised, if you'd like.

22 John?

1 COMMISSIONER McCARTHY: I agree with what Carolyn
2 said and others have said. I, too, struggle with the
3 portion on the GLP-1s from the standpoint of they are very
4 expensive, and so they have a big impact. But the return
5 on investment can be huge, and so there could be huge
6 savings for the Medicaid program.

7 So the point I want to make, though, is when the
8 early drugs came out for hepatitis C, states tried to put
9 some limitations on there. For instance, we had put
10 limitation on it, you had to be sober in order to get one
11 of the drugs, because our clinical people were telling us -
12 - both our pharmacist and our medical director were saying
13 that if you were to take that drug and then stop taking it
14 and you weren't sober, the next time you try to take it,
15 it's less effective and the next time. So that's just my
16 concern on this one is I would assume some states would
17 have put some type of logical clinical criteria around some
18 of those drugs, like seeing weight loss over a period of
19 time, so that there isn't something like diversion or
20 something like that going with it.

21 So I think that's where I'm struggling with this
22 one is I know as Medicaid directors, we always think of the

1 negative because we see those bad things, but on this one,
2 there's a huge positive, too. So I think it's going to be
3 -- I agree with what Carolyn said of this is why you need
4 that integrated program to have those two things work
5 together.

6 CHAIR JOHNSON: Thank you, John.

7 Doug?

8 COMMISSIONER BROWN: Thank you.

9 I was going to go right where John went with
10 hepatitis C. If you wind back the clocks, 2013, 2014,
11 hepatitis C, \$84,000-per-treatment drug in the market,
12 millions of people that need to be treated, multiply them
13 together, you get budgets bigger than all the pharmacy
14 budget together. Care was rationed at that point, treating
15 the sickest patients first, and then you basically -- as
16 prices began to come down, you could treat more and more
17 people to where it is today, where generally, in most
18 states now, drugs are available for people that have
19 hepatitis C.

20 \$11 billion is a lot of money in the estimate. I
21 think it's probably underestimated, and the reason I say
22 that is because you have GLP-1s that are driving trend in

1 Medicaid. In the prime Medicaid trend report, GLP-1, that
2 class is the second largest class-driving trend. Weight
3 loss is the sixth largest class that's driving the trend
4 right now in Medicaid from a pharmacy perspective. And
5 that's looking at 2022 and 2023 data.

6 The other thing that's important to understand is
7 in the new drugs that came out that are originally
8 indicated for weight loss, Medicaid didn't have to cover
9 those products, because they were indicated strictly for
10 weight loss. Subsequently to that, those drugs got
11 additional indications for cardiovascular indications, and
12 then states had to provide coverage for that. As a result,
13 you see a number of states have now added those drugs to
14 preferred drug list programs with the edits and the
15 requirements around the prior authorizations around BMI,
16 around sustained weight loss, and the like.

17 But I go back to what we've always known about
18 weight loss is without diet and exercise, you're not going
19 to maintain a lower weight. And to just have a program
20 that says, yes, we have to cover these drugs and people are
21 going to be on them for long periods of time, when they go
22 off of them, the weight is likely going to come back,

1 right? And so how long do you continue to pay for this?
2 What's the long term? What's the game plan here or the
3 rollout of this? And so that's my concern here is the kind
4 of opening access to this.

5 And this is much different than AIDS wasting
6 where for weight gain, they made drugs available so states
7 cover products for cachexia, and so that to me is
8 completely different than weight loss in that regard. I
9 understand the long-term side effects. I understand,
10 Adrienne, your points about that and relative health. I
11 get all that.

12 There is a concern about what this costs. How do
13 you fund this in a program where we can't fund everything
14 that we want to cover today?

15 The other piece I want to comment on is I'm
16 absolutely in favor of linking the dates between the Part D
17 program and Medicaid for coverage and making sure CMS -- my
18 recommendation would be CMS would have to do that, or
19 you're going to see Medicaid having to cover that for the
20 year prior before Part D is going to jump in there and
21 cover that.

22 So I'll stop my comments there but reserve the

1 right to come back into the discussion.

2 CHAIR JOHNSON: You do have a right to come back
3 if you need to. Thank you so much.

4 All right. Tricia.

5 COMMISSIONER BROOKS: Just a quickie on a point
6 others haven't made is I definitely think we should comment
7 on requiring agents and brokers to present the MSP options.
8 But I say that with the caveat that there needs to be some
9 kind of oversight or quality assurance to make sure that's
10 happening. That gets so far away from Medicaid. I don't
11 know to what extent we would see an impact, but I think
12 it's an important policy to have in place.

13 CHAIR JOHNSON: Thank you, Tricia.

14 Patti and then Heidi.

15 COMMISSIONER KILLINGSWORTH: I would like to
16 focus my comments on the second potential area of comment
17 around sort of the unified HRA and the codifying timelines
18 for the HRA and integrated care plan.

19 If we just think practically about what are the
20 primary Medicaid benefits that are being delivered to a
21 dually eligible beneficiary, it's long-term services and
22 supports and behavioral health, right? So we're talking

1 about in this context, people who have pretty significant
2 care needs. And part of my frustration in integrated care
3 is we tend to align to the Medicare requirements or the
4 Medicare timelines, and so 90 days to do an assessment, 120
5 days to develop an integrated care plan for someone who
6 needs or uses long-term services and supports or has
7 significant behavioral health needs is just too long.

8 Now I realize we're setting minimum standards,
9 but my fear is always that we default to the minimum
10 standards, right, because that's what the law now says.
11 And so I would like to see us include some sort of a -- not
12 just in the -- well, this isn't a chapter. This is a memo,
13 but making it clear that it would be, you know -- or the
14 minimum timeline prescribed or established by the state
15 Medicaid agency for integrated long-term services and
16 supports and our behavioral health services, right, really
17 making clear that the state is already prescribing
18 timelines for these other really important benefits, and we
19 shouldn't begin in a unified approach to default to a later
20 timeline, which is less responsive to the needs of a
21 population who may need benefits now or end up in an
22 institution.

1 CHAIR JOHNSON: Thank you, Patti.

2 Jami, did you have a comment?

3 [No response.]

4 CHAIR JOHNSON: Okay, all right.

5 Heidi?

6 COMMISSIONER ALLEN: Thank you.

7 I just wanted to comment about the GLP-1 drugs
8 and the potential for these to really widen health
9 disparities in the United States, particularly racial and
10 ethnic health disparities. I think that -- and, you know,
11 obviously in common class disparities, but the compounds of
12 these drugs are pretty widely available for anybody that
13 can shell out a couple hundred dollars a month. And that's
14 what people who are not getting it through their ESI and
15 they're -- you know, are doing right now or through
16 Marketplace coverage. But people on Medicaid don't have
17 that as an option, and low-income people in Medicare don't
18 have that as an option either.

19 And so I fear that, you know, with the research
20 suggesting that they're effective well beyond diet and
21 exercise has ever been and that that results in downstream
22 improvements in cardiovascular health, I think that if

1 Medicaid doesn't step forward to make sure that these are
2 available to our enrollees, that we will be seeing trends
3 where low-income minority populations have, again, this,
4 like, widening health outcomes of disparities. And we are
5 always like, how can we fix disparities? What can we do
6 about disparities? Well, I think this is a prime example
7 of something that we can do about disparities, and I think
8 that we definitely should.

9 CHAIR JOHNSON: Thank you, Heidi.

10 Dennis.

11 COMMISSIONER HEAPHY: I agree with Heidi's
12 comments and Patti's, and just building on Patti's a little
13 bit, what's missing is the quality of those plans, because
14 having a plan in place does not mean it's worth much.

15 And so I don't know how this actually fits into
16 this, into the recommendations, but unless we tie quality
17 to this, it really -- 30 days, 90 days -- doesn't really
18 mean anything. And we're discovering that in all the work
19 that we're doing with dual eligible plans. When the state
20 actually looks at those plans, they find that the plans
21 really aren't necessarily aligned with what a member's
22 needs are or what a member would want or in the member's

1 own words. So I think it's really important that we look
2 at some of the existing best practices and in determining
3 the quality of these ICPs.

4 And then the other piece is, the issue is the
5 brokers, not the advertising of the cards. And so I think
6 it's like -- I totally agree with doing away with the
7 advertising, the cards, and maybe secret shoppers to make
8 sure the brokers are actually sharing information
9 appropriately. We need to do that. But what we really
10 need to deal with -- and I think CMS is trying to deal with
11 this -- is really reducing the ability of brokers to exist.

12 And so how can we prevent -- how can we build up
13 states' capacities that should provide people with -- what
14 do you call it? -- conflict-free information about the
15 options that are available to them, to be on the -- what's
16 the program? The SHIP program. Yes, I think we need to
17 look toward that.

18 So yes, it's great, but I think a statement about
19 we need to do further work is important.

20 CHAIR JOHNSON: Thank you so much, Dennis.

21 Jami?

22 COMMISSIONER SNYDER: Yeah, I think I just have a

1 clarifying question. I know during the presentation, when
2 we were talking about the GLP-1 issue, there were a couple
3 of recommendations in terms of how we could comment on the
4 particular matter. And one had to do with just the
5 definition of overweight versus obesity. The other had to
6 do with based on some work that we've done historically
7 around state's ability to implement prior authorization
8 criteria.

9 Clearly, a lot of the discussion today has been
10 around the larger policy issue, and just curious to know,
11 in terms of protocol for the Commission, how we incorporate
12 or do we incorporate information around that larger policy
13 discussion into our comment letter.

14 EXECUTIVE DIRECTOR MASSEY: Yeah, sure. So why
15 don't I start, and then maybe, Chris, you can finish, which
16 is that when it comes to the comment letters on any NPRM,
17 the basis for MACPAC offering a comment is prior work that
18 we can rely on.

19 I think some of the conversation that we've been
20 having this afternoon is really interesting in terms of the
21 approaches, the appropriate use of GLP-1s, what the
22 potential effect that may have on budgets, et cetera. But

1 because we as a Commission do not have clinical expertise,
2 we will likely not opine on those elements in the letter
3 because that is not traditionally the role that we have
4 adopted as a Commission.

5 So, Chris, what would you add to that?

6 MR. PARK: Sure. And I think, you know, some
7 examples of like the hepatitis C drugs came up today, which
8 is a good example of where, you know, states had a wide
9 range of different prior authorization criteria linking it
10 to like liver damage scores, the sobriety type of, you
11 know, certain time of not using drugs or before you could
12 get the treatment. And also, as Doug mentioned, kind of
13 like follow up, you know, like how many times do you
14 necessarily cover it if it wasn't successful or things like
15 that?

16 So that is where -- you know, there's this gray
17 area, and particularly without like a clear definition of
18 obesity, you know, there are common definitions of like BMI
19 that are used, but, you know, without that clear definition
20 of what obesity is versus overweight, there's some leeway
21 potentially, you know, where states could have some
22 flexibility of determining what that might be. And, you

1 know, are there any guidelines that CMS could provide that,
2 you know, clarifies that a little bit, like a common
3 definition of BMI may be acceptable -- or, you know, to
4 Doug's point, like if they stop taking a drug, gained the
5 weight back, you know, can states kind of limit how many
6 times they potentially cover the drug in their situation?

7 So I think that's kind of where we would
8 necessarily land without like saying like this is what
9 obesity is or, you know, overweight, just trying to provide
10 maybe a little bit more parameters of what CMS would think
11 would be like acceptable within the parameters of the
12 rebate program.

13 And the other thing is just, you know,
14 potentially clarifying what Medicaid's responsibility might
15 be for dually eligible beneficiaries, particularly when if
16 there's a period when it's not considered a covered Part D
17 drug at that point, because, the statute prohibits Medicaid
18 for paying for Part D -- for drugs for Part D individuals.
19 And the statute is tied to kind of the definition of, you
20 know, this is for Part D individuals, for coverage of such
21 drugs and what does such drugs mean? And so it's not -- I
22 don't think it's super clear that states definitely have to

1 cover it, and I don't think it's super clear that they
2 don't have to cover it. So, you know, some more guidance
3 there as to what the expectation might be, you know, with
4 more of a legal expertise than I have.

5 EXECUTIVE DIRECTOR MASSEY: That's helpful.
6 Thanks so much, Chris.

7 CHAIR JOHNSON: Thank you, Chris.

8 Michael, Mike.

9 COMMISSIONER NARDONE: I was just going to say
10 that I appreciate the work of going through the guidance,
11 and I'm very supportive of the provisions that seek to
12 better integrate services between the two -- for dual
13 eligibles. And so, generally, I'm very supportive of those
14 with, I think, Patti's very good caveat about other
15 instances where the plan needs to be developed more
16 expeditiously because people are at risk of
17 institutionalization.

18 On the drug coverage for obesity drugs, you know,
19 I think the coordination between Part D and Medicaid, I
20 think, is an important point, and so that's kind of what I
21 would be highlighting.

22 So I guess I just want to just comment around

1 just generally being supportive of where you're headed with
2 the guidance as you've kind of laid it out in this memo.

3 CHAIR JOHNSON: Thanks, Mike.

4 Dennis?

5 COMMISSIONER HEAPHY: Thanks.

6 And I just have to throw it out there because
7 it's been on my mind since looking at the document, and
8 that is the narrow definition of "obesity" versus being
9 overweight. There are folks who have complex medical
10 conditions. They have asthma and a heart condition, and
11 the doctor is going to say just gain six more pounds, and
12 we'll be able to get you on the medication. And so it's
13 this like warped sort of -- like, you can't just look at
14 the weight itself. You have to look at the person's
15 totality and what their overall health needs are.

16 I'm not trying to, like, bust the budget, but how
17 much do we actually give to the providers to actually
18 determine, based on the criteria that could be used, but to
19 look at the overall person's health to see if this
20 medication would actually be helpful in reducing EDs and
21 hospitalizations and improving overall quality of life.
22 Again, also looking at, like, different SDOH aspects.

1 Thanks.

2 CHAIR JOHNSON: Thank you, Dennis.

3 And then Heidi.

4 COMMISSIONER ALLEN: Yeah, I just wanted to
5 follow up with that. I think that's such a good point,
6 Dennis, that you really don't want to incentivize people to
7 have to gain weight in order to get access to treatment.
8 And Wegovy is approved for overweight in combination with
9 other health risk markers, and so by saying it only is
10 obesity and it doesn't consider overweight, you're taking
11 out an indication for which it's FDA approved.

12 But the reason I hop back on here is that I want
13 to hesitate not to go too far down the hepatitis C
14 comparison route for thinking about utilization management,
15 because my understanding is that hepatitis C drugs were a
16 cure, and that these are not at all considered a cure.
17 They're considered chronic disease management. And so the
18 assumption is that, yes, absolutely, people stop taking it
19 will gain back the weight, and I think there's been a
20 number of clinical trials to show that that's true. And so
21 by saying, okay, if you failed treatment -- like, framing
22 that as a treatment failure that then can be used for

1 utilization management to say, oh, we helped you lose 100
2 pounds, and then we stopped giving you the medicine, and
3 then you gained it back, and so you're not eligible for
4 treatment, I don't think that that is an appropriate
5 comparison to the hepatitis C. I think that whatever
6 medical indications and treatment protocols exist for the
7 drug should be the ones that are implemented in Medicaid.

8 CHAIR JOHNSON: Thank you, Heidi.

9 Any other commissioners?

10 [No response.]

11 CHAIR JOHNSON: All right. So, Drew and Chris, I
12 think you heard overwhelmingly that anytime we can better
13 align the Medicare and the Medicaid programs, we want to do
14 that. And so, hopefully, you have enough feedback to start
15 that draft letter. But any other clarifying questions from
16 both of you or additional thoughts?

17 [No response.]

18 CHAIR JOHNSON: Okay. All right. Thank you so
19 much.

20 Yeah.

21 UNIDENTIFIED SPEAKER: [Speaking off microphone.]

22 CHAIR JOHNSON: We have a list of people, right.

1 Oh, no, you're good. Okay, thank you.

2 All right. Thank you both.

3 So now we're going to go back to public comments.

4 We're going open it up. We do invite people in the
5 audience to raise their hand if they'd like to comment.

6 Make sure, though, that you introduce yourself and the
7 organizations you represent, and we do ask that you keep it
8 to three minutes or less if you can. So we appreciate
9 that. Let's see what we have.

10 Peggy?

11 **### PUBLIC COMMENT**

12 * MS. McMANUS: Yes. I'm Peggy McManus with the
13 Got Transition Program, and I want to thank the staff and
14 the Commissioners for taking up this topic.

15 There were four things that I just wanted to add.
16 Regarding measures, we have an article that I'll share with
17 the MACPAC staff on suggested measures for transition
18 planning, transfer, and integration.

19 Regarding improving access and measurement, it
20 will depend a lot on EMR functionality, which right now is
21 very limited. And so what could be done in terms of
22 improving the tracking of the transition-age youth, keeping

1 track of the receipt of the transition readiness
2 assessment, the medical summary, the identification of
3 primary care provider, the final pediatric visit, the
4 exchange of medical summary, the initial visits, that is
5 still very much a gap in our field.

6 The importance of using EPSDT was measured. I
7 think that's a fabulous idea, building on CMS's recent
8 guidance, and including more timely notification of when
9 the changes are going to happen in care and coverage,
10 particularly explaining what will happen when you lose
11 EPSDT, and ensuring receipt of an up-to-date medical
12 summary before they leave EPSDT.

13 And finally, on some value-based payment options,
14 to think about ways to promote pediatric and adult system
15 processes and increasing the adult primary care workforce
16 capacity.

17 Thank you very much.

18 CHAIR JOHNSON: Thank you so much, Peggy. We
19 appreciate it.

20 Any other comments?

21 [No response.]

22 CHAIR JOHNSON: All right. Looking like we don't

1 have any.

2 We do want to remind you in the audience, if you
3 have some questions that you have later on that you'd like
4 to submit, you can do so through the MACPAC website.

5 And with that, we will be taking a short break.
6 We'll be back at 2:40. Thank you.

7 * [Recess.]

8 CHAIR JOHNSON: All right. Thank you. Welcome
9 back.

10 So for the remainder of the afternoon, we're
11 going to be exploring the critical topic of self-direction
12 in Medicaid HCBS, and so to begin, we have Brian O'Gara,
13 who's our analyst, and Gabby Ballweg, who's our research
14 assistant. And they're going to provide an overview of
15 what self-direction models and key considerations for
16 strengthening these programs look like. And then, we're
17 going to have a great panel conversation that I'm very
18 excited about.

19 So I will turn it over to both of you to get us
20 started.

21 **### INTRODUCTION TO SELF-DIRECTION FOR HOME- AND**
22 **COMMUNITY-BASED SERVICES (HCBS)**

1 * MR. O'GARA: Great, thank you. Good afternoon,
2 Commissioners. Gabby and I will be discussing the kickoff
3 of a new project focusing on self-direction for home- and
4 community-based services.

5 So just to quickly level set, I know that MACPAC,
6 we previously considered self-directed providers as part of
7 our work around Medicaid payment policies for the direct
8 care workforce. I just want to be clear that this work is
9 not stemming from that or is not in the same vein, and we
10 shouldn't think of this work as particularly tied to either
11 payment or workforce policies.

12 The objective of this new project is to produce a
13 foundational resource on self-direction and to examine it
14 as a mechanism through which states deliver HCBS to
15 beneficiaries and also as a starting project to kind of
16 gather input from stakeholders and to identify potential
17 policy areas for future work.

18 To that end, I'll be providing a brief background
19 and overview of the statutory framework that guides self-
20 direction, and then Gabby will be diving into more detail
21 on a lot of those elements, including state flexibilities,
22 program administration, evaluations, and the next steps for

1 this work.

2 So some background. Medicaid home- and
3 community-based services are, of course, provided to
4 individuals with long-term services and supports needs.
5 They're designed to allow them to remain in the community
6 and live independently, and one of the ways that states
7 deliver HCBS to individuals with LTSS needs is through
8 self-direction, which is a consumer-controlled model of
9 delivery as opposed to a traditional agency-delivered
10 model.

11 Participants in self-direction control their own
12 care by hiring representatives or -- excuse me -- by hiring
13 workers or -- with the assistance of representatives,
14 hiring workers, overseeing and terminating those workers
15 who are often family members, friends, or other
16 acquaintances. And self-direction affords participants
17 greater autonomy to choose and control their own care
18 compared to that traditional agency-delivered model.

19 The guiding tenet of self-direction is that
20 participants are capable of determining the types of
21 assistances and services they need to remain independently
22 and independently in the community, and to that end, CMS

1 has several requirements for states to help support
2 beneficiaries in controlling their own care and services.

3 CMS requires that states, when offering self-
4 direction, implement person-centered planning processes.
5 These are led by the participant with optional assistance
6 from a chosen representative, and they focus on identifying
7 the participant's strengths, preferences, needs, and
8 desired outcomes.

9 States also require a service plan for self-
10 direction, which is a written document outlining the
11 specific services and supports the individual will receive
12 to meet their needs and stay in the community.

13 Information and assistance services and supports
14 help individuals navigate the self-direction process from
15 identifying personnel needs to ensuring services are
16 properly managed.

17 Another key element is financial management
18 services, or FMS entities. These entities assist with
19 managing budgets, handling payroll, paying taxes, and
20 tracking expenses. And it's important to note that while
21 not all individuals who self-direct utilize FMS, many
22 individuals do.

1 States also have to have in place and maintain a
2 quality assurance and improvement system to identify and
3 address issues to ensure services delivered through self-
4 direction are effective and appropriate.

5 And finally, if the individual self-directing
6 does receive budget authority, which Gabby will discuss
7 later, the state must obviously provide them with an
8 individualized budget to pay for services.

9 Just a quick overview of nationwide enrollment.
10 Self-direction models are available in all 50 states and
11 the District of Columbia, and last year, there were over
12 1.5 million beneficiaries enrolled in self-direction,
13 mostly through Medicaid. But it's important to note that
14 this figure does include some other funding sources, such
15 as the Veterans Health Administration and the Older
16 Americans Act.

17 States have broad flexibility to target self-
18 direction by geographic region, services, and populations,
19 which Gabby will also discuss soon.

20 Self-direction began as the Cash and Counseling
21 demonstration. This was launched by ASPE in 1997 using
22 Section 1115 demonstration authority. The goal of this

1 Cash and Counseling demonstration was to assess the
2 feasibility, advantages and disadvantages of self-direction
3 in financing and delivering personal assistance services
4 for Medicaid beneficiaries.

5 The pilot began in three states: Arkansas,
6 Florida, New Jersey. And eligible Medicaid beneficiaries
7 there volunteered to receive a cash allowance with
8 counseling services in lieu of using a traditional agency-
9 directed model of care. Participants hired their own
10 workers, managed their own budgets, and designated
11 representatives to help them control their care where
12 necessary.

13 Compared to the traditional agency-delivered
14 model of care, beneficiaries in the Cash and Counseling
15 demonstration reported higher satisfaction with their care
16 and quality of life as a result of participating in the
17 pilot program.

18 The states that originally participated in the
19 Cash and Counseling demonstration, those programs by 2011
20 had all become the modern self-direction programs, either
21 through 1915(c) or Section 1115 demonstration authorities.

22 Now we'll briefly touch on statutory framework.

1 States have several options under Title XIX of
2 the Social Security Act to offer self-directed services.
3 States can use several Medicaid waivers or state plan
4 authorities concurrently, or they can just use authorities
5 on their own to offer self-direction. For example, Oregon
6 utilizes every authority in this table to offer self-
7 directed services, while Rhode Island offers self-direction
8 solely through 1115 demonstration authority.

9 Each of these authorities have different
10 requirements that dictate how the state must design and
11 administer their self-directed programs. Elements such as
12 eligibility, contracting, the use of family providers, and
13 payment structures are just some of the key elements that
14 depend on which authority states select to use. And Gabby
15 will be touching on those elements soon.

16 As you can see here, Section 1915(c) is currently
17 the most commonly used authority to deliver self-directed
18 services. That has been the case historically because it
19 is the oldest authority for self-direction, but states are
20 increasingly turning to other authorities either in
21 concurrent use or using other authorities on their own to
22 offer these self-directed services.

1 There's also been some recent rulemaking. In the
2 final access rule from May, there was, of course, the
3 provision that 80 percent of all Medicaid payments to
4 homemaker services, home health aide services, and personal
5 care services must be spent on direct care worker
6 compensation. That mandate does apply to self-directed
7 services offered under 1915(c), (I), (j), (k), and 1115
8 authorities.

9 And the rule also requires states to report every
10 other year on a set of nationally standardized HCBS quality
11 measures. This is referred to as the "HCBS quality measure
12 set." And according to CMS, CMS encourages states to use
13 the measure set to the extent that measures are applicable
14 to a specific HCBS program, regardless of delivery system
15 type.

16 Beginning by July 2028, states must report every
17 other year on some of these HCBS quality measure sets,
18 regardless of the type of delivery model, therefore
19 including self-directed services.

20 And now I will hand it over to Gabby.

21 * MS. BALLWEG: Thanks, Brian.

22 So now we're going to move forward into a

1 discussion of some of the state flexibilities in self-
2 direction program design.

3 States have considerable flexibility when
4 designing their self-directed HCBS programs within this
5 aforementioned statutory and regulatory framework that
6 Brian just reviewed.

7 One of the major flexibilities that states may
8 leverage as they design their self-direction programs is
9 whether to offer beneficiaries either employer authority,
10 budget authority, or both. When a beneficiary has employer
11 authority, that means that the beneficiary can choose who
12 provides their HCBS. When a beneficiary has budget
13 authority, they have an individualized service budget
14 that's based on their functional needs. And then within
15 that budget, they can set a wage for their HCBS worker that
16 they will be paid.

17 States have also introduced additional
18 flexibilities within budget authority that allow
19 participants to allocate some of their service funds to
20 goods and services that can help promote independence, such
21 as assistive technology or home modifications.

22 According to the AARP's 2024 National Inventory

1 of Self-Directed Long-Term Services and Supports, 44 states
2 had at least one self-direction program that included
3 budget authority, and the top 10 states with the largest
4 growth in their self-direction programs from 2019 through
5 2023 also offered budget authority.

6 In addition to decisions around employer and
7 budget authority, states must also consider whether to
8 allow a representative to self-direct services for or in
9 coordination with a beneficiary. Most states permit the
10 use of representatives to help self-directing individuals
11 to manage their services and budgets.

12 States that allow representatives may require a
13 formal designation, but that's not a federal requirement.
14 If a state does allow for the election of a representative,
15 they're generally restricted from serving as the paid
16 caregiver as well. However, there is an exception to this
17 rule for parents of minor children with disabilities.

18 States have the authority to determine who can
19 provide HCBS under self-direction programs. CMS does not
20 dictate qualifications for caregivers, but does require
21 that states must establish qualifications.

22 To reduce opportunities for fraud, waste, and

1 abuse, states often implement protections such as
2 background checks and abuse registries.

3 Variation in requirements for caregivers can
4 exist across self-direction programs within a state,
5 especially around training and certification, and these
6 variations can often align with specialized skills required
7 for a specific service.

8 In many cases, states will offer flexibility to
9 allow family members to deliver care, generally with the
10 condition that they are not the beneficiary's
11 representative. States can set limits on the use of family
12 caregivers, such as the total hours of services they may
13 provide per week or a specific service setting in which
14 they can provide these services.

15 States that permit family caregivers to provide
16 self-directed services generally consider whether the
17 existing provider network is able to reach beneficiaries.
18 So this could be workforce sufficiency considerations or
19 geography. They also consider whether the existing
20 workforce can provide culturally competent care and adhere
21 to the beneficiary's person-centered service plan.

22 According to the National Resource Center for

1 Participant-Directed Services, over 50 percent of self-
2 directing individuals will hire a relative or someone they
3 know when they have the opportunity to do so.

4 As Brian had mentioned, states must also have a
5 quality assurance and continuous improvement system for
6 their self-direction programs. These systems help ensure
7 quality, identify potential risks to participants and
8 employ mechanisms to mitigate these risks, such as criminal
9 background checks for HCBS workers or checks to support
10 financial accountability.

11 Regulations require that states guarantee the
12 necessary safeguards are in place to protect the
13 individuals receiving services and maintain financial
14 accountability for the funds expended under a self-directed
15 HCBS program.

16 Self-direction programs must balance these
17 requirements with the need for flexibility to ensure that
18 the participants can fully exercise their autonomy while
19 self-directing their services and still receive the
20 adequate supports and protections they need.

21 States will vary in how they design their quality
22 assurance and continuous improvement programs to manage

1 risks. For example, one state disallows payments for
2 personal assistance services while a beneficiary is
3 hospitalized, and they do this by comparing the PAS and
4 hospital claims for the beneficiary using the state's
5 Medicaid management information system.

6 Another state requires its managed care
7 organizations to monitor for fraud and abuse and report
8 certain utilization anomalies, such as the underutilization
9 of services. The state also conducts quarterly audits.

10 Lastly, some states can also engage in more
11 stringent monitoring for services provided by relatives.

12 States have the flexibility as well to determine
13 which populations they would like to serve through their
14 self-directed HCBS service delivery models. Each self-
15 direction program may have different eligibility
16 requirements within and across states.

17 An analysis conducted by the AARP, which includes
18 self-direction funded by Medicaid and other sources, found
19 that in 2023, all states offered the self-direction HCBS
20 delivery model for adults over the age of 65 and adults
21 with physical disabilities. Over 90 percent of states
22 offered self-direction for adults with I/DD and adults with

1 traumatic brain injury. Approximately 86 percent of states
2 offered self-direction for children with I/DD, and just
3 under half of states offered self-direction for adults with
4 serious mental illness.

5 States have the flexibility to select which
6 services are available for self-direction. According to
7 Applied Self-Direction, the most commonly self-directed
8 services include personal care, transportation, and respite
9 services. There's no comprehensive list defining which
10 HCBS can be self-directed, and states have considerable
11 flexibility to identify services to self-direct.

12 States can vary widely in the quantity of
13 services available for self-direction and which services
14 they allow to be self-directed.

15 In a previous analysis of Section 1915(c) waivers
16 supporting home-based services, round-the-clock services,
17 and day services, 40 states offered self-direction for
18 home-based services, and 22 states offered self-direction
19 for day services in at least one of their 1915(c) waivers.
20 No state offering round-the-clock services under a Section
21 1915(c) waiver offered a self-direction option for that
22 service.

1 In addition to the program design flexibilities,
2 states must also consider how they plan to administer their
3 self-directed service delivery model. To effectively
4 administer the self-directed HCBS delivery model and
5 conduct monitoring and oversight, states may collaborate
6 across state operating agencies and rely on a variety of
7 third-party administrators.

8 In this section, I'm going to review select self-
9 direction program administrators, but please note there are
10 more, and we will be continuing to delve into these and
11 exploring them as we continue this work.

12 When states administer self-directed HCBS, some
13 choose to nest all of their self-direction programs under
14 the state Medicaid agency, while others may delegate the
15 administration of one or more of the state's self-directed
16 Medicaid programs to separate state operating agencies.
17 These operating agencies outside of the state Medicaid
18 agency may include state departments focused on aging or
19 I/DD populations, among others. For example, one state
20 administers its Medicaid self-directed HCBS program across
21 four separate operating agencies.

22 According to CMS, when states operationalize

1 self-direction programs, they should also consider the
2 following: monitoring in a managed long-term services and
3 supports, or MLTSS environment; identifying backup
4 supports; maintaining workforce registries; and ensuring
5 caregiver certification and training.

6 In addition to the state-operating agencies,
7 states may also work with third-party entities to support
8 their self-direction administration. These entities may
9 assist the state in providing required information and
10 assistance supports and financial management services.

11 When a beneficiary has budget authority, their
12 state self-direction program must also include FMS entities
13 as a support to perform employer-related and tax
14 responsibilities or to assist beneficiaries in managing
15 these budget-related tasks themselves. However,
16 beneficiaries are not required to use an FMS entity if they
17 don't choose to do so. FMS entities must be able to assist
18 beneficiaries in understanding their billing and
19 documentation responsibilities, performing payroll tax and
20 employment benefit services, purchasing goods and services,
21 and monitoring the beneficiary's self-directed budget.

22 Regarding information and assistance supports,

1 they must be available to beneficiaries who are self-
2 directing their HCBS. The amount and frequency of
3 information and assistance support provision varies at a
4 beneficiary's choice, and the state or third-party entities
5 contracting with the state, such as support brokers, case
6 management agencies, and even on occasion FMS entities,
7 among others, may furnish information and assistance
8 supports.

9 Depending on the beneficiary's needs or
10 preferences, information and assistance professionals may
11 support the beneficiary in accessing services, they may
12 assist in developing the service plan or service budget and
13 monitor the provision of services and support budget
14 management.

15 Next, we're going to move on to our evaluations.

16 Some of the most robust evaluations of self-
17 directed programs come from the cash and counseling
18 demonstration. In an evaluation of the original three
19 pilot Cash and Counseling programs that Brian discussed,
20 the demonstration was associated with a favorable impact on
21 beneficiaries and their caregivers. For example, compared
22 with individuals receiving agency-directed services, Cash

1 and Counseling beneficiaries were more satisfied with their
2 care and quality of life.

3 Additionally, caregivers were about 20 percentage
4 points more likely to be very satisfied with their care
5 recipient's service arrangements, relative to those
6 providing service in an agency-directed service delivery
7 model.

8 They also expressed higher levels of satisfaction
9 with their own lives, compared to caregivers providing
10 agency-directed services.

11 Although caregivers and beneficiaries were
12 broadly satisfied with Cash and Counseling, the
13 demonstration was associated with adverse effects on
14 Medicaid costs for demonstration-covered services.
15 Overall, monthly HCBS costs under Cash and Counseling were
16 higher across all three states and all age groups receiving
17 services when compared with agency-provided services.
18 However, researchers generally attributed the cost
19 differential to unmet care needs among beneficiaries in the
20 traditional system.

21 Furthermore, some of the increased costs in the
22 demonstration were partially offset by savings on other

1 Medicaid services, like nursing facilities services and
2 home health.

3 Beyond the Cash and Counseling demonstration,
4 there are more limited empirical analyses of self-directed
5 HCBS service delivery models, and some recent studies have
6 assessed the effectiveness of self-direction for people
7 with behavioral health needs, and other studies have
8 suggested service costs and self-direction are very similar
9 to those in the agency-directed HCBS.

10 Most of these studies are on a smaller scale than
11 some of the Cash and Counseling evaluations, and they all
12 have limitations.

13 I'm now going to move forward with our next
14 steps.

15 For this session, we welcome the Commissioners'
16 questions and feedback related to the elements of self-
17 direction for HCBS that we discussed today, including state
18 design in a self-direction program, program administration
19 and specifically Commissioner insight into program
20 administration, and opportunities and challenges for states
21 and stakeholders in self-direction delivery models.

22 We will return at the February 2025 Commission

1 meeting with findings from state and stakeholder
2 interviews, and I thank you for your attention today.
3 We're going to be turning directly to our participant
4 panel.

5 [Pause.]

6 CHAIR JOHNSON: So I think while we're waiting
7 for the panelists to come on, we'll go ahead and take a
8 couple of questions for you. I will say be brief, but
9 maybe we'll just say one or two Commissioners or so. Any
10 questions or thoughts?

11 Let's see. Heidi.

12 COMMISSIONER ALLEN: I'll be super quick. I had
13 two questions that I thought were -- or things that popped
14 up to me is, one, the risk management systems and criminal
15 background checks and how that impacts, like, communities
16 that have been disproportionately harmed by policing and
17 whether or not it prohibits people from hiring a relative
18 that might have a criminal background check -- or criminal
19 background.

20 And then for the FMS entities, I'm curious about
21 whether or not people provide benefits like health
22 insurance and vacation time. And then what state policies,

1 like, you know, that you can't simultaneously have support
2 hours at the same time as somebody is hospitalized, like,
3 how do they do vacation time? Then are they not able to
4 offer anything even for people who are working full-time?

5 So that was my two thoughts.

6 CHAIR JOHNSON: Thank you, Heidi.

7 Carolyn?

8 COMMISSIONER INGRAM: Thanks for all of the
9 background work you've done. I had just a few questions to
10 see what you found in markets.

11 One is what parameters states have put on in
12 terms of controls on these types of services in order to
13 protect beneficiaries. I think, in some cases, at least
14 I've seen some pretty horrible harm to members and
15 beneficiaries that resulted in death actually by people who
16 were supposed to be their caregivers or close to the
17 family. So I'm wondering what types of programs have been
18 put in place to monitor that.

19 And then secondly, there are systems I know that
20 have been put in place, and I'm sure Patti can talk about
21 some of these, but the EVV vendors and those types of
22 things which have best practices. And I'm just curious if

1 you saw some of those in states, but also, they can also be
2 kind of costly and very complex in their IT administration
3 and how it actually gets played out in the field when
4 people have to log into systems, whether or not they have
5 access to Wi-fi and tablets or if they're done through
6 apps. And I'm wondering if you've seen any best practices
7 or examples of that and then also how they report out
8 effectiveness besides just tracking who comes in to see
9 somebody. What are the outcomes that we're actually seeing
10 out of that data? And I'm assuming Patti's got some of
11 that that she can share.

12 So that if we are investing in these programs and
13 spending a lot of money on them to keep people in the
14 community, which is a good thing -- that's what we want to
15 do -- but what type of outcomes are we actually seeing from
16 that care? And are we ending up spending so much money
17 developing these complicated systems that it's wasting the
18 money instead of going to the people that need help in the
19 community?

20 So thank you.

21 CHAIR JOHNSON: Thanks, Carolyn. I appreciate
22 that.

1 Patti?

2 COMMISSIONER KILLINGSWORTH: I'm going to mention
3 just a couple of things maybe for us to delve into as we
4 continue to dig into this topic. One, I know is kind of on
5 the agenda, which is really understanding from the state's
6 perspective, policy or operational barriers as it relates
7 to -- or challenges as it relates to self-direction and
8 just making sure that we understand that as well as getting
9 the beneficiaries' perspective.

10 As a Payment and Access Commission, I was a
11 little troubled by the findings around the higher costs
12 related to self-direction and would love to delve deeper
13 into that and really look since so many -- well, all states
14 offer self-direction as a model, really being able to look
15 at average utilization of services in self-direction models
16 versus those that are provided more in agency-directed
17 models and see if we see increased utilization and if we
18 kind of understand the factors that account for that.

19 And I think I'll leave it at that for the moment,
20 but I'm confident I'll have more input at a later time but
21 anxious to get on with the panel discussion.

22 CHAIR JOHNSON: Thank you. Thanks, Patti.

1 We'll just have Dennis, then, and then Mike, and
2 then we'll go to the panel. So, Dennis?

3 COMMISSIONER HEAPHY: I think one of the reasons
4 why this is important, at least from a consumer
5 perspective, is that just as there's an institutional bias,
6 there has traditionally been an agency bias in provision of
7 services, and oftentimes agency workers are not able to
8 provide all the services that an individual needs. And so
9 there are nursing-level services that a health aide from an
10 agency cannot do, that someone who's a consumer employer
11 can actually have provided their service, can have nursing-
12 level services provided for them in the home because
13 they're the employer and not the agency. As the employee
14 works for that individual, they're answerable to that
15 person and not to an agency, and so the person actually has
16 the relationship with that person. And so the relationship
17 is not with the agency itself. I just think it's important
18 to raise it up and why this is such an important
19 conversation in terms of people's ability to remain in the
20 community.

21 I know there's research going on right now about
22 access to in-home care providers during COVID and comparing

1 folks who were in the agency versus folks who were consumer
2 employers. So I can bring some of that information to you.

3 So I'd just like to contextualize this as really
4 a means of providing choice to folks and the opportunity to
5 live in the community the way they do, and there are things
6 that I do as a consumer employer that I would never be able
7 to do with an agency. And so for me, I've been on the
8 agency model and don't know who's going to come. Folks
9 have more complex care needs, and a lot of folks actually
10 want to work with an individual. So just, yeah, I won't
11 opine on it, but just to make that clear why this is so
12 important.

13 CHAIR JOHNSON: Thank you, Dennis.

14 And then Mike?

15 COMMISSIONER NARDONE: I was just going comment
16 on one of the things that I'd like to better understand is
17 the type of supports that are provided to the worker in the
18 self-directed setting, training.

19 Also, are there other supports that are provided
20 to help, say, an individual understand like what they
21 should do in a particular situation, emergency situation,
22 those types of supports?

1 And I'm also interested in the models around EVV,
2 because I do think it has some capability to provide some
3 support to the workers, and I'm wondering if that's being
4 used as of now. I mean, I know a lot of it's around fraud
5 and abuse, but I think it also has capabilities much beyond
6 that. And I'm just wondering the extent to which states
7 may be employing that.

8 The last thing I was going to ask, just in terms
9 of the numbers, it says 1.5 million people are in part of
10 self-directed programs. I know that's not just Medicaid,
11 right? Tomorrow we're going to hear some numbers around
12 how many people are in home- and community-based services,
13 which is like 3 million. So I guess what I'm trying to
14 understand is, does that mean half the people are in self-
15 directed programs? I know I'm probably not understanding
16 that right, but I'm just trying to get a sense of the
17 sizing because we're going to have some more information on
18 HCBS tomorrow. So I was wondering if you could comment on
19 that.

20 MS. BALLWEG: Yeah, I'm happy to respond to that.
21 So in the work that we're doing tomorrow with the HCBS
22 dataset, we actually were looking at that and seeing if we

1 could look at self-direction in there. And there's
2 actually not a flag in T-MSIS specific to self-direction.
3 There's one for services supporting participant direction,
4 which does not cover the full gamut of self-direction. So
5 we can't quantify a specific number of how many people
6 receiving HCBS are self-directing.

7 In that figure, it's about 60 percent or so. A
8 little over 60 percent of the individuals in there are
9 funded by Medicaid, based on where that statistic came
10 from. So that gives you a little bit better of a scope or
11 an idea.

12 COMMISSIONER NARDONE: So of the 1.5 million, 60
13 percent of those are --

14 MS. BALLWEG: About, about, yeah.

15 COMMISSIONER NARDONE: About 60. Okay, that's
16 helpful.

17 CHAIR JOHNSON: All right. Thanks, Mike.

18 All right. I'll turn it back over to Gabby and
19 Brian then to introduce the panel.

20 **### PANEL ON SELF-DIRECTION FOR HOME- AND COMMUNITY-**
21 **BASED SERVICES (HCBS)**

22 * MS. BALLWEG: Thank you for that discussion.

1 So we are having this panel today to complement
2 MACPAC's ongoing work to develop a foundational
3 understanding of self-directed home- and community-based
4 services in Medicaid, including how states -- exploring how
5 states design and administer their self-directed HCBS
6 models, as well as any barriers that may exist to the
7 effective program administration of self-directed services.

8 Through our conversation with panelists, Brian
9 and I plan to obtain insights on the beneficiary experience
10 in self-directing services, including opportunities and
11 challenges, and design considerations that states must make
12 when establishing and administering these programs.

13 To this end, we have invited four panelists for
14 today's session. We're joined by Patricia Brennan, the
15 Director of the Office of Education on Self-Directed
16 Services, Waiting Lists, and Special Projects with the New
17 Jersey Division of Developmental Disabilities. We're also
18 joined by Mark Sciegaj, a Professor of Health Policy and
19 Administration and Professor in Charge of the Bachelor of
20 Science Degree in Health Policy and Administration at the
21 Pennsylvania State University. Our third panelist is
22 Pamela Zotynia, the Service Director of Participant-

1 Directed Services at Values into Action, and the mother of
2 our fourth panelist, Robert Zotynia, a Self Advocates
3 United as One Power Coach, Artist, Changemaker, and Self-
4 Direction Participant. Thank you all for joining us today.

5 And with that, my first question goes to Robert.

6 Robert, could you please explain why you decided to self-
7 direct your services?

8 * MS. ZOTYNIA: Robert uses assistive technology,
9 so be patient with us.

10 You ready?

11 * MR. ZOTYNIA: Thanks for inviting me to speak
12 with you today. It is truly an honor.

13 I was fortunate to grow up in a family who
14 believed I should not be treated differently just because I
15 happened to have disabilities, and they instilled this
16 belief in me. I attended regular classes in school, not
17 segregated special education classes. I received all of my
18 supports in the classroom, and I made a lot of friends. I
19 also learned a lot of things I probably would not have been
20 exposed to in special ed classrooms.

21 So, when I graduated, it was a bit of a shock
22 when I was referred to segregated adult programs. I tried

1 several day programs, but I found them boring most days.
2 And sometimes they would trigger my anxiety when my peers
3 had bad days and became loud and disruptive. I never
4 blamed them. But being a person with mobility challenges,
5 it can cause stress when you can't move out of the way
6 without someone assisting.

7 Over time, this type of environment began to
8 impact my health. My body became tight from constantly
9 reacting to stress. I began exhibiting mood swings that
10 professionals refer to as behaviors, and I developed some
11 serious stomach issues that became life-threatening.
12 Because I needed constant monitoring to manage my health
13 challenges, my mom and I decided a residential setting
14 would be best. We assumed the provider would be able to
15 follow the medical recommendations, including closely
16 monitoring my diet due to the damage to my stomach.

17 Unfortunately, this did not work out as we hoped.
18 In the 17 months I lived in the group home, I had 12 visits
19 to the emergency room and two inpatient hospitalizations.
20 My mother was and is my best advocate. She demanded that
21 the provider follow the medical orders and provide the care
22 that I deserved.

1 Eventually, the provider issued a 30-day notice
2 informing us they were terminating service. That's when we
3 decided I would move back home and self-direct my services.

4 That was almost 10 years ago. I'm authorized for
5 in-home and community support 24 hours per day. I hire,
6 train, and manage my staff so they know exactly how to
7 assist me. They help me with everything: my personal care
8 needs, my job, accessing my technology and equipment, my
9 household responsibilities, and navigating the community.

10 In addition to daily service notes, they document
11 my moods, sleep patterns, consumption, fluid intake, and
12 bowel movements so we can intervene if I'm experiencing an
13 issue and to share with my doctors.

14 I have six staff, and all of them have worked for
15 me between six and ten years, including during the
16 pandemic. I haven't been to the hospital in seven years.
17 Having control of my life through self-direction is the
18 best decision I ever made.

19 I also use a supports broker to assist me, but
20 it's a provider-managed service.

21 MS. ZOTYNIA: He's done.

22 MS. BALLWEG: Thank you, Robert.

1 I'm also wondering, can you share some of the
2 examples of the services and supports that you self-direct?

3 MS. ZOTYNIA: So he did not program that in, if
4 you don't mind. If Robert doesn't mind, I'll help him
5 respond to that. Is that okay with you? Okay.

6 So he is authorized for and self-directs in-home
7 and community support, which you may have heard referred to
8 as "habilitation" in other states. He's authorized for
9 that 24 hours per day, seven days a week. He has variances
10 for that so that he can have more than 14 hours of service
11 in a day. That was established when he left the group
12 home, who established that he had a very high level of
13 need.

14 He also is authorized for mileage reimbursement,
15 although I'll be honest with you, we've never utilized it
16 because we're just too lazy to do the paperwork. He will
17 likely begin using that if I am ever not available and my
18 credit card goes away with me.

19 He's, at times, needed nursing service. You
20 cannot self-direct nursing service. It's a discrete
21 service within the waiver. But in Pennsylvania, a nurse
22 license, an LPN or RN, qualifies the support worker to

1 provide enhanced in-home and community support. So we have
2 hired nurses who are paid as in-home and community support
3 workers, but they bring the skills Robert needs.

4 We discontinued that a few years ago because
5 Robert has learned to manage his health fairly well, and we
6 didn't really feel we needed to take a nurse from someone
7 else who's probably been waiting for a nurse for decades.
8 There's a shortage.

9 Is that it? Yeah.

10 MS. BALLWEG: Thank you both.

11 My next question is going to be for Pam. As both
12 a parent and caregiver, what has your experience been with
13 self-direction, and how has that impacted your family?

14 MS. ZOTYNIA: So I have both personal and
15 professional experience with self-direction. So I'm going
16 to speak from my personal experience as Robert's mom.

17 Robert's 38. We've used probably every model of
18 service that's been around for the past 37 years since he
19 was diagnosed and enrolled in services. He didn't always
20 receive services. We've used day programs. We've used
21 group homes. We've used -- family support service was a
22 service years ago. I don't even know if it still exists.

1 The majority of those are provider-managed, and
2 although I don't like to give you the impression that we
3 don't think providers provide good service -- they
4 certainly do -- but it comes with some restrictions that
5 didn't allow Robert to have the flexibility that he really
6 was looking for.

7 So, when we moved towards self-directing 24 hours
8 a day and Robert was able to have complete control while
9 following rules and regulations because, you know, Medicaid
10 comes with a lot of rules and regulations, which we're cool
11 with, we really saw him begin to thrive. When we saw that
12 happening, it began to relieve stress on me, on his sister,
13 and on his father. So it helped us -- it helped us find a
14 balance in our home. It helped Robert become very
15 integrated in our community because he decides where he's
16 going to go and when he's going to go. He decides if, you
17 know, hey, I'm tired, I'm going to sleep late today.
18 There's no "Hurry up. Get up. The van is here. You got
19 to get to day program," because there's this short window
20 that you can get in and or they close the door because of
21 billing issues. It's really -- I understand it from a
22 business perspective, but it doesn't really work in real

1 life.

2 It's allowed me -- although it's a lot of work --
3 I don't want to give anybody the impression it isn't a lot
4 of work when you self-direct, and I tell every family we
5 encounter, it's given me a sense of security that Robert
6 will be okay when I'm no longer here. He's been able to
7 build a staff complement of, ironically, all men, which is
8 very unusual, who understand him, connect well with him.
9 He connects well with them too, who are almost like his
10 friends until -- they're always his friends. Let me take
11 that back. But they're able to jump in if there's a
12 crisis. They're able to intervene quickly, so there are
13 very rarely crises.

14 Robert used to have mental health crises daily,
15 sometimes multiple times in a day, sometimes resulting in
16 us having to go to the ER. That hasn't happened in years
17 because we track so many things, and the guys are amazing
18 at tracking that after we trained them and supported them
19 in that, that we can see that data and jump in quickly and
20 know that something that happened today or yesterday has
21 caused anxiety or has increased Robert's pain.

22 We didn't see that when he lived in the group

1 home. As hard as they tried, it just didn't work. He
2 constantly was in the hospital or at the doctor. Like he
3 mentioned, he hasn't been to an ER in seven years now,
4 knock on wood, because I really don't want to go this
5 weekend.

6 I hope that answers your question.

7 MS. BALLWEG: Yes, it definitely did. Thank you,
8 and thank you both for being so open and willing to share
9 with us.

10 This next question is going to be for Mark.
11 Beyond the required person-centered planning process, the
12 service plan, the individualized budget, information and
13 assistance supports, states have broad flexibility in
14 designing their self-directed HCBS delivery models. Could
15 you please describe some of the key design considerations
16 states typically make as they develop their self-directed
17 HCBS programs?

18 * DR. SCIEGAJ: Sure. And, you know, depending on
19 whether it's an employer authority model, which enables the
20 participant to have control over and the choice of worker,
21 or if it's more of a budget authority model, which enables
22 them to have control over the worker but also to purchase

1 additional permissible goods and services, one design
2 feature is whether the participant is going to be the
3 employer or is the participant going to be a co-employer,
4 meaning that they would refer somebody to an agency, and
5 the agency would hire that individual to serve that
6 participant. So that's one area.

7 Within budget authority, states, you know, set
8 the parameters of what are the allowable goods and services
9 that would be, you know, permissible in the program, so,
10 you know, coming up with that constellation of services.

11 A major area, I think, design feature is before
12 you even get into the programs, how do you convey
13 information to potential users about the programs? How
14 does that information get highlighted and distributed on
15 your website? How does it actually get conveyed in the
16 initial meeting that that individual may have with a
17 counselor or support broker or case manager?

18 And oftentimes, people will come into these
19 situations and they're not really prepared or don't feel
20 that they're prepared for self-direction. So ensuring that
21 there's -- in the design, that the question about self-
22 directing or not self-directing can be revisited or as that

1 person becomes more comfortable in this new arrangement in
2 their lives.

3 Building in staff time, because these initial
4 discussions with, you know, new participants, they can be
5 time-consuming, a lot of explanation. It takes more than
6 one visit for those, that information to be processed and
7 for them to move forward.

8 Another area for design consideration is the use
9 of representatives. Most programs will allow participants
10 to have a representative to assist them in their managing
11 and directing of their services, so, you know, figuring
12 out, are there going to be any restrictions to that
13 particular role?

14 Another challenge -- and I think this was
15 mentioned in the previous panel -- is that consumers who
16 want to self-direct, it can be a challenge at times to find
17 a reliable and appropriately skilled worker. I think it
18 was mentioned that some states do have worker registries,
19 and unfortunately, you know, those are a great start. But
20 they're not the -- just because they have a registry
21 doesn't mean that that adequately solves this particular
22 issue. Sometimes the registries are ineffective because

1 they'll have lots of workers, but the workers may not be as
2 responsive to individuals reaching out to them regarding
3 possible employment, which leads to, you know, another
4 design question about who -- can the participant hire a
5 family member, and are there going to be restrictions on
6 family members who can be employed or could be hired in
7 this manner?

8 Most participants in self-directed programs do
9 hire a family member, and that sometimes is just an
10 artifact that they can't find workers outside of the
11 family. A recent study showed that most participants would
12 prefer -- you know, they don't have to rely solely on
13 family, and they would prefer to have an opportunity to
14 have non-family members as well.

15 The question was raised by one of the
16 Commissioners, and certainly a design feature that states
17 need to consider is how to create risk management systems.
18 You know, how can you develop specific policies and
19 procedures that will, you know, support staff, will support
20 participant workers, will support the participant, you
21 know, develop a process to identify situations that could
22 pose potential harm and assess the likelihood of their

1 occurrence? So finding ways in the design process of
2 mitigating risk and responding to potential risky
3 situations is a key design feature, as is developing
4 quality control measures and finding out, you know, where
5 the program is effective, where does it need to improve and
6 throughout this whole -- you know, that process, ensuring
7 that the voice of those consumers are engaged and involved
8 in that process.

9 So those are some of the design features that
10 states often don't have to deal with in developing these
11 programs.

12 MS. BALLWEG: That's really helpful. Thank you.

13 MR. O'GARA: And I think it's great, Mark, that
14 you mentioned kind of conveying self-direction to
15 consumers, because we actually have Tricia with us, who's
16 from the Office of Education and Self-Directed Services in
17 New Jersey, so that's a great segue.

18 Tricia, we've been talking a lot today about kind
19 of design and administration flexibilities that are
20 available to states. I think it'd be helpful for the
21 Commissioners to hear some examples of what that looks like
22 for a state. So could you just give us a quick overview of

1 what self-direction looks like in New Jersey, including how
2 your state uses some of those flexibilities, what services
3 might be available for self-direction, and maybe which
4 populations can self-direct?

5 * MS. BRENNAN: Sure. So thank you all for having
6 me join you today, and some of the things that Mark
7 actually touched upon, I'm going to speak upon as well.

8 I wanted to give you a little bit of the history,
9 though, and how some of this was established in New Jersey,
10 because I think it's key to understand some of the way in
11 which it was designed.

12 So New Jersey has been providing the option for
13 self-directed services since the late '90s. So it's really
14 rich in our history. Initially, it was through the Cash
15 and Counseling, and that's the Personal Preference Program,
16 and that's through our sister agency, the Division of
17 Disability Services.

18 The Division of Developmental Disabilities began
19 in the early phases of something called "self-
20 determination," and that was part of a governor's
21 initiative, and it was for people who had reached on the
22 priority waiting list.

1 In the late '90s, the New Jersey Institute of
2 Technology, NJIT, did an extensive study of people on the
3 priority waiting list and saw that people really didn't
4 want to go in, weren't really opting for options such as
5 group home settings or traditional programs. And our
6 system at that time was solely contract-based. So you had
7 a choice of a contracted service or nothing.

8 What happened in 2002, we're sitting at the
9 table, and it was actually one of my first weeks in my new
10 role in central office, and a core group of family members
11 came to us and said, "If you gave us the Medicaid dollars,
12 we could do it better." So what we did is we engaged those
13 stakeholders for an extensive period of time and built the
14 foundation in a small -- you know, it was a governor's
15 systems change that we were working on at the time. It was
16 a large piece, and it was a five-year pilot program that
17 launched self-direction for people who were on the priority
18 waiting list for Medicaid waiver services and for those who
19 are spending their school entitlement. So, at that time,
20 you had a choice of self-direction or contracted services.

21 If you move, fast forward a few years, we also
22 then became--offered to offer another waiver program, which

1 is the supports program, as we moved our whole entire
2 system out of the contracted system into the fee-for-
3 service system around 2014.

4 Again, we had the ability to -- all people on
5 both waiver programs had the ability to self-direct. So it
6 doesn't matter which waiver program you're on. You have
7 the ability to self-direct.

8 We utilized two fiscal models for people to
9 choose from, the vendor fiscal employer agent model and our
10 agency with choice model.

11 The waiver services that people had the choice to
12 self-direct are no different than the waiver services of
13 people in our traditional settings, provider-based
14 residential settings. It's community-based supports,
15 individual supports, hourly interpreter services, respite,
16 supports brokerage, and I might talk a little bit more
17 about supports brokerage in one of the other questions.
18 It's a newly launched service, but it's needed because of
19 some of the responsibilities of self-direction. Assistive
20 technology is available. That's through a community
21 vendor. Goods and services, environmental modifications as
22 well. Natural supports training, transportation in a

1 single passenger, and vehicle modification.

2 As people enter into our system through intake or
3 some at just the end of their school entitlement, they have
4 the opportunity to receive their support through self-
5 direction or through a provider agency, and they have the
6 option to do a little bit of both.

7 MR. O'GARA: Great. Thank you so much for giving
8 us that detailed overview of what self-direction looks like
9 in New Jersey.

10 So we've talked a lot about states obviously have
11 kind of a lot of complex choices they can make when
12 designing and administering these programs. So, Tricia and
13 Mark, I was wondering if you could just both briefly
14 describe some challenges that states face in administering
15 these programs, and either of you can begin with that
16 question, or I'll just pick on Mark so that we can start.

17 DR. SCIEGAJ: Okay. I was going to say Tricia
18 should go first since I went first.

19 MR. O'GARA: Oh, sorry.

20 MS. BRENNAN: It doesn't matter if you want me
21 to.

22 DR. SCIEGAJ: No, no. I think one of the -- you

1 know, if you think of the information and assistance
2 function and you think of the financial management services
3 functions, okay, I think one of the key considerations for
4 states, challenges for states is whether those are going to
5 be labor services or whether they're going to be an
6 administrative activity. And whatever direction the state
7 goes in will have some impact on the number of providers
8 for those different services, will also have an impact on
9 how the state gets reimbursed for those services. So, you
10 know, there are pros and cons to either way, but that's
11 certainly that -- making that decision regarding those
12 services is a challenge.

13 MS. BRENNAN: So, for us, I see one of the
14 biggest challenges as being maintaining flexibility for the
15 individuals and the people and the families while ensuring
16 fiscal integrity at the same time.

17 So, you know, there's a lot of checks and
18 balances and guardrails that need to be put into place, you
19 know, so that people can have that flexibility, but there
20 are certain pieces that, you know, there is accountability
21 for. We face challenges with that.

22 We also face challenges with their interaction

1 between our fiscal agents and the families to the point
2 that sometimes we have a new unit, that the basis being
3 that liaison between both of them. And one of the other
4 challenges is the amount of responsibility, helping people
5 understand the amount of responsibility that goes along
6 with self-direction.

7 We have -- one of our self-advocates recently
8 said to us -- and it makes -- you know, his quote, we use
9 it all the time is, "It's not" -- and he uses communication
10 devices to share it with us. We said, "Why are you self-
11 directing? What would you tell anybody?" He said, "It's
12 not easy, but it's worth it." And one of the other ones
13 said, "I like being the CEO of my own life." So those are
14 the pieces that, you know, you have to keep in mind, but
15 it's the responsibility and fiscal accountability for all
16 those pieces that may seem, you know, be a deterrent for
17 some folks.

18 MR. O'GARA: Thank you both. I'm sure the
19 Commissioners will have lots of questions about guardrails
20 and accountability features.

21 I want to turn to Robert and Pam now and ask,
22 what challenges do individuals and their families face when

1 self-directing home and community-based services?

2 MS. ZOTYNIA: Are you ready?

3 MR. ZOTYNIA: There are other challenges I've
4 encountered along the way.

5 MS. ZOTYNIA: Hang on. Technology. Not always
6 our friends.

7 Ready?

8 MR. ZOTYNIA: There are other challenges and I
9 think --

10 MS. ZOTYNIA: Still not our friends. See if I
11 can make this work for you.

12 MR. ZOTYNIA: There are other challenges --

13 MS. ZOTYNIA: It just wants to start at the end.
14 Give me a second.

15 While I'm trying to fix this for him, I can talk
16 from my perspective. So I agree with everything you guys
17 just said. There is a lot of responsibility that we
18 assume, families, self-advocates, when we make this
19 decision. And all the rules and regulations are written by
20 bureaucrats. No offense to anybody on this call who is a
21 bureaucrat. I have many friends who work in bureaucracy.
22 But they're not generally written in plain language so even

1 a typical family would understand, and they're extremely
2 difficult for self-advocates to navigate and understand.

3 We do in Pennsylvania have supports brokers. I'm
4 actually a certified support broker in Pennsylvania,
5 Maryland, and I've been trained in New Jersey, although I
6 only currently provide support in Pennsylvania and always
7 interested in looking at what other states are doing. That
8 is a huge benefit. If that's available, it should be
9 always, always recommended.

10 My opinion, although I'm all about choice and
11 people have the right to make decisions for themselves and
12 decide who they want to use, what providers and what
13 services, part of me really feels that when people start
14 using self-direction, it should almost be mandatory that
15 they have a support broker for maybe the first six months
16 to get set up, to learn how to navigate the FMS, to choose
17 if they have a choice, which FMS model they're going to
18 use. It's very complicated.

19 Robert's going to talk a little bit about some of
20 the challenges he's had. He is his own common law
21 employer. He assumed that role this year. Prior to that,
22 we can have -- "surrogates," they call them in

1 Pennsylvania. So he had selected. I was his surrogate at
2 one point. His dad was his surrogate at one point. And
3 then he felt he -- after a couple of years, he can do this
4 because he has a supports broker. I don't think he would
5 ever be able to do it without that level of support, and
6 the supports broker is really only assisting him. They're
7 not doing anything for him. They're --

8 I'm talking about it. You want me to stop
9 talking about that because you want to talk about it? All
10 right.

11 Let me see if -- I'm going to see if his app will
12 work now.

13 MR. ZOTYNIA: There are other challenges I've
14 encountered along the way. There are other challenges I've
15 encountered along the way. But it's been --

16 MS. ZOTYNIA: It just wants to --

17 MR. ZOTYNIA: I learned about self-direction --

18 MS. ZOTYNIA: Got it.

19 MR. ZOTYNIA: -- because my mom has worked in the
20 field for 35 years. It was not the first option offered to
21 me by any of the numerous supports coordinators I've had
22 over the years. We brought the information to them. I

1 always tell people who are interested in self-direction
2 that it's not always easy.

3 One of the benefits is you can control your
4 services and customize your day, but with this control
5 comes great responsibility. As I'm sure you're aware,
6 whenever a person accepts Medicaid funding, there are rules
7 and regulations that must be followed. Understanding these
8 rules can be difficult at times, especially if you are not
9 familiar with bureaucratic language.

10 It can also be challenging to find staff. The
11 last time I had a staff vacancy was about six years ago.
12 It took me eight months to find the right person.

13 I'm lucky that I share my home with my mom, and
14 she was able to support me while I recruited. I believe
15 one of the barriers to finding and maintaining staff is the
16 lack of benefits, especially health insurance. There is no
17 mechanism within Medicaid to pay for insurance or pay time
18 off. Staff need health insurance, and so do their
19 families.

20 Another challenge is addressing performance
21 concerns when staff are not meeting the expectations of the
22 job. So it's very important to explain the job

1 responsibilities and expectations on day one and make sure
2 everyone understands.

3 I use my supports broker to help me with this so
4 there's no misunderstandings. In Pennsylvania, we have two
5 options to choose from for financial management services.
6 I chose the vendor fiscal employer agent model, and I am
7 the common law employer. This means I am responsible for
8 reviewing and approving timesheets so my staff get paid.
9 This is done electronically using an app on my phone.

10 I have physical challenges. Navigating apps is
11 difficult, but it is my responsibility, and according to
12 our state DD office, no one else should have access to this
13 information. I needed to write a letter explaining this
14 challenge and requesting a reasonable accommodation so my
15 supports broker can review the timesheets with me. After I
16 confirm they're correct, she approves them via the app.
17 Not many people know this is an option, although I tell
18 everyone I can. I believe this is the reason very few
19 people with intellectual disabilities act as the common law
20 employer. If they and their families knew they could
21 request reasonable accommodations, perhaps we would see
22 more people like me choose self-direction and take control

1 of their lives.

2 There are other challenges I've encountered along
3 the way, but it's been my experience if you work
4 collaboratively with your team, there is no barrier that
5 can't be resolved when you use self-direction.

6 MS. BALLWEG: Thank you both for those answers.

7 All right. We're going to be moving into the
8 final question of today's panel before we turn it over to
9 the Commission. As we wrap up this moderated portion of
10 the panel, this final question is going to be for all of
11 you. So, in 30 seconds or less, could you please share one
12 thing that we have not yet discussed today about self-
13 directed HCBS and Medicaid that you think would be
14 important for the Commission to consider as we continue to
15 work on this topic? And let's start with Mark.

16 DR. SCIEGAJ: Oh, okay. In 30 seconds, my
17 recommendation would be to structure in ways to give
18 participants a greater voice in these programs. There's no
19 requirement that state programs have consumer engagement,
20 but in those programs that do have consumer advisory
21 boards, I think it can add to that program's effectiveness
22 and efficiency, so giving greater voice to the

1 participants.

2 MS. BALLWEG: Thank you.

3 And let's go to Tricia next.

4 MS. BRENNAN: Mine is very similar. My main
5 thing is to not have the primary focus be on the services
6 and supports. It should really be about thinking about the
7 services second and the person's focus on what their dreams
8 are, so focusing on the people so that whatever it is that
9 they want for their life and building the supports and
10 services around them, because everybody should have the
11 right to live, love, work, and play in their community, but
12 they may need additional services and supports to help them
13 achieve that good life. So, in order to achieve that
14 success, people who are self-directing and their families
15 and any other member of the circle of support needs to be
16 at the center of the policy deriving. We also want to make
17 sure that the goal is to create the infrastructure and
18 supports and equal opportunities for all people.

19 So again, really changing the focus, not being of
20 what services and supports can you get by through self-
21 direction, what do we need to make sure is in place, what
22 are the guardrails, but what is it that people want for

1 their lives, and what's going to make people successful,
2 and then how can we support them best and build it around
3 them?

4 MS. BALLWEG: Thank you.

5 And then we'll go to Pam next.

6 MS. ZOTYNIA: Robert and I are going to combine
7 our time. We were consulting.

8 Robert thinks that every state should allow the
9 person with a disability to have complete budget control.
10 Not all states have that as an option.

11 We both also agree that all the planning should
12 be -- there should be something in the language that
13 requires it to be very person-centered, which I think is
14 kind of what Trish and Mark were getting at there.

15 And financial management services, they vary
16 state to state. Some have options. Some have only one.
17 Some have 17. We strongly feel there should always be an
18 option, at least two to choose from. Competition is never
19 a bad thing. I think it improves the quality of any
20 organization, company.

21 And the other thing is, at least in Pennsylvania,
22 when we select a financial management service, they have a

1 contract, which I'm sure they do in each state. Those
2 contracts expire, and every single time they expire, we're
3 looking at a new vendor. So, it's begin again, relearn
4 something. We would really like to see -- we understand
5 why contracts are developed and selected by procurement the
6 way they are, but we struggle with why change contracts
7 when the current contractor is meeting the requirements of
8 the contracts. We certainly understand if they're not. It
9 creates a great deal of stress.

10 We just went through that in Pennsylvania this
11 year. I work at a support brokerage. We support 10
12 percent of the people who use that vendor, and every one of
13 those families was in a meltdown for months over it. And
14 it's not just getting them enrolled, but it's training
15 their staff on how to use a new clocking app, a new EVV
16 app. There's a lot involved in that. So you kind of get
17 to a point. It takes a couple of years to get to the point
18 where things are going good, and there you go, the
19 contract's out for a bit again. So I don't know what can
20 ever be done about that, but we felt compelled to share
21 that.

22 MS. BALLWEG: Thank you both, and thank you to

1 all of our panelists for participating in this moderated
2 portion.

3 And with that, I will turn it back for
4 Commissioner questions.

5 CHAIR JOHNSON: Thank you so much, and I just
6 want to echo your thank-you to the panelists -- Trish,
7 Mark, Robert, and Pamela -- for sharing your time, your
8 expertise, your experience, and your insights. You just
9 have no idea how much this is going to help us as we
10 continue down this road to really understand this area and
11 really understand exactly how we can be more helpful.

12 And, Robert and Pamela, hearing directly from a
13 beneficiary truly underscores -- and I know my
14 Commissioners, fellow Commissioners agree with me, this
15 really underscores the work that we do and why it's so
16 important, so we really appreciate that.

17 So, at this time, I'd like to open the floor to
18 my fellow Commissioners for some questions and comments for
19 our panelists. So, anyone is first up?

20 All right. Let's go with Sonja and then Angelo.

21 COMMISSIONER BJORK: Hi. Thanks for the great
22 panel.

1 I'm wondering if our consumer folks and your mom
2 can talk a little bit about the procurement support
3 services. I'm not really familiar with how that works. So
4 what kind of business is that, or how do you help folks
5 connect with good providers?

6 MS. ZOTYNIA: You're talking about the support
7 broker service?

8 COMMISSIONER BJORK: Yeah, yeah. The support
9 broker.

10 MS. ZOTYNIA: Okay, okay.

11 COMMISSIONER BJORK: I don't really know that
12 term.

13 MS. ZOTYNIA: Okay. So, it varies by state. In
14 Pennsylvania, it's called a "supports broker." In many
15 states, it is.

16 COMMISSIONER BJORK: Okay.

17 MS. ZOTYNIA: It's separate from the service
18 coordinator. So, everyone who has services and has an
19 individual support plan is required to have a supports
20 coordinator.

21 The supports broker is different. They are only
22 available to people who self-direct. In Pennsylvania,

1 that's called "participant-directed services," and the
2 service definition defines the tasks that we are allowed to
3 do.

4 It's a pretty long list, but it basically falls
5 into three buckets" assisting with employer-related
6 duties, so things like recruiting, hiring, managing,
7 helping you develop those tools in your home and learning
8 that; increasing your knowledge so that you understand
9 compliance rules and you remain in compliance; and
10 navigating natural supports, helping people connect to non-
11 paid supports in the community.

12 A good example that I often use is Robert happens
13 to be an artist, and when he said years ago, hey, I'm
14 really interested in connecting with other artists, a very
15 well-meaning supports coordinator referred him to a
16 specialized program for people with disabilities that was
17 an artist's apprenticeship that's waiver-funded. And we go
18 there and we buy artwork, and it's amazing, but it wasn't
19 what he was looking for. He wants to connect with typical
20 people in the community who may or may not have
21 disabilities. So that's what we do, is help you sort of
22 create that everyday life.

1 MS. BRENNAN: And can I -- I'm going to just add
2 a couple things. Yeah, exactly.

3 So, we launch supports brokerage in New Jersey,
4 but as a lot of people were saying, it is a lot of
5 responsibility as the -- you know, "Maybe I want to self-
6 direct, but there's so much responsibility that goes along
7 with it. If someone could help me with those pieces,
8 that'd be a great service."

9 New Jersey, we did work closely with some of the
10 folks in Pennsylvania with looking at it, and we launched
11 the service, probably the worst time to launch a service,
12 2019 in the fall, so right before COVID. So we, you know,
13 are struggling with enhancing it as a service and, you
14 know, different pieces of it, but it is an option for
15 people who are saying exactly that, you know, your supports
16 coordinator is going to help you find, you know, a service
17 provider, but they're not going to help you connect to find
18 that class in that community that you may be looking for.
19 And maybe you're looking for -- you've got a parent who
20 says, you know, my person or the -- I want to find a class
21 that -- you know, I want to find a cooking class in the
22 community. You know, the parent is trying to help somebody

1 self-direct or the person who is -- they'll have time to
2 check all those different places out. They're going to do
3 some of that background research of this, you go here for
4 this type of thing, here for that type of thing. They're
5 going to connect you to your community and figure those
6 pieces out and help you also hire self-directed employees,
7 help recruit staff, figure those extra pieces, but not the
8 support coordinator role.

9 And a lot of times, there are families who are
10 like, "I can do that. I got it on my own," and others who
11 say, "I really need someone to help me do that." And it's
12 a service they can choose from their waiver of service.

13 COMMISSIONER BJORK: Great. Thank you so much
14 for clarifying.

15 CHAIR JOHNSON: Thank you.

16 Angelo?

17 COMMISSIONER GIARDINO: I too wanted to thank all
18 the panelists.

19 And particularly for Pamela and Robert, again,
20 being self-directed sounds like it's been so
21 transformational. Do you have thoughts about when and how
22 we should introduce the option of self-direction, and what

1 would be useful to start preparing someone for what sounds
2 like is a really heavy lift but worth it?

3 MS. ZOTYNIA: Self-direction should be the first
4 thing offered to anyone who walks in a door to enroll for
5 services. It should always be the first conversation.

6 It wasn't always -- it's supposed to be in
7 Pennsylvania. I think it's actually mandatory. It doesn't
8 always happen that way, but years ago -- Robert is 38. So,
9 years ago, it didn't even really -- it was around, but not
10 like it is today.

11 But having that conversation first, because my
12 experience -- and I come from the advocacy world. Prior to
13 where I am today, I worked in advocacy for decades.
14 Families are often led to believe they must depend on
15 providers. That's the only solution they have, even if
16 they don't necessarily want that.

17 And this new generation is growing up in a very
18 different educational setting than 40-, 50-year-olds did.
19 Robert was one of the first people in our school district
20 who was included in school and went with typical students,
21 graduated cap and gown with his peers, received services,
22 but in a regular classroom. He didn't envision a life of

1 segregation where I hear from people now who are like,
2 "What do you mean you're referring me to a day program?
3 Like, why would I want to go there? I want a job. I want
4 a girlfriend or a boyfriend. I want a life."

5 So, my recommendation is it always, always,
6 always should be the very first conversation, but with the
7 understanding that people are given the information and
8 understand it's not always easy. There are supports
9 available to help you, but there are times where it's been
10 stressful for us in our house when we were sort of building
11 it. And it's much better now than it was back then,
12 because we kind of got in a groove, and we found good
13 staff. But I was not -- and I work at home now too. So,
14 if staff calls off, I'm here. I didn't always do that. I
15 used to have to go to an office like everybody else was
16 doing, and it was so stressful for me, that without a
17 supports broker, this never would have happened, because I
18 would come home tired and not be able to do that.

19 And I'm sorry, Trish. I keep --

20 MS. BRENNAN: No, I just wanted to add that the
21 reason our new office is that we've only been around for
22 three years, three years in February has come about, is to

1 educate people on the option of self-direction. So, as you
2 heard me mention that our system moved from contracted-
3 based with option of self-directing, so anybody had choice
4 of provider-managed or self-direction. But to really -- so
5 people can be empowered to make that their own decision if
6 they want to self-direct or go the provider-managed route,
7 because not everybody really understands what it truly
8 means and the options that are available to them. So, our
9 goal is to do that.

10 And also, we've been having sessions with
11 families statewide to facilitate networking sessions, and
12 we have peer-to-peer networking sessions so that families -
13 - so it's not so alone.

14 So, one of the things we heard from families is
15 self-direction can be isolating because it's us trying to
16 do it ourselves. What we've done now is we've been
17 building together, in-person and virtually, sessions for
18 people who are self-directing and for families who are
19 self-directing locally. So, like to say, hey, how did this
20 work out for you when you were trying this? Or hey, do you
21 know if there's somebody in your community? And the people
22 with the lived experience share it the best, but we're just

1 there to facilitate it. That's the role of our educational
2 piece, the Office of Education and Self-Directed Services,
3 to help people do those next steps.

4 DR. SCIEGAJ: I just wanted to add one last
5 little point of having the staff be fully cognizant of what
6 self-direction can add to that individual's life. Not
7 often are these folks entering into these occupations fully
8 aware of what self-direction is and how it functions.

9 And when you're working with somebody who's
10 coming into the system, I totally agree with Pam, self-
11 direction should be that one of the first things that is
12 discussed. Not everybody is going to be prepared to take
13 that option at that point in time. But again, if you
14 design in to have that conversation at regular intervals, I
15 think we'd have more people selecting the option at some
16 point.

17 MS. ZOTYNIA: I just want to add one more thing,
18 because Mark mentioned staff, and I had forgotten about
19 this. So, Robert has a couple of staff who work with him
20 now who also worked with him in a group home when he lived
21 there years ago. And I remember -- I mean, we are
22 documenting everything we need to document. He has daily

1 service notes. We go over and above, even our state TD
2 office, who we share it all with, are like, "Who's making
3 you document all this?" And I'm like, "I am, because we
4 need to. And you are too." But I remember them coming
5 here and saying, "Where's the book?" because they were
6 expecting this giant book of paperwork that they were so
7 used to having to complete in provider-managed programs
8 because of licensing requirements. And I'm like, "There's
9 no book. This is our home. It's not a facility." So, we
10 have Google Docs. You're going to spend 15 minutes
11 documenting. If you're spending more than that in your 10
12 hours that you're here, you're over-documenting. And we'll
13 help you figure out how to kind of minimize that.

14 So, it's a different culture. It's just a
15 different culture. The same service, but it's a different
16 way of delivering it.

17 CHAIR JOHNSON: Thank you.

18 Jami and then Dennis.

19 COMMISSIONER SNYDER: Thanks so much for joining
20 us today.

21 I had the opportunity to work in two states, both
22 of which offered self-directed care. A large percentage of

1 individuals who are eligible took advantage of self-
2 directed care in one state, and it wasn't used really at
3 all in the other state that I worked in. And so, I'm kind
4 of curious to hear from you what you think sort of those
5 barriers might be that kept individuals from taking
6 advantage of this option.

7 And I know you've alluded to many of them, and
8 for instance, just making sure it's the first option that's
9 offered to individuals that are eligible. But I'm curious
10 to know, do you think it's more about system design, or is
11 it about individual awareness of the option, or is it about
12 the lack of training or educational resources? Or maybe
13 it's all of those things, but just curious based on your
14 experience, what the kind of primary barriers might be to
15 individuals really taking advantage of self-directed care
16 as an option, viable option.

17 MS. ZOTYNIA: I'm going to jump in on that one.
18 I think everything you just said, but I would add to that
19 for families and for self-advocates, it can be -- fear can
20 be a part of it, fear of the unknown. I'm on my own.
21 There's no provider I can call. There's no staff coming in
22 because there's a snowstorm or they're sick. Tag, I'm it.

1 There's no one to help us navigate any of the other parts
2 of Robert's life, and there's a lot of parts. He has a lot
3 of technology. He uses a power chair. His power chair
4 broke a couple of months ago. I'm trying to find a vendor
5 to fix it. There's no one for me to pick up the phone and
6 call to help with that.

7 If he had a provider, it's kind of their
8 responsibility to do all those things for him, even
9 Medicaid, making sure he has no lapse in Medicaid. A
10 provider is never going to let his Medicaid lapse. They're
11 going to do everything in their power to keep him
12 authorized, but that's kind of on us right now. And we
13 manage it well, but I do think about that when I'm not
14 here. Hopefully, somebody opens the mail when he starts
15 getting letters from Social Security and Medicaid and
16 responds to those things. So, who is going to do those
17 pieces?

18 So, I think it's really helping people see that
19 there are resources out there, and I have also found and
20 have done this. Robert and I both do this, talking to
21 someone who uses the model. So, we've done that
22 individually. Robert has done presentations. He has a

1 whole PowerPoint that he does and talks to self-advocates
2 about, you know, here's how you can build this life that
3 you deserve and desire, and there's help out there, and we
4 are happy to be part of your circle of support as you get
5 there. That has been very helpful to families.

6 MS. BRENNAN: And I just want to add, I think a
7 lot of it is the education piece, because as folks are
8 exiting the school system, they may not be aware of all the
9 options that are out there. And making sure that
10 everybody, when they come through our doors and intake,
11 really understands and they're empowered to make that
12 choice of if I want a self-director, I want to go provider-
13 managed, what is it that I want for my life, and going
14 those next steps.

15 And it's also connecting people. So, what we've
16 seen at some of our early phases of where we throw stuff
17 out in different counties, hey, we're having a family
18 networking session. It's for people who are self-
19 directing, who have a vested interest in self-direction,
20 and it's facilitated by the division of our Office of
21 Education and Self-Directed Services. We see people who
22 have been self-directing for about 20 years getting

1 together and sharing things. And at the same time, there
2 are people who just want to know new pieces, and they
3 connect with each other. And these great bonds are formed
4 of, hey, do you want to hear what I'm doing? And then it
5 starts to sound like, well, maybe it's something that I
6 would like to do, or saying, hey, I've been through
7 something similar, so making those connections and
8 providing those opportunities for education, especially
9 from people with lived experience.

10 We have similar peer-to-peer sessions, same
11 thing. If you're interested in self-direction, you can
12 come to these as well, but they're only for -- they're not
13 for providers. They're only for people who are self-
14 directing or who have an interest in it. And then that's
15 where some of the other educational pieces come through in
16 the connections. It's a lot of really understanding what
17 it means and understanding the responsibilities and not
18 being worried that you don't have the support. So, it's
19 needing to have that support of potentially having the
20 ability to hire a support broker, having the support of
21 your support coordinator, and your whole building that good
22 circle of support as well.

1 CHAIR JOHNSON: Thank you.

2 Dennis.

3 COMMISSIONER HEAPHY: Thanks.

4 First, kudos to you, Robert and Pamela, for
5 making this work because it is very challenging to do this.

6 As a matter of fact, years ago in Massachusetts,
7 Robert, you wouldn't have been able to be eligible for the
8 self-directed because your family is involved. And back in
9 the day, it was really only if you could do it yourself,
10 direct everything individually as a person. That's the
11 only way -- that's the only way folks were actually
12 eligible to do this. So, the program has advanced since
13 then, and now we have lots of folks that self-direct. But
14 that's the way it started, very individualistic and not at
15 all interpersonal.

16 And so, my question, I guess, is for Mark and
17 Tricia, and that's -- what other models have you seen in
18 other states that you would look to that would have best
19 practices and for folks who are self-directing services?
20 And I mean, not just -- when I say services, I mean all
21 services. So, the Cash and Counseling would cover all
22 services, not just direct services provided in the home.

1 MS. BRENNAN: So, when you say what other models,
2 do you mean other states and how they're doing something?
3 There are some other states that we have been researching
4 as we talked a little bit about support brokers and trying
5 to enhance it and figuring out those different ways.
6 That's definitely something that New Jersey is definitely
7 trying to make sure we can enhance supports for people who
8 are self-directing.

9 And there are a couple other states who are doing
10 other ways that are working in certain pockets a little
11 better, but we're trying to implement it statewide. So
12 that's a different way as well.

13 We've been working to implement it statewide. We
14 do definitely find challenges with accountability. We find
15 challenges with different aspects of implementation and
16 barriers that we hit with some of the things that are
17 written in our waiver. So that's definitely a challenge.

18 DR. SCIEGAJ: Yeah, I think that there are -- you
19 look at the growth of self-direction in states, obviously
20 California has almost half the total number of folks self-
21 directing. New York has grown significantly over the last
22 10 years. So, I think in terms of best practices, I'm -- I

1 don't know if I could point to a particular state, because
2 I think they're -- you know, each state probably has things
3 that it does really, really well.

4 This goes back to one of the previous questions:
5 Why did it grow so much in one state versus the other
6 state? And I think part of answer to that is, is self-
7 direction part of the culture within that, you know, the
8 overall Office of Medical Assistance in that state? And if
9 it is, I think that has an impact on how the program gets
10 presented. Is it presented first, as Pam would suggest it
11 should be, or is it just presented as one of the options?
12 I think that people, you know, staff education and training
13 around this as an option, because I think people enter into
14 those occupations from academic programs that are a little
15 bit more biased towards agency approaches, and to empower
16 somebody to self-direct their own services or manage their
17 own services is a bit of a paradigm shift. And I think
18 states that are successful in this area have from the
19 leadership down integrated the principles of person-
20 centered approaches and empowering of individuals.

21 COMMISSIONER HEAPHY: Yeah. I have other
22 questions, but I don't want to dominate the conversation.

1 So, I'll let Tricia go.

2 CHAIR JOHNSON: Tricia, yeah.

3 COMMISSIONER BROOKS: Thanks, Dennis, and thank
4 you all.

5 Robert, that is just so powerful to hear directly
6 from beneficiaries. I really, really appreciate you taking
7 the time to do this.

8 I have two questions. I'm going to get them both
9 out quickly. I've heard education and training. So, in
10 terms of someone moving from, you know, point A to being
11 self-directed, is there a playbook? Is there a step-by-
12 step transition, here's how you take this responsibility
13 on, and then here's how you take the next responsibility on
14 and so on and so forth? So that's my first question.

15 And the second question is, it sounds like it's a
16 lot of work for Robert. Does Robert get paid for his time
17 in managing his care

18 MS. ZOTYNIA: So, I'm going to help Robert answer
19 that.

20 No. So, the person receiving service would not
21 get paid because they're getting service, but Robert also
22 holds the role of common law employer. I previously did.

1 His dad previously did. That role cannot be paid. Our
2 understanding is that's a Medicaid rule.

3 I've never really researched it to see if that's
4 true or not, because it didn't really matter to us, but
5 whoever is -- sits in either the managing or common law
6 employer role, that is an unpaid position. I will say it
7 never bothered us, but I will tell you many families are a
8 bit upset about that because it can take a lot of time.
9 And it takes, you know, time away from either their workday
10 or their, you know, whatever.

11 So, if I'm not here and Robert was not common law
12 employer and he had to go find like a friend or an extended
13 relative to do it, it's a big ask.

14 I forgot what your first question was.

15 COMMISSIONER BROOKS: Oh, sorry. It's about
16 step-by-step training so that you can transition to
17 independence as your own self-directed care manager.

18 MS. ZOTYNIA: Go ahead, Trish.

19 MS. BRENNAN: I was going to just say that, you
20 know, we don't have -- we're still developing because we're
21 a newer unit, a whole new office from almost three years
22 developing the different pieces of the training that need

1 to go into place. But we do honor the fact that everybody
2 is individual. So, it's going to be based upon the person,
3 right? And what works for one person is not going to work
4 for somebody else.

5 But what we've seen -- and we've been helping
6 families to share some of the things that have worked for
7 them. So, we have a couple of 00 we have a mom who put
8 together this amazing spreadsheet and shares her template
9 of how she tracks her staff and time and everything. And
10 we've done webinars with those families to share to other
11 families, and we've learned from them as well, some really
12 great tools that, you know, we wouldn't have even thought
13 to come up with, that families have come up with, and we're
14 working on getting people to share, you know, the different
15 pieces that work for them.

16 We've had some webinars, some, you know, just web
17 chats with where families that have been really successful
18 and will work with how they train their staff, give
19 presentations. There've been even a small -- couple of
20 small conferences that do the same thing.

21 When it comes to play-by-play playbook, each FI
22 does their own, does their own exact what you need to do,

1 how you enroll, how you onboard, all those pieces for their
2 staff, depending upon whether you choose the fiscal agent,
3 employment model. or the agency with choice model. So, it
4 would depend upon each model that we have.

5 But we are actively working on more educational
6 tools for families, and for people under services, we're
7 working on a couple of different ones that our peer-to-peer
8 group is putting together, because those are people who are
9 self-directing and we have, like, really great
10 conversations with them when we meet with them about what
11 they do and they don't like when they're interviewing a
12 staff and they don't want to hire that staff, and maybe
13 their mom likes the staff and they don't like the staff.
14 We have some really great conversations.

15 So again, we're still developing some of those
16 pieces, but it's key to listen to those with lived
17 experience and who have been doing it for some time. The
18 families that came to me in 2002 are the families we call
19 upon the most because they've really, you know -- the one
20 mom who talks about what it was like to have to fire a
21 staff that she loved that her son didn't like because it
22 was somebody like her, and he wasn't fun to hang out with

1 and figuring out all those different pieces and sharing
2 that and how you have to take that into consideration.

3 MS. ZOTYNIA: So, in Pennsylvania, we are also
4 refining our tools. But we've spent -- I sit on a work
5 group with our PDS point person in our DD office and a
6 bunch of other folks, and I think we spent about two and a
7 half years writing a participant-directed services, which
8 is self-direction in Pennsylvania, manual, which has now
9 been moved -- like, it has to go through legal and all
10 these steps before anybody ever said it would be, you know,
11 15 years from now before they publish it. But -- so we've
12 worked on that.

13 We are constantly working on training tools. The
14 brokerage that I work for, we have a whole kit that we use
15 that we developed and are willing to share that, you know,
16 with others. They just have to be, you know, willing to
17 accept it, but you would think people would want to do
18 that, but that doesn't always work that way.

19 But we do a lot of webinars, a lot of trainings,
20 not only with families, but also with supports
21 coordinators, because there's turnover.

22 MS. BRENNAN: Yeah.

1 MS. ZOTYNIA: You know, there's a lot of
2 turnover, and they have a lot to learn. It's not just
3 self-direction. So, you know, we go in and we do some
4 webinars with them, partly to try to increase our
5 referrals, because, you know, we're a business, but also to
6 help them understand the service, so they're accurately
7 referring people and people are able to make informed
8 decisions. And that's very important to me as a family
9 member. Even if I do a referral meeting, I always go over
10 these things and say to people like, "You know, we've been
11 there. We've selected a service and then figured out next
12 week, oh, we don't really want that." And now, you know,
13 that poor provider is out of luck because we're ended
14 service with them. So, people really need that knowledge
15 to make an informed decision, but they still can change
16 their mind because, you know, that's their right to do
17 that.

18 MS. BRENNAN: And we've recently added -- support
19 coordination competencies is something that's in the works,
20 and we just recorded a piece about self-direction. And
21 that's something that they're going to have to, you know,
22 complete that section. It was a webinar that my colleague

1 and I and my assistant director and I did for about self-
2 direction 101 so that all support coordinators have to
3 really have a good understanding of what it is as they're
4 moving forward, because that's the key piece. Sometimes
5 you can have a family really knows they want to self-
6 direct, but if it's a brand-new support coordinator who is
7 newly hired by the agency and they don't quite understand
8 that piece, that can put up a barrier. So, we're making
9 sure that that's mandated for support coordinators. We
10 just recorded it. It hasn't completely come up yet, but
11 they already did as a broad one, but it wasn't mandated
12 before. It was something they could choose to go to. Now
13 we're saying you have to do it, and one of your core
14 competencies is you have to understand what self-direction
15 is and explain it to all your families.

16 CHAIR JOHNSON: Thank you.

17 And it looks like we have Mike and Heidi with
18 questions.

19 COMMISSIONER NARDONE: Thank you for this panel.
20 I feel I'd be remiss if I didn't just thank you. Given my
21 many years that I spent in state government in
22 Pennsylvania, I like the heavy focus on Pennsylvania. So,

1 it's good to see you.

2 Tricia and Pam may have already answered this,
3 but I just wanted to kind of maybe see if there were other
4 things that would be helpful to workers in terms of
5 providing supports for them as they're conducting their
6 working in the field.

7 I think you mentioned some more training,
8 education, but I'm wondering if -- Pam, the thing that
9 really struck me when you said when you had to deal with
10 the wheelchair, power wheelchair, you kind of felt like you
11 were on your own, right? And I just was wondering if there
12 are things that you would like to see built into the
13 program to help with self-direction and provide support to
14 folks who are self-directing. Are there other things other
15 than some of the things you mentioned as well as Trish
16 mentioned to help this?

17 And the other comment I want to make is -- and
18 maybe this is more a question for Mark. My recollection
19 is, in Pennsylvania, that although self-direction is very
20 much part of the I/DD waiver, it's really been a struggle
21 in the elderly and disabled waivers to implement self-
22 direction or to introduce self-direction. I'm wondering if

1 it's a cultural thing, if it's an education thing, because
2 I think that the state has had -- the commonwealth has had
3 much less success in terms of introducing this concept to
4 the aging waiver. And I wonder if that's true in other
5 states as well.

6 MS. BRENNAN: I want to add -- I just want to add
7 something to that piece, just kind of show some of the
8 things that we're doing with aging, because it's kind of
9 exciting for me as well.

10 New Jersey is one of the first five states
11 awarded the ACL grant to bridge the gap between aging and
12 disability services, and what we've been able to do is
13 start to -- we've worked in so many silos, and then what
14 we're doing now is really working together with our agency
15 with aging. So that is so cool because -- and we say this
16 all the time. So, my colleague, Andrea, who I never would
17 have known -- I work directly for the assistant
18 commissioner. She works directly for the assistant
19 commissioner. They all work for the commissioner at DHS.
20 But we never would have known each other if it weren't for
21 this grant to bridge the gap between aging and disability
22 services. We never would have worked together.

1 And now we have done trainings. So, her staff
2 has done some trainings for all of DDD. We've done --
3 we've brought the area agencies on aging into our family
4 networking sessions for people who are self-directing
5 because it's -- you know, share what resources are
6 available out there and really, you know, educate the
7 agencies on aging and what self-direction is as well.

8 So, we're starting to bridge those gaps and
9 cross, you know, braid the services together and intertwine
10 so they're no longer working in our single-lane silos.

11 DR. SCIEGAJ: And also, I think historically,
12 younger populations have been better advocates for
13 themselves, and so that's why you might see larger numbers
14 or more acceptance of self-direction in those populations.
15 But I feel that we are, you know, beginning to turn a
16 corner with older adults, with elders and self-direction.

17 I think there has been historically sort of a
18 bias that somehow you turn, you know, 70- or 80-years-old,
19 you're no longer able to manage your life anymore. And I
20 think that kind of perception has shifted over the last
21 decade. But certainly, younger populations have been much
22 better advocates and wanting of this particular option.

1 CHAIR JOHNSON: All right. Heidi.

2 COMMISSIONER ALLEN: Thank you all so much for
3 being here. Really enjoyed this panel.

4 I want to follow up on something that Robert said
5 about sick leave -- well, specifically like vacation time
6 is what was mentioned. But I was thinking about other
7 benefits that people really rely on like sick leave,
8 paternal leave, retirement savings, vacation time, and
9 wanted to follow up on this health insurance because, I
10 mean, it seems like ideally you want somebody to stay, and
11 yet people are going to have natural transitions. You
12 know, women might give birth. Fathers might want to be
13 home with the baby. Somebody might themselves get sick.
14 And it seems really challenging to ask people to give up
15 that protection for this kind of job, which we all feel
16 like is such an important job.

17 And so, I'm wondering like what Medicaid could do
18 to help people, help employers be able to support their
19 employees in a long-term way so that they'll both be able
20 to recruit, but also keep people in these positions.
21 That's my first question, and then I have a second
22 question.

1 MS. ZOTYNIA: Okay. So, I'm going to help Robert
2 answer that.

3 What is available -- so there's no benefits
4 because it's a fee-for-service. You must provide a service
5 in order for Medicaid to reimburse. So, you can't pay
6 people when they're not here at work. You can't pay for
7 health care. You can't do any of that.

8 But what we can do is offer what's called a
9 "benefit allowance," and I think it's like \$2 an hour or
10 something. So, if I'm paying you \$20 an hour, I can give
11 you this benefit allowance. So, you actually see \$22 in
12 your paycheck, with the assumption that you're using that
13 to buy health care or compensate you when you take off a
14 week to go to the beach or whatever.

15 And Robert does offer that. All of his employees
16 are receiving that.

17 But the reality is health care is really, really
18 expensive. So even on the exchange in Pennsylvania, we
19 have our own -- it's called "Pennie" or something. And
20 they're telling me they're paying a real lot of money for
21 health care, almost to the point where they don't even want
22 to buy it. They want to just hope they live through the

1 year, and they'll take the hit on their taxes when time
2 rolls around. But it's just not right.

3 If there was a way -- and I don't know that there
4 is a way -- that even if there could be some sort of a
5 coalition that you could purchase -- I'm thinking back to
6 my days where I worked for another company and we purchased
7 -- we were a small company. We purchased through our
8 chamber of commerce. So, we got a group rate, even though
9 we only had three employees. If they could build something
10 like that in the state so that the support workers could
11 purchase their insurance, that way they would at least get
12 a better rate and better health care.

13 I don't know what the solution is. All I know is
14 it's a struggle. People need health care, and the best
15 workers leave jobs because -- even if they really enjoy
16 working with the person, because they have to take care of
17 their families.

18 We are fortunate that most of the guys that work
19 for Robert, their spouses have health care through their
20 jobs. So at least they're covered, but not all of them.
21 We have one guy right now who's told us, as much as he
22 loves being here, he's getting married. He's got to

1 provide for his new wife, and he's got to find something
2 with health care. He's part-time here in the evening, so
3 he's hoping it doesn't impact him. But we will be sad to
4 see him go, but we'll certainly understand that. We can't
5 pay for it. I can barely pay for my own health care. I'll
6 buy them dinner, but I won't buy them health care.

7 MS. BRENNAN: With our agency with choice model,
8 so if you choose to go that route, there is additional
9 dollars that come out of the person's budget if you use
10 that model. And if the person works over a certain amount
11 of hours in a week and they meet the certain criteria, they
12 can purchase health care, but it comes out of the person's
13 budget. So that's the different model.

14 And people have to make that choice, and that's a
15 hard choice when you're becoming -- so many families are
16 like, well, which choice, which fiscal agent do I use?
17 It's their preference. Weighing that is a lot of
18 responsibility, trying to figure out which type of fiscal
19 model do I want to use, because we have two of them. And
20 then the one does have the option of benefits, but
21 additional dollars come out of your budget. So, you have
22 to figure those pieces out.

1 MS. ZOTYNIA: And in addition to that, some of
2 the -- I know one AWC in Pennsylvania that limits the
3 worker to 29 hours a week so that they're not obligated
4 under the ACA to provide employer health care, which is
5 wrong in my opinion.

6 COMMISSIONER ALLEN: That seems like a really
7 significant issue and something that we could continue to
8 think about.

9 My second question is that in earlier session
10 today, we've been talking about transitions to care for
11 youth with special health care needs. And when you age
12 into adulthood, which we know when a lot of education
13 service is also in, if that was a particular challenge -- I
14 know it was a long time ago. Robert, you're fully an adult
15 now, but if you remember that transition and if there's
16 anything that you would add to us to think about it as
17 we're working on that issue as well.

18 MS. ZOTYNIA: So, Robert has always had physical
19 challenges. He has cerebral palsy. So, he's had a lot of
20 surgeries, orthopedic-related surgeries throughout his
21 life. He didn't really develop his significant health
22 issues till he was in his mid-20s. So, we managed at home.

1 We had really good health care, for one. And there's some
2 great pediatric facilities in Pennsylvania and in Delaware
3 that we access. So, he had great health care and got
4 through those years.

5 It was when he left school, became an adult,
6 entitlements are over, even insurances are over. He
7 couldn't even get PT and OT anymore like he once did. He
8 went to rehabs as a child for years and got PT and OT and
9 speech every single week, and then you become an adult and
10 it's like everything ends. And we'll give you 10 speech
11 therapy visits in a year, but you better have, like, 27
12 doctors signing something that says you need this.

13 So, the challenge really became in adult life and
14 also finding medical professionals who have the necessary
15 skills for whatever your medical issue is, who are trained
16 to work with people with intellectual disabilities and
17 people who don't communicate in a traditional way. That's
18 been a challenge.

19 When Robert was 19 years old, he had surgery. It
20 was sort of minor. He had some digits on his feet
21 amputated, and when we were at that appointment discussing
22 it and decided that's the route he wanted to take as

1 opposed to a more invasive surgery, the nurse came in and
2 handed me the paperwork. And I said, "I can't sign that.
3 I'm not his guardian. He is a competent adult. He has to
4 sign his own paperwork." And they argued with me about
5 that and were like, well, he can't do that. He has a
6 disability and he can't talk and blah, blah, blah. They
7 had three doctors come in who talked to Robert for 15
8 minutes, and every one of them said he's clearly telling us
9 to throw them in the garbage. Like, he is consenting to
10 this, and he can make his mark. So that's a challenge for
11 adults.

12 I mean, I've gotten calls frequently from people
13 who -- adults with disabilities who are at the hospital, in
14 the ER, and doctors who are afraid to provide medical care
15 because they're not sure they're able to consent to it,
16 even though we know they are. So, they're looking for
17 someone else to come in and sign off on that, and they
18 don't really care who it is. And that's a problem. So,
19 educating the medical community would go a really long way.

20 I'm not sure if I actually answered your question
21 because I tend to go down rabbit holes.

22 COMMISSIONER ALLEN: No, it was very helpful.

1 Thank you.

2 MS. ZOTYNIA: Okay.

3 CHAIR JOHNSON: That's very, very helpful.

4 All right. Any other comments or questions from
5 the Commissioners?

6 [No response.]

7 CHAIR JOHNSON: Hearing none.

8 So, I just have to say this really was a great
9 way to kick off this work. Great background that you all
10 both shared with us. And then also this panel was very
11 exceptional. I really appreciate the time that you all
12 took to come out and talk with us.

13 So, I'll look at Gabby and Brian. Anything else
14 that you all want to do in terms of closing out with the
15 panel? Are we okay?

16 MS. BALLWEG: I don't think so. Just thank you
17 all for joining us today. We really appreciate your time.

18 CHAIR JOHNSON: Thank you so much. We do.

19 MS. BRENNAN: Thank you for having us.

20 MS. ZOTYNIA: Thank you.

21 CHAIR JOHNSON: Take care.

22 MS. ZOTYNIA: Bye.

1 CHAIR JOHNSON: All right. So, Commissioners, we
2 do have a couple more minutes, then, for additional
3 conversation and discussion if you'd like. So, if there
4 are any themes that you wanted to highlight or other areas
5 of investigation based on the conversation with the panel
6 and the earlier conversation, then we have Gabby and Brian
7 here to help us walk us through that.

8 All right. So, Patti.

9 COMMISSIONER KILLINGSWORTH: So just kind of
10 following up on some of the remarks really from all the
11 panelists, but particularly from Patricia and Mark around
12 some of the ways to really improve access to self-directed
13 programs, I think we talked about information requirements,
14 which could come in a number of ways. And I'm just sort of
15 thinking about my own experience as a state leader in
16 Tennessee and really trying to get these programs really
17 accessible to people, making them a part of welcome letters
18 to home- and community-based services, making sure that
19 they are a part of member handbooks for managed care
20 programs, that there are special handbooks I believe were
21 talked about that are specific to self-direction.

22 We actually made -- developed materials that had

1 to be reviewed with every single person at their initial
2 person-centered planning meeting and annually thereafter,
3 and that they were -- the health plan was required to get a
4 signature from the person saying I do or I don't want to
5 direct my own services. And it was language that the state
6 developed.

7 Even with all of that, we learned very quickly
8 that service coordinators just weren't quite comfortable
9 having these conversations with people, you know, and
10 there's a way to ask a question to get a no. And so, we
11 had to do specialized training really with coordinators and
12 make sure that was a required part of their training so
13 that they would really understand how to have a good
14 neutral conversation that was informative and allowed an
15 informed decision, obviously good training for the person
16 or any authorized representative in terms of the
17 expectations and requirements and then for their workers as
18 well.

19 And then maybe one of the things that we did that
20 was most important was that we measured utilization on an
21 ongoing basis. So, we wanted to know health plan to health
22 plan like how are you doing getting people enrolled into

1 self-directed programs, and we looked at that on a very
2 regular basis.

3 And then ultimately through our Money Follows the
4 Person rebalancing demonstration offered financial
5 incentives to health plans based on the percentage that
6 they were increased, that they were able to achieve over
7 time.

8 So, I just think there's a lot of things that can
9 be done to make sure that people have an opportunity to
10 avail themselves of the options that are there within their
11 states.

12 And then I would continue to just say, as we look
13 into this -- Patricia, in particular, mentioned kind of the
14 accountability challenges and some of those pieces. And so
15 really understanding what those guardrails are, how to
16 ensure accountability, a look at cost relative to provider-
17 delivered services and just kind of balancing the payment
18 and access issue as we go along.

19 Thank you.

20 CHAIR JOHNSON: Thank you, Patti.

21 Dennis.

22 COMMISSIONER HEAPHY: Thank you.

1 I knew I was wrestling with part of the
2 presentation. That's because it was a very IDD-focused
3 model of care, and when you have different populations of
4 folks who are receiving -- who are actually coordinating
5 their services with a personal care attending, consumer
6 employer -- that's a model, we call it "consumer employer."
7 Different people have different needs, and so it's about
8 choice.

9 And so, in Massachusetts, at least people can
10 choose to have a CORI, and if they do, the mechanism is
11 there for them to, you know, have their PCA CORI checked.
12 For those who don't want to require a CORI, they don't have
13 to. There are folks that if they want more intensive
14 training, they can get that. And folks who don't want to
15 do it and they want to make sure they're training the PCA
16 to do it their way, then they can do that.

17 And so, I think for me, it's better understanding
18 the different models, I think, and Massachusetts at least
19 would be a revolution if you asked or required notes to be
20 taken on what the PCA did during the day with the
21 individual. But there might be people who might want that,
22 and so if they do, they should have the right to have that.

1 But it's really about the flexibility and ensuring that
2 it's about supporting the people's right to live in the
3 community in the least-restrictive setting possible.

4 And, you know, with EVV, making sure that the PCA
5 is there, is actually showing up doing it, like -- and
6 leaving when they say they're leaving. That's all fine and
7 good. It's just when they're there, it's what they're
8 doing. It's ensuring the person can live in the community
9 in the way that they want to and giving each -- like, a
10 parent or a child or an older person, they want to know
11 that information, let them have it.

12 Thanks.

13 CHAIR JOHNSON: Thank you so much. Appreciate
14 that.

15 Heidi.

16 COMMISSIONER ALLEN: Thank you. This is a great
17 panel.

18 I realize, though, that I'm missing some
19 fundamental information on this topic. Like, how does this
20 intersect with dual eligibility and Medicare? And I was
21 curious about how, like, Money Follows the Person, which I
22 thought was something similar -- is this different money?

1 So, I don't know if there's materials that you just want to
2 send me personally that get me caught up. But I came into
3 the conversation a little bit like -- so this is home- and
4 community-based services, and this is available as part of
5 home- and community-based services. Who all is eligible
6 for it, and for how long? And what are the exclusion
7 criteria? I think it would just be helpful to have, like,
8 more basic understanding of that.

9 CHAIR JOHNSON: Any other comments or questions?

10 Oh, Jami.

11 COMMISSIONER SNYDER: I was just going to note,
12 again, something that Pamela mentioned when I'd asked about
13 access to self-directed care. She said one of the barriers
14 is really around fear, and then a couple of the panel
15 participants talked about the importance of peer education
16 and peer support in overcoming some of that fear. I just
17 wanted to make note of that again, because I think that is
18 a really important piece of the equation in terms of
19 ensuring that individuals understand the availability of
20 the service and really want to take advantage of it as an
21 option.

22 CHAIR JOHNSON: Great call-out. Thank you.

1 And then, Tricia, I think I saw your hand up.

2 COMMISSIONER BROOKS: Yeah. I want to understand
3 better the different roles that they talked about, and in
4 particular, they talk about the support coordinator. It
5 sounded like the support coordinator sort of fills gaps in
6 what you self-direct. But just understanding those roles
7 more explicitly would be helpful.

8 CHAIR JOHNSON: No, that's great. That was one
9 of my questions, too, so I appreciate that, Tricia.

10 COMMISSIONER BJORK: There's the broker, too.
11 Remember, it's two roles.

12 CHAIR JOHNSON: Right. And the broker, right,
13 that Sonja mentioned. Right.

14 Any other?

15 Oh, Dennis.

16 COMMISSIONER HEAPHY: I guess and how that role
17 differs in different states and what type of program.
18 They're all very different in how they run the program, and
19 also what type of program the state has.

20 COMMISSIONER BROWN: Well, it could also be
21 different waivers in the same state.

22 COMMISSIONER HEAPHY: Yeah.

1 COMMISSIONER BROWN: I don't think the support
2 broker is a thing in the elder waivers. So, I think it
3 could be a variation within the state as well.

4 COMMISSIONER HEAPHY: It may be population-based.

5 CHAIR JOHNSON: Any other ones?

6 [No response.]

7 CHAIR JOHNSON: Okay. So, Gabby and Brian, this
8 was, again, great. We really appreciate your efforts, and
9 you got a lot of feedback from us. And I know we'll have
10 more questions to you, but really appreciate where you
11 started with this, and I can see it really ending in a
12 great place. So, we really appreciate your efforts. Thank
13 you.

14 All right. So, with that, we are going to go to
15 our final public comment, and so it's open now for public
16 comment. We do invite you all in the audience to raise
17 your hand if you'd like to offer any comments. Please make
18 sure you're introducing yourself and the organization that
19 you represent, and as always, we ask that you keep your
20 comments to three minutes or less.

21 Let's see. We have one. Camille?

22 **### PUBLIC COMMENT**

1 * MS. DOBSON: Good afternoon, Commissioners.
2 Camille Dobson, Deputy Executive Director at Advancing
3 States. We represent the aging and disability agencies
4 that deliver public and community services for older adults
5 and people with disabilities. And this was such an amazing
6 afternoon. Appreciate you so much taking on this issue.
7 It's shrouded in lots of mystery and, I think, confusion,
8 so different in every state.

9 And a lot of the comments I was going to make,
10 Patti has already made, perhaps not surprisingly.

11 But I wanted to -- in particular, around older
12 adults, I think Mike's point also about it being different
13 based on population. You know, we continue our support to
14 states, really, to understand the critical role of the
15 labor case manager, the support coordinator, the service
16 coordinator, whatever you call them. You know, they are --
17 they're the linchpin in starting a person's journey to
18 self-direction.

19 It is harder for them than it is to direct people
20 to agencies and services. There's a tremendous amount of
21 turnover in case management. Our members are complaining
22 not just about the direct care workforce but also about

1 their case management rosters and the difficulty of
2 retaining case managers.

3 We have been in more than one state where the
4 case manager is making the decision themselves about
5 whether they think the person can self-direct, particularly
6 in aging waivers. And so I think that this is a really --
7 again, the need for support brokers, CMS doesn't require
8 every state. They recommend that every state have a
9 support broker or a function to support the person who's
10 self-directing, separate from the FMS and separate from the
11 provider, and not every state has it. And I think that's
12 also a deterrent.

13 So there are lots of opportunities, I think, for
14 you to make recommendations for ways to strengthen self-
15 direction, because it has -- the satisfaction is very, very
16 high from our members who survey their folks and ask if
17 they've been self-directing.

18 Dennis is a living example, I know. But I guess
19 we're very appreciative that you're diving into this topic
20 because it is filled with confusion, mystery. Not every
21 state does it. California has got more than half. Between
22 California and New York, they have probably three-quarters

1 of the people self-directing in the country, which makes
2 the rest of the programs across the country very, very
3 small and unique and many times hard to manage for our
4 state members.

5 So thank you.

6 CHAIR JOHNSON: Thank you, Camille. We
7 appreciate that comment.

8 Any other comments?

9 [No response.]

10 CHAIR JOHNSON: Okay. In the absence of none, if
11 you do have additional comments later, feel free to visit
12 our website, and you can submit your written comments there
13 anytime. And then also on the screen, you'll see that we
14 have our MACPAC presentations are available for downloading
15 for this meeting on our website as well.

16 So, with that, we will adjourn this meeting
17 today. Thank you so much for such a great day, great
18 conversations, a lot for us to think about, and we will see
19 you all tomorrow at 9:30 a.m. for our public session.

20 * [Whereupon, at 4:47 p.m., the meeting was
21 recessed, to reconvene at 9:30 a.m., Friday, September 13,
22 2024.]



PUBLIC MEETING

Ronald Reagan Building and International Trade Center
Hemisphere Room
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, December 13, 2024
9:33 a.m.

COMMISSIONERS PRESENT:

VERLON JOHNSON, MPA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
DOUG BROWN, RPH, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
MICHAEL NARDONE, MPA
JAMI SNYDER, MA

KATHERINE MASSEY, MPA, Executive Director

AGENDA

PAGE

Session 7: Timely Access to HCBS: Policy Option on Provisional Plans of Care
 Tamara Huson, Senior Analyst and Contracting Officer.....265

Session 8: HCBS Spending and Utilization
 Gabby Ballweg, Research Assistant.....287
 Janice Llanos-Velazquez, Principal Data Analyst....294

Session 9: Findings from a Technical Expert Panel on Medicaid Payment Policies to Support the Home- and Community-Based Services (HCBS) Workforce
 Emma Liebman, Senior Analyst.....318
 Katherine Rogers, Deputy Director.....319

Session 10: Highlights from the 2024 Edition of MACStats
 Asher Wang, Analyst.....354
 Chris Park, Policy Director and Data Analytics Advisor.....n/a

Public Comment.....364

Adjourn Day 2.....369

P R O C E E D I N G S

[9:33 a.m.]

1
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CHAIR JOHNSON: Good morning. Happy Friday, and thank you for joining us for our second day of our MACPAC Commission meeting.

We're looking forward to this morning's conversation, and we will be continuing our discussion on HCBS. So with that, we have Tamara Huson, our Senior Analyst and Contracting Officer, joining us as we return to our discussion on provisional plans of care for HCBS and potential policy options for ensuring timely access to services.

So, Tamara, over to you.

TIMELY ACCESS TO HOME- AND COMMUNITY-BASED SERVICES: POLICY OPTION ON PROVISIONAL PLANS OF CARE

* MS. HUSON: All right. Thank you. Good morning, Commissioners.

So I'm back again to talk about provisional plans of care, specifically to present for your consideration a policy option directing CMS to issue guidance.

I'm just going to start with some quick background. First, just a reminder that today, when

1 looking at this graphic, we're focused on Step 3 in the
2 eligibility and enrollment process for individuals that are
3 seeking HCBS, which is the development of a person-centered
4 service plan, or a PCSP. And a PCSP is a document that
5 describes the services and supports an individual requires
6 to meet their needs and their individual preferences, and
7 statute dictates that HCBS can only be provided pursuant to
8 a written plan of care.

9 So one way that states can expedite delivery of
10 Section 1915(c) home- and community-based services is to
11 use a provisional plan of care, which is a type of
12 preliminary service plan that identifies the essential
13 Medicaid services that can be provided in the person's
14 first 60 days of waiver eligibility. And states may call
15 provisional plans of care by other names, such as "interim
16 service plans," "temporary service plans," or "initial
17 plans of care."

18 Provisional plans of care have been allowed since
19 2000, when it was described in the state Medicaid director
20 letter, known as Olmstead Letter No. 3, which was issued in
21 response to the 1999 *Olmstead v. L.C.* decision.

22 And states document in Appendix D-1 of their

1 Section 1915(c) waivers if they allow the use of a
2 provisional plan of care and their procedures for
3 developing such plans.

4 So I want to recap the review of our -- or the
5 results of our waiver review. We received a few questions
6 about our waiver review. So I want to provide a few more
7 details on our process for some additional clarification.

8 So, as you recall, we contracted with The Lewin
9 Group to conduct an environmental scan, and one item in
10 that scan was a review of Appendix D-1-d of states' Section
11 1915(c) waivers to see if the waiver had language allowing
12 for the use of provisional plans of care. And so Lewin
13 found such language in 17 states.

14 Then we also received a list of waivers by state
15 from CMS that had language on provisional, interim, or
16 temporary service plans. And so after cross-referencing and
17 combining these two data sources, we found that 24 states
18 allow for the use of provisional plans of care across 59
19 Section 1915(c) waiver programs.

20 So this table here shows that data. It is
21 slightly updated from the table that was included in our
22 October presentation. We received some feedback after that

1 presentation that led us to make a few changes and re-
2 verify all of this information.

3 I would also just like to emphasize the data here
4 is a count of waivers by state in which those Section
5 1915(c) waivers have language authorizing the use of
6 provisional plans of care. So it does not necessarily mean
7 that the state is currently using the provisional plan of
8 care authority, and we don't have a good count of what that
9 is.

10 I also want to recap the themes from our
11 stakeholder interviews and provide some new information.
12 So I shared the findings from our stakeholder interviews
13 that we conducted over the summer with you in October, but
14 since then we've gone back to a few people to gain
15 additional insights on the reasons for low state uptake of
16 provisional plans of care and on the need for guidance on
17 this topic.

18 But first, again, I just want to recap what we
19 shared in October. So we heard from state officials and
20 national experts that provisional plans of care were most
21 often used for emergency situations, such as natural
22 disasters or hospitalizations. However, our interviews

1 also indicated that few states are actually using
2 provisional plans.

3 So of the four national organizations that we
4 spoke with, none of them were aware of any states using
5 provisional plans of care. And then we spoke with five
6 states, and of those five states, one said that they are
7 not currently using this flexibility, two states shared
8 that they do use provisional plans but not very often, and
9 then two states were actually unsure.

10 And then finally, since the larger scope of this
11 project on timely access also includes presumptive
12 eligibility for non-MAGI populations, we also heard from a
13 number of states that are using Section 1115 demonstrations
14 that they use what is essentially a provisional plan of
15 care and provide a limited benefit package for those
16 individuals that are found presumptively eligible.

17 So this slide is some new information and is
18 informed by both our original round of interviews as well
19 as the additional ones that we conducted since October.

20 So one of the most prominent reasons that we
21 heard that can contribute to low state uptake of this
22 policy is a lack of awareness. So the feedback from

1 experts in three states that we spoke with indicates that
2 states are not operationalizing this flexibility. A couple
3 of interviewees noted that waiver approvals can contain
4 legacy language and hypothesized that states had not fully
5 implemented the authority. Another contributing factor may
6 be state staff turnover, which can lead to a loss of
7 programmatic knowledge and the ability to update operating
8 procedures quickly. Two interviewees also talked about how
9 there may be a lack of awareness in the hospital discharge
10 planning process about how to use provisional plans of care
11 for Medicaid beneficiaries.

12 A few interviewees also cited limited state
13 capacity, administrative complexity, and competing
14 priorities as a reason why states may not be using
15 provisional plans of care.

16 So CMS advises that states that want to implement
17 this policy should submit a waiver amendment, which can be
18 a resource-intensive and administratively burdensome
19 process. Changes to waiver programs require state staff
20 resources and time to develop new policy, identify
21 operational changes, for example, changes to case
22 management systems, as well as time to educate both state

1 staff and HCBS providers.

2 Finally, among many competing priorities,
3 implementing provisional plans of care may not always be at
4 the top of the list. For example, states and CMS officials
5 noted that the volume of recent regulatory action that
6 states have been working to come into compliance with, such
7 as the final rule on ensuring access to Medicaid and also
8 other regulatory action around person-centered planning
9 from the past few years.

10 Then we also heard that in some states, their
11 operational processes affect decisions to use or not use
12 provisional plans of care. In particular, three states
13 shared with us that they complete the level of care
14 assessment and develop the PCSP together in the same
15 meeting, thus, kind of negating the need for an interim
16 service plan.

17 And then finally, provisional plans of care may
18 not be feasible or may not be appropriate for all
19 individuals. So for example, interviewees noted that a
20 provisional plan of care may not be appropriate for
21 somebody who needs the full array of services to safely
22 discharge from the hospital back to the community.

1 Then this slide on guidance has mostly the same
2 information as my last presentation, but I want to recap a
3 little bit. So the guidance and provisional plans of care,
4 again, comes from the 2000 Olmstead Letter No. 3, and
5 nothing more recent has been published.

6 There is a brief mention in the section 1915(c)
7 technical guide about how states should describe in
8 Appendix D-1 on service plan development the procedures the
9 state will use to develop interim service plans and the
10 duration of said plans.

11 I'll also note that just on Wednesday, CMS held a
12 webinar detailing revisions to the Section 1915(c) waiver
13 application and the technical guide, and those changes will
14 be rolled out on Monday. And in that webinar, they noted
15 some very small revisions to the technical guide on
16 provisional plans of care.

17 In our interviews, we also got mixed responses on
18 the need for additional guidance on the use of provisional
19 plans. So again, two states that are rarely using this
20 authority shared that it's a long-standing flexibility that
21 they've used, and they didn't feel they needed additional
22 guidance.

1 National experts, however, all pointed to the
2 fact that so few states are using provisional plans of
3 care, and they expressed desire for additional guidance, as
4 it could encourage more states to use this flexibility.

5 When we spoke with CMS, they again pointed to
6 Olmstead Letter No. 3 and the long-standing ability that
7 states have had to use provisional plans, saying that
8 there's no new policy that warrants additional guidance.

9 They also noted that they've not received any
10 recent technical assistance requests. Instead, CMS
11 highlighted for us how they've been trying to promote the
12 use of provisional plans, such as in recent webinars, the
13 preamble to the access rule, a Center for Medicaid and CHIP
14 Services Information Bulletin titled "Ensuring Continuity
15 of Coverage for Individuals Receiving Home and Community-
16 Based Services," and at recent Advancing States HCBS
17 conferences. And in each of these instances, CMS has
18 reiterated that the authority is already provided in that
19 Olmstead letter.

20 So to move on to our policy option, our policy
21 option reads that the Centers for Medicare & Medicaid
22 Services should issue guidance to outline the Medicaid

1 authority, either state plan or waiver, that states can use
2 to adopt provisional plans of care and to identify policy
3 and operational issues that states should consider in the
4 course of implementation.

5 So again, as I just stated, interviewees were
6 really mixed on the need for guidance. National experts as
7 well as one state agreed that guidance would be helpful.
8 Two states, again, that have operationalized the use of
9 interim service plans said they did not need additional
10 guidance.

11 But the apparent lack of awareness and the
12 limited use of provisional plans of care indicates that
13 there might be a need for additional guidance.

14 Interviewees noted that CMS could better describe
15 the intent of the policy and how provisional plans of care
16 could be used, including state examples and how to
17 operationalize the policy.

18 Interviewees also noted that specific guidance on
19 this topic would provide reassurance to states that they're
20 operating their programs in accordance with the statutory
21 and regulatory rules that govern HCBS. And one expert also
22 noted that provisional plans of care could help states meet

1 the new timeliness requirements in the access rule.

2 This policy option also proposes that CMS clarify
3 for states that provisional plans can be used for all HCBS
4 authorities, including Section 1915 state plan options and
5 Section 1115 demonstrations. Olmsted Letter No. 3 is
6 specific to 1915(c) waivers because it predates the other
7 1915 state plan options, and while we have identified one
8 state that uses provisional plans of care in its Section
9 1915(i) SPA and its 1115 demonstration, there's no guidance
10 expressly stating that this flexibility is allowed for
11 these other authorities.

12 When we spoke with CMS, officials there said that
13 there's nothing prohibiting the use of provisional plans in
14 these other authorities, and they noted that the regulatory
15 language on person-centered planning is fairly consistent
16 across all the Section 1915 authorities.

17 In particular, CMS officials noted that the
18 requirement for Section 1915(i) generally follows that of
19 Section 1915(c), and this is consistent with the findings
20 from our work on 1915 authorities.

21 Finally, one expert hypothesized that interim
22 service plans might be a useful tool for Section 1915(i)

1 programs but may be less so for 1915(k) since those usually
2 have a smaller benefit package, but they ultimately
3 supported the clarification that this policy option would
4 provide.

5 Then finally to talk through some of the
6 potential effects of this policy option. So state Medicaid
7 agencies and operating agencies for HCBS programs may
8 benefit from greater clarity on how to authorize and
9 implement the use of provisional plans of care.

10 If guidance leads to more states using
11 provisional plans, the number of new enrollees who have a
12 provisional plan could increase, potentially leading to
13 more timely access of services. In emergency situations,
14 this more immediate access to services could enable
15 individuals to remain in or return to the community as
16 opposed to going into an institutional setting.

17 An increase in the number of provisional care
18 plans can affect the entities responsible for providing
19 them as well. So in states where plans are responsible for
20 developing PCSPs, the staff, such as caseworkers, would
21 need to be trained on how and when to operationalize the
22 use of provisional service plans. And use of provisional

1 plans of care may allow enrollees to more quickly be
2 connected with HCBS providers.

3 Providers would also need to be educated on the
4 difference between a provisional plan and a regular PCSP
5 and how services authorized could differ between the two
6 versions. A decrease in services could negatively affect
7 providers, although many stakeholders noted that there are
8 typically more services authorized in a full PCSP than a
9 provisional plan of care.

10 And finally to finish with some next steps.
11 Today it would be most helpful to know if Commissioners
12 have any feedback on the proposed policy option. I'm also
13 happy to answer any additional questions. And if you are
14 supportive of the policy option, then I'll return in
15 January with the recommendation language and draft chapter
16 for our March 2025 report to Congress.

17 And with that, I turn it back to you. Thank you.

18 CHAIR JOHNSON: Thank you, Tamara. That was very
19 helpful.

20 All right. So I'll open the floor to
21 Commissioners. So again, just so we level set, really want
22 to get your feedback on the policy option, if that's what

1 you want to pursue, but also to any clarifying questions
2 that will be helpful to the conversation will be great. So
3 with that, I'll open the floor.

4 All right, Mike.

5 COMMISSIONER NARDONE: Thank you, Tamara. That's
6 very helpful. I'm generally supportive of the policy
7 option.

8 I wanted to ask, though, in the previous month,
9 we also had a presentation about presumptive eligibility,
10 and I'm just wondering, there was also some -- it seemed to
11 be some misunderstandings around when presumptive
12 eligibility could be used, who could be an agent to do the
13 presumptive eligibility, what some of the fiscal potential
14 liabilities were around presumptive eligibility. And I was
15 wondering, did you consider -- or in talking to states, is
16 that also potential, something we could marry into this
17 recommendation as all part of kind of the effort to level
18 the playing field in terms of institutional versus HCBS
19 care?

20 MS. HUSON: Sure. So maybe just a quick recap of
21 what we heard when we spoke with folks about presumptive
22 eligibility. So one is just a reminder that presumptive

1 eligibility for non-MAGI populations can be done through
2 two different authorities, so through Section 1115
3 demonstrations or by expanding hospital PE using a SPA.
4 And so there is a lot of guidance around that second avenue
5 of using hospital PE through a SPA, even though only one
6 state that we know of has done that for the non-MAGI
7 populations specifically.

8 But then thinking about the Section 1115
9 demonstrations, similarly, there was no consensus among the
10 interviewees about whether guidance was or was not needed
11 for that avenue. So again, we spoke with five states that
12 have PE programs for their non-MAGI folks, and of the state
13 officials we spoke with, one state strongly supported the
14 need for guidance, while two other states did not. And
15 then the other states really just talked about how TA with
16 CMS was the most important thing for them in developing
17 their programs.

18 Again, among experts, similar to this, there's
19 kind of a general feeling that guidance is always helpful.
20 But one expert noted that since much of this work is being
21 done through the 1115 demonstrations, which really does
22 rely heavily on that technical assistance, that back-and-

1 forth, that what we're kind of seeing is policymaking
2 through waiver applications. And they wanted to kind of
3 consider the tradeoff of formal guidance for an 1115 and
4 about how you may lose some flexibility and the ability for
5 states to really tailor programs to their state environment
6 versus if CMS were to issue formal guidance with some
7 parameters around how states could do that.

8 And then we also did ask CMS again about guidance
9 for presumptive eligibility, and they indicated at that
10 time that they were not planning to issue any guidance
11 around how to do it in 1115 waivers.

12 So I hope that's a helpful recap of kind of what
13 we heard and why we didn't move forward with a policy
14 option at that time around presumptive eligibility.

15 CHAIR JOHNSON: Thank you, Tamara.

16 Dennis.

17 COMMISSIONER HEAPHY: Thank you. Could you go up
18 to the Olmstead Letter No. 3 slide? Thank you.

19 When I look at this letter, I look at the timing
20 of it, and it comes right after the Olmstead Agreement in
21 1999. It's really about ensuring that states are upholding
22 their obligation to the civil rights of folks who live in a

1 community in the least restrictive setting possible.

2 So when I look at this, I see that Medicaid -- or
3 CMS, rather, is providing states the ability to use a means
4 of preventing people from being institutionalized
5 unnecessarily. And so I think it's really important for us
6 to support the proposal in the sense that states should be
7 taking advantage of any means possible to ensure people's
8 civil rights are being upheld and that they're reducing
9 people from unnecessarily being institutionalized when they
10 could be in a community setting.

11 CHAIR JOHNSON: Thank you, Dennis.

12 Patti?

13 COMMISSIONER KILLINGSWORTH: Continuing on with
14 the comments that Dennis made, I do think the timing is
15 really, really important and that it signals access to
16 services for people who are otherwise institutionalized or
17 at risk of institutionalization. And I really do think
18 that this is an issue which sort of strikes at the heart of
19 access to home- and community-based services and the
20 fundamental institutional bias that continues to be in the
21 law.

22 So if you want to go into an institution, you may

1 do so without delay, and you may have your services
2 retroactively covered, notwithstanding some plan of care
3 that has to be developed by the state or the state's
4 delegated entity after you are determined eligible for
5 those services, as is the case with home- and community-
6 based services. So we've replaced a hurdle, an obstacle to
7 services in the community that doesn't exist for services
8 in an institution, and we've placed an obstacle to
9 reimbursement for those services.

10 And it seems to me that when you're talking about
11 someone who is at risk of institutionalization, we should
12 make it easier for them to be able to access at least the
13 urgently or immediately needed services that are required
14 to keep them in the community and not have them be
15 institutionalized, as opposed to requiring yet another
16 administrative hurdle for those services to be made
17 available to them, an administrative hurdle both for them
18 in terms of the plan of care but also an administrative
19 hurdle for the state in terms of "Oh, no, if you want to do
20 this thing, which will make sure that people can actually
21 access the services that they need in a timely manner, you
22 need to go get special authority for that."

1 Should we just expect that states can make those
2 services available to people when they are immediately
3 needed, including through the use of interim service plans,
4 initial service plans, whatever in the heck we want to call
5 them? Our goal should always be to ensure that people have
6 timely access to the supports they need when and where they
7 need them in a way that, as Dennis said, protects their
8 civil rights to receive those services in the most
9 integrated setting appropriate for their needs.

10 And so I think this is one where not just -- I
11 mean, the guidance -- my fear is that the guidance will be
12 written and it will be written in a way that makes it
13 harder for states to do what they may, in fact, already be
14 doing. And I'll give you an example of that, and I'll just
15 apologize in advance if this messes anything up, which I
16 always worry about.

17 So, in Tennessee, there are three 1915(c)
18 waivers, which since right after that Olmstead letter have
19 allowed for initial plans of care.

20 When we created our 1115 demonstrations, our
21 managed long-term services and supports programs, we
22 identified the need for immediately needed services to be

1 provided right away, right? Not 90 days from now, but
2 right away when people need them while that person -- that
3 more sort of comprehensive person-centered support plan is
4 being developed.

5 We didn't put that in our waiver, by the way.
6 It's in our contracts, which CMS also approves. But it
7 wasn't sort of a waiver amendment or a waiver authority.
8 It's just something that we do because it's the right thing
9 to do for people, and it is specified in contract language
10 approved by CMS. So there may be easier ways for states to
11 do some of these things short of "I got to go through a
12 public comment process. I've got" -- who in their right
13 mind is going to say, "No, I don't think you should make
14 services available to people when they need them. I think
15 you should make them wait"? So we should make that process
16 easier for people.

17 And I would hope that any guidance that would be
18 issued would try to make that as easy for states as
19 possible in order to improve access to services and keep
20 people out of institutions.

21 CHAIR JOHNSON: Thank you, Patti.

22 So from your remarks, then, when we look at the

1 recommendation as written, as we're suggesting, are there
2 things in there that you think we want to make sure that
3 we're considering? I'm just trying to get a sense of where
4 we would go from your remarks that you have. Patti?

5 COMMISSIONER KILLINGSWORTH: There we go. Sorry.
6 I was struggling.

7 I would like to see us maybe add some language
8 about an expectation that the language is crafted in a way
9 so as to make it -- I don't know what the right word to say
10 is -- at least administratively burdensome as possible,
11 right? So the most expeditious or efficient ways for
12 states to be able to do that.

13 What I wouldn't want to see is, oh, you have to
14 go get a waiver amendment in order to be able to make
15 services available to people more quickly.

16 CHAIR JOHNSON: Okay. And then also another
17 point is that we can also put more description in the
18 chapter as written, too, as well, to indicate that. All
19 right. That's very helpful.

20 COMMISSIONER KILLINGSWORTH: Thank you.

21 CHAIR JOHNSON: Dennis?

22 COMMISSIONER HEAPHY: Yeah, I think it's also

1 going to be helpful in the chapter to really contextualize
2 this within Olmstead and do a much deeper explanation of
3 why it's there and both to support the state's obligation,
4 but that this is actually means of supporting the state's
5 ability to implement Olmstead.

6 CHAIR JOHNSON: Thank you, Dennis.

7 Any other thoughts or comments from the
8 Commissioners?

9 [No response.]

10 CHAIR JOHNSON: Is there general support, then,
11 for this potential recommendation policy? I see a shake of
12 hands. All right.

13 Tamara, is there anything else that you would
14 need from us? I think we all are in agreement that
15 additional guidance is always helpful. I just want to make
16 sure that CMS understands the intent and some other options
17 in terms of how they can make sure they're providing that
18 for states.

19 MS. HUSON: Yep. That's great. Thank you.
20 That's everything I need to move forward.

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

22 [Pause.]

1 CHAIR JOHNSON: All right. We're going to have
2 Gabby and Janice join us next to talk about HCBS spending
3 and utilization that represents findings from our
4 investigation into HCBS spending and utilization over the
5 last couple of months.

6 [Pause.]

7 **### HCBS SPENDING AND UTILIZATION**

8 * MS. BALLWEG: Hello, and good morning,
9 Commissioners.

10 Today Janice and I are going to share high-level
11 results from a two-year analysis investigating Medicaid
12 home- and community-based services spending and utilization
13 between 2019 and 2021 using data from the Transformed
14 Medicaid Statistical Information System, or T-MSIS.

15 This project expands on MACPAC's 2017 HCBS claims
16 analysis chart book which analyzed HCBS use and spending
17 patterns from 2010 through 2013 among fee-for-service
18 Medicaid beneficiaries using the Medicaid Analytic eXtract
19 files, or MAX files.

20 The purpose of this analysis is to develop a
21 baseline of data from which we can analyze Medicaid
22 spending and utilization among LTSS subpopulations.

1 I'm going to begin this presentation with some
2 background on utilization and spending patterns in HCBS and
3 how this analysis fits into the Commission's HCBS access
4 framework.

5 Next, I'll discuss the analysis itself, and then
6 I'll turn it over to Janice who will provide an overview of
7 our methods followed by a review of high-level findings
8 from the T-MSIS data.

9 Janice will then dig into the 2021 dataset to
10 discuss variations in demography among Medicaid HCBS users
11 and to detail HCBS utilization and spending patterns across
12 an array of stratifications.

13 Lastly, Janice will highlight some key takeaways
14 from today's presentation and conclude with our next steps.

15 As a reminder, Medicaid beneficiaries who use
16 long-term services and supports, or LTSS, are a diverse
17 group spanning a range of ages with different types of
18 physical and cognitive disabilities and various services
19 and supports needs.

20 HCBS are an optional benefit that all states
21 provide, and they're designated to allow people -- they're
22 designed to allow people with LTSS needs to live in their

1 home or a home-like setting in the community.

2 In 2021, over 2.5 million individuals used HCBS.
3 The total number of HCBS users in a year can vary based on
4 the methodology used to identify HCBS users, and please
5 note that this total excludes HCBS users from one state due
6 to some data quality concerns.

7 States will vary in the types of services they
8 offer to HCBS users, and they also can vary in their
9 service definitions, with over 60 different specific
10 services available to HCBS users, such as case management
11 or day services.

12 To facilitate national analyses of HCBS users and
13 expenditures by service type, researchers have classified
14 these services into categories which we call the "HCBS
15 taxonomy." Some of these HCBS taxonomy categories include
16 round-the-clock services, supported employment, and day
17 services.

18 The Centers for Medicare and Medicaid Services
19 provides a list of 12 subpopulations from which states can
20 choose their target HCBS populations for Section 1915(c)
21 waivers.

22 In our review of waivers, we found that many

1 serve more than one of these subpopulations so we can we
2 consolidated the subpopulations into six groupings.

3 This organization also mirrors other studies that
4 use similar groupings, and it will allow for easier
5 comparison across similar populations.

6 The subpopulations are as follows: individuals
7 with intellectual or developmental disabilities or autism
8 spectrum disorder, those under age 65 with potentially
9 disabling conditions, older adults which includes people
10 over age 65, people with brain injuries, individuals with
11 mental illness, serious emotional disturbance or substance
12 use disorder, and those with HIV/AIDS.

13 You may notice that we usually say in our work
14 the phrase "individuals under age 65 with a disability,"
15 but here we're using the term "potentially disabling
16 conditions." We do this because there's no disease
17 severity or functional assessment data in the T-MSIS
18 analytic files, or TAF, which we use for this work. So, we
19 have to rely on diagnosis codes to identify possible
20 disabilities for this LTSS subpopulation. So that's why
21 we're using the phrase "potentially disabling conditions"
22 in order to indicate that these beneficiaries in the

1 subpopulation have at least one condition that could be the
2 basis of a disability.

3 The services HCBS users require will vary both
4 across and within subpopulations by type intensity and
5 cost, depending on the recipient's health and functional
6 status. This also depends on the nature and severity of
7 their disability, the setting in which they reside, and the
8 availability of formal and informal supports.

9 These beneficiaries often receive services and
10 supports for many years or even decades. As a component of
11 LTSS, Medicaid spending on HCBS has outpaced spending on
12 institutional care since 2013.

13 In 2021, Medicaid programs spent approximately
14 \$82 billion on HCBS compared to about \$67 billion on
15 institutional care. Also, please note that the total HCBS
16 expenditures do exclude spending from one state due to some
17 data quality concerns.

18 Spending also varies by HCBS authority. On
19 average, Section 1915(c) waiver services as opposed to
20 state plan services accounted for the majority of HCBS
21 expenditures. However, it's also important to remember
22 that Section 1915(c) waiver authority has been available

1 for longer than some of the state plan authorities.

2 Lastly, spending on LTSS varies by subpopulation,
3 and some beneficiary populations account for a
4 disproportionate share of LTSS expenditures relative to
5 their share of LTSS users.

6 However, limited research on spending and
7 utilization across LTSS subpopulations has prevented us
8 from identifying the extent of these differences and
9 stratifying these findings by factors that could influence
10 access to HCBS.

11 As we continue with this presentation, I would
12 like to note that all of the Medicaid expenditures that
13 Janice and I discussed today comprise both the state and
14 federal share of all the LTSS expenditures.

15 This analysis also ties into the Commission's
16 HCBS access framework. As a reminder, the Commission
17 established this framework in 2022 and recognizing that we
18 can't fully identify disparities in HCBS access without
19 accounting for differences in states' eligibility criteria
20 for HCBS and the other domains of access, this work is only
21 examining one of the four domains, which is the use of
22 services domain.

1 Moving on to the analysis. While research exists
2 on use and spending in Medicaid LTSS, there's relatively
3 little detailed information across demographic
4 characteristics, LTSS subpopulations, HCBS taxonomy
5 categories, and delivery systems. Absent this additional
6 research, it's challenging to identify the extent to which
7 some of these differences in use and spending in Medicaid
8 LTSS occur across these different groups.

9 Through previous MACPAC work, we heard from state
10 and federal officials, as well as national experts, that
11 more effort is necessary to explore the causes of existing
12 health disparities, but data are lacking. Stakeholders
13 emphasize the importance of stratifying data, and one
14 expert noted that these data would allow policymakers to
15 monitor and ensure populations are adequately served.

16 In 2017, MACPAC, in collaboration with
17 Mathematica, analyzed HCBS use and spending patterns for
18 Medicaid fee-for-service HCBS users and beneficiary
19 subgroups from 2010 through 2013 using the MAX data, which
20 is a predecessor to T-MSIS. However, due to some data
21 quality concerns with the MAX data, the study did not
22 include managed care, nor did it classify state plan

1 services to the HCBS taxonomy categories.

2 We built off of this 2017 study to conduct this
3 preliminary analysis of the T-MSIS analytic files, or TAF
4 data, on HCBS spending and utilization and categorized our
5 data by demographic characteristics, HCBS taxonomy
6 categories, and LTSS subpopulations.

7 This analysis will establish a baseline of data
8 from which to better understand some of the differences in
9 use and spending across these groups. The data include
10 both HCBS and institutional LTSS utilization and
11 expenditures. However, our primary area of interest for
12 this project is HCBS, which will be the focus of our
13 presentation today.

14 And with that, I'm going to turn it over to
15 Janice to discuss the methodology and some of our findings.

16 * MS. LLANOS-VELAZAQUEZ: Thanks, Gabby.

17 So to measure HCBS spending and utilization, we
18 partnered with Mathematica to analyze TAF data from
19 calendar years 2019 to 2021. Just a note here that our
20 analytic period does include data that cover the COVID-19
21 public health emergency in 2020, which had a major impact
22 on the utilization of all health care services, including

1 LTSS. And we didn't make any adjustments to our data to
2 address changes that may be attributable to the public
3 health emergency.

4 For our analysis, we first identified LTSS
5 claims, both HCBS and institutional care, by using several
6 data elements on a claim. To identify institutional LTSS
7 and HCBS covered under Section 1915 waivers, we adapted our
8 methodology from CMS's LTSS expenditures and users report.
9 And to identify HCBS covered under Section 1115
10 demonstrations, we adapted the methodology from KFF's state
11 health facts.

12 Next, once we've identified the LTSS claims, we
13 linked them to the eligibility file to identify certain
14 beneficiary characteristics of interest, such as age,
15 gender, and eligibility group, and to classify
16 beneficiaries into the six subpopulations that Gabby listed
17 earlier. Please note that the subpopulations are not
18 mutually exclusive, and beneficiaries are counted in each
19 subpopulation for which they met the criteria.

20 And lastly, we stratified the results by
21 beneficiary characteristics and the six LTSS subpopulations
22 for granular-level analysis.

1 As shown on this table, from 2019 through 2021,
2 the total number of Medicaid beneficiaries and the number
3 of HCBS users increased, while the number of institutional
4 LTSS users decreased. The number of Medicaid beneficiaries
5 increased from 91.6 million in 2019 to 97.7 million in
6 2021, which represents a 6.7 percent increase. The number
7 of HCBS users increased by 15.4 percent over that same time
8 period, which outpaced the growth in Medicaid enrollment.

9 From 2019 to 2021, the number of institutional
10 LTSS users decreased from 1.8 million to 1.5 million in
11 2021, which represents a 17.5 percent decrease.

12 Before we review the rest of the data in this
13 presentation, I just wanted to note a couple things. One,
14 the table on this slide and the graph on the following
15 slide, they exclude data from at least one state due to
16 data quality concerns. However, for the remaining figures
17 in this presentation, we include all states and D.C. for
18 completeness.

19 And also, while our analysis did include data
20 from 2019 to 2021, we found that the data remained fairly
21 consistent for all three years. So, for the purposes of
22 this presentation, we're just focusing on 2021.

1 On this graph, we're showing the state
2 distribution of HCBS and institutional LTSS users as a
3 share of all Medicaid beneficiaries in 2021. The dark blue
4 bar on the bottom represents HCBS users, and the light blue
5 bar on the top represents institutional LTSS users.
6 Nationally, 3 percent of beneficiaries use HCBS, and 1
7 percent use institutional LTSS. And this is shown in that
8 bar in the middle labeled United States.

9 In the majority of states, the percentage of HCBS
10 users was higher than the percentage of institutional LTSS
11 users, which ranged -- the users -- HCBS users ranged
12 between 1 and 9 percent of Medicaid beneficiaries. And the
13 percentage of institutional LTSS users ranged between 1 and
14 3 percent of Medicaid beneficiaries.

15 Next, we'll compare demographic characteristics
16 of Medicaid beneficiaries and HCBS users as a whole and
17 across the six subpopulations.

18 So, first, we'll take a look at age. For two
19 subpopulations, age was part of the criteria used to
20 classify beneficiaries into these groupings, which ends up
21 being borne out in the age composition of these groups.
22 So, among beneficiaries under 65 with potentially disabling

1 conditions, we only see beneficiaries under 65, and among
2 older adults, we only see beneficiaries over 65.

3 Compared to the overall Medicaid population, HCBS
4 users were older, with over 30 percent of users aged 65 or
5 older, compared to just under 10 percent of the Medicaid
6 beneficiaries.

7 Across the HCBS user subpopulations that include
8 children, we found that the share of children was smaller
9 compared to the overall Medicaid population. Beneficiaries
10 with I/DD or ASD and mental illness, SED, or SUD had the
11 highest percentage of beneficiaries aged 18 and younger,
12 with 22 percent among I/DD or ASD and about 21 percent
13 among beneficiaries with mental illness, SED, or SUD.

14 Next, we'll compare the distribution of race and
15 ethnicity across groups.

16 In MACPAC's previous work, we've highlighted the
17 state variation in the quality of race and ethnicity data
18 as reported to T-MSIS. So, for this analysis, we
19 supplemented state-reported data with the TAF race and
20 ethnicity imputation file to estimate the proportion of
21 race and ethnicity among beneficiaries.

22 HCBS users were less likely than the overall

1 Medicaid population to identify as Hispanic and more likely
2 to identify as white.

3 In 2021, 14 percent of HCBS users identified as
4 Hispanic, compared to 26.8 percent of all Medicaid
5 beneficiaries.

6 In four of the six subpopulations, over half of
7 the beneficiaries identified as white, and that is among
8 the I/DD or ASD subpopulation, individuals under 65 with
9 potentially disabling conditions, individuals with brain
10 injuries, and those with mental illness, SED, or SUD.

11 The HIV/AIDS subpopulation had the largest share
12 of beneficiaries that identified as Black and non-Hispanic
13 with 56.3 percent and the largest share that identified as
14 Hispanic with 17.7 percent.

15 And older adults had the largest share of
16 beneficiaries that identified as Asian or Pacific Islander
17 with 13.2 percent.

18 Next, we'll take a look at the distribution of
19 eligibility groups. The majority of HCBS users were in the
20 aged or blind or disabled eligibility group, comprising
21 almost 73 percent of beneficiaries, compared to 19 percent
22 in the overall Medicaid population. Among four

1 subpopulations, I/DD or ASD, individuals under 65 with
2 potentially disabling conditions, and those with brain
3 injuries, and HIV AIDS were in the blind or disabled
4 eligibility group. And the largest -- and older adults by
5 definition were almost exclusively in the aged eligibility
6 group, and the largest share of beneficiaries in the
7 children eligibility group was among beneficiaries with
8 mental illness, SED, or SUD with 15.1 percent
9 beneficiaries.

10 Taking a look at beneficiaries' dual eligibility
11 status, that is, that they're eligible for both Medicare
12 and Medicaid, the data show that full-benefit dually
13 eligible beneficiaries were more prevalent among HCBS users
14 with 49.3 percent compared to the overall Medicaid
15 population with just 10.3 percent. Older adults had the
16 largest share of full-benefit dually eligible beneficiaries
17 with 92.6 percent, followed by individuals with brain
18 injuries with 62.2 percent.

19 There are three subpopulations where over 50
20 percent of their population was enrolled in Medicaid only,
21 and that is beneficiaries with I/DD or ASD, individuals
22 under 65 with potentially disabling conditions, and

1 individuals with mental illness, SED, or SUD.

2 On this graph, we're showing the distribution of
3 gender across Medicaid and HCBS users, which was fairly
4 similar across all groups, with the exception of older
5 adults where females account for the largest share compared
6 to other subpopulations.

7 Finally, we're taking a look at the distribution
8 of geographic location, which was also fairly similar
9 across all subpopulations, with the majority of
10 beneficiaries residing in urban areas.

11 We'll now review some high-level findings related
12 to HCBS spending and utilization stratified by taxonomy and
13 by subpopulation.

14 In 2021, there were about 3.3 million HCBS users
15 and \$84 billion in HCBS spending when including data from
16 all 50 states and D.C. Round-the-clock services was one of
17 the most commonly used HCBS taxonomies, with 33.5 percent
18 of users, and it also accounted for the largest share of
19 total HCBS spending, with 44.6 percent.

20 Case management was another taxonomy that was
21 commonly used but comprised a much smaller share of total
22 HCBS spending, with just 2.2 percent.

1 Looking at HCBS spending and utilization by
2 subpopulation, the data show that the largest
3 subpopulations among HCBS users were individuals with
4 mental illness, SED, or SUD, with about 1.4 million
5 beneficiaries; older adults with about 1 million
6 beneficiaries; beneficiaries with I/DD or ASD with about
7 814,000 users; and individuals under 65 with potentially
8 disabling conditions, with about 593,000.

9 The subpopulations with the highest total HCBS
10 spending were beneficiaries with I/DD or ASD, with almost
11 \$44 billion in 2021, and beneficiaries with mental illness,
12 SED, or SUD, with almost \$40 billion.

13 The distribution of HCBS users and expenditures
14 varied by subpopulation. The dark blue bar represents
15 users, and the green bar represents expenditures.

16 As shown on this graph, the I/DD or ASD
17 subpopulation comprised 24.5 percent of users but accounted
18 for the largest share of spending at 52.1 percent, and
19 beneficiaries with mental illness, SED, or SUD, accounted
20 for the second largest share of spending at 47.4 percent.

21 On the next several slides, we will highlight
22 spending and utilization among the four largest LTSS

1 subpopulations for the five most commonly used taxonomies
2 within each subpopulation.

3 On this graph and the following graphs, the dark
4 blue bar represents users, and the light blue bar
5 represents expenditures.

6 Among beneficiaries with mental illness, SED, or
7 SUD, the most commonly used HCBS taxonomy was mental health
8 services and behavioral health services, with 35.7 percent
9 of users. However, the largest share of expenditures was
10 for round-the-clock services at 42.5 percent.

11 Among older adults, the data show that just over
12 half of older adults, at 51.6 percent, used round-the-clock
13 services, which also accounted for the largest share of
14 their expenditures.

15 Compared to other subpopulations, older adults
16 used round-the-clock services and home-based services at a
17 higher rate.

18 Among beneficiaries with I/DD or ASD, similar to
19 other subpopulations, round-the-clock services again was
20 the most commonly used taxonomy, with 36.6 percent of
21 users, and had the highest share of expenditures. Compared
22 to other subpopulations, the I/DD or ASD subpopulation used

1 case management at a higher rate with 32.6 percent of
2 users.

3 And finally, among beneficiaries with potentially
4 disabling conditions, we see that round-the-clock services,
5 again, was the most commonly used taxonomy and accounted
6 for the largest share of spending. Compared to other
7 subpopulations, this group used equipment, technology, and
8 modifications at a higher rate, but this taxonomy accounted
9 for the smallest share of their HCBS expenditures at under
10 1 percent.

11 So, to recap the high-level findings we reviewed
12 today, compared to the overall Medicaid population, HCBS
13 users were older, less likely to identify as Hispanic, more
14 likely to be in the blind or disabled eligibility group,
15 and more likely to be dually eligible for Medicare and
16 Medicaid.

17 And we covered a few specific findings among
18 subpopulations. We discussed their age, race, ethnicity,
19 eligibility groups, and dual eligibility status.

20 In addition, we also discussed how the
21 distribution of HCBS spending and utilization varied by
22 subpopulation, where we found that beneficiaries with I/DD

1 or ASD accounted for the highest share of total HCBS
2 expenditures. And each subpopulation varied in their HCBS
3 taxonomy category utilization, likely reflecting each
4 subpopulation's unique needs. Among most subpopulations,
5 round-the-clock services was the most commonly used
6 taxonomy and accounted for the largest share of
7 expenditures, and case management was another commonly used
8 service but accounted for a small percentage of
9 expenditures.

10 As for our next steps, we welcome Commissioner
11 feedback on the areas of interest based on the data we've
12 presented today. We will develop an issue brief with the
13 high-level findings, and we intend to use the new HCBS
14 dataset for future analyses and publications.

15 And with that, I'll pass it back to you. Thank
16 you.

17 CHAIR JOHNSON: Thank you so much. That was
18 great. I mean, anytime we can get more information about
19 data, we're excited about it. I see the folks over here
20 very happy about it, for sure.

21 So, let me turn it over to the Commissioners.
22 Again, if you all could provide your insights or your

1 thoughts around what's presented and any things we want to
2 go a little bit deeper on as well. So, I'll open the
3 floor.

4 All right, John.

5 COMMISSIONER McCARTHY: One observation and one
6 question. Heidi and I both had the same reaction when we
7 saw that chart where you showed the dual eligibles and
8 using HCBS services, and I think you had something like 90
9 -- was it 92 percent or 99 percent on that chart for older
10 adults? Yeah. I mean, it just goes to show you that work
11 that we've looked at, why it's so important on duals. And
12 you've got a program that basically is paying for all these
13 services, and it's a completely separate program paying for
14 those services. So, I just need to point that out. It's
15 like the work that we do on duals is so important because
16 of that chart there. Also, kind of, in my opinion, calls
17 into question which program should be paying for those
18 services, but we'll talk about that another day.

19 The other one is, if you go back to the charts
20 where you looked at utilization by type and their case
21 management was in there -- so for, like, the I/DD
22 population and the aged population -- keep going. It's the

1 graphs. If I was reading it right, it was only like 32
2 percent of the population was using case management. And I
3 was just wondering if there was something with our data on
4 that that's not being captured or if -- I don't know if
5 Patti might have greater insight into this. Because if
6 you're on an I/DD waiver or in most aged waivers, every
7 year your plan of care needs to be re-looked at. And so
8 usually, there's case management that goes with that. And
9 so, I was just wondering.

10 The dollar amount seems maybe right because
11 states don't pay a lot for that, but the utilization of it
12 seems relatively low in comparison, but what utilization
13 you would think on an annual basis would be. So that would
14 just be a question I would have on our data on that one.
15 Not saying that data's wrong. I was wondering if people
16 are enrolled, for instance, in managed care, if the case
17 management is not being captured because it might be in a
18 cap payment or something like that.

19 CHAIR JOHNSON: Thanks, John.

20 Mike?

21 COMMISSIONER NARDONE: So, I wanted to start with
22 a question. First of all, this is great data. We could

1 spend lots of time on this.

2 I was wondering, can you just help me understand
3 the difference between round-the-clock and home-based
4 services? Are they the same services in terms of, like,
5 personal care or attendant services, but one is continuous
6 around-the-clock versus maybe four hours a day? Is that
7 the main difference? I just want to understand that.

8 MS. BALLWEG: I think we can go back to the HCBS
9 taxonomy and clarify that for you. There are differences,
10 and CMS has a really nice chart that lists them out. So,
11 we can go back and give you a good answer for that.

12 COMMISSIONER NARDONE: Great. Thank you.

13 So, I had a couple of thoughts, too. John, I was
14 wondering -- and I might have missed this when you talked
15 about it -- is there could be -- one of the things I'd like
16 to, if we can explore -- is the difference between the data
17 from MCOs versus fee-for-service, like the distinctions
18 there. I think you raised that in your memo, and I guess I
19 wanted to reinforce that I think that would be very helpful
20 to be able to look at. That might be one of the reasons
21 why you're not picking up case management for people who
22 are in a capitation program.

1 I just wanted to be clear, too. I think it'd be
2 interesting to look at, and I just want to make sure I'm
3 understanding the way your -- the methodology is. When
4 you're looking at the different populations, for the most
5 part, I think those populations would line up into waiver
6 categories. Like, they would be fairly lined up with
7 waiver categories, with the one exception -- and I might be
8 wrong, right? -- being the SMI SED, that those might be
9 actually expenditures that are more across waivers, because
10 you're looking at actual claims, right, in terms of -- so I
11 think it'd be interesting to maybe look at that in terms of
12 the waivers. In other words, where are the SMI
13 expenditures in terms of specific waivers? I think it
14 would be interesting to track that over time, because I
15 assume this is -- and particularly as we look at the aging
16 waivers, is that number increasing? I just think it would
17 be helpful to look at that in terms of the data that you
18 are putting together.

19 And just on the duals point, I think that the one
20 takeaway that I had was just, you know, in addition to
21 John's point, is that the variation in the duals
22 population. We kind of always think -- you know, I think

1 MACPAC has done a good job in the past of, like,
2 recognizing the different subpopulations that are part of
3 that, and I think this data really helps to drive that
4 home. So, thank you.

5 CHAIR JOHNSON: Thank you, Mike.
6 Tricia?

7 COMMISSIONER BROOKS: Just a couple of things.
8 We love data, so thank you for this.

9 Can you go to the graph that was the state
10 distribution, I think? We don't see state names, and I'm
11 really curious here. I mean, my gut reaction is that this
12 might reflect the average median income in a state, you
13 know, for elders or something, that states that have higher
14 income, you know, would have fewer beneficiaries as a
15 share. But do we plan to label the states if we do a brief
16 and include this?

17 MS. LLANOS-VELAZQUEZ: So, I mean, we do have
18 state-level data, but for the purposes of this one, we
19 wanted it to keep it high-level and, like, not focus in on
20 specific states, but for future analyses, that's something
21 we could consider.

22 COMMISSIONER BROOKS: Yeah, I think it would be

1 helpful to have it in the brief.

2 The other thing I think that would be helpful is
3 to understand the average annual cost of beneficiaries
4 compared to who's in HCBS versus institutional care.

5 Thank you.

6 CHAIR JOHNSON: Thank you, Tricia. Great points.
7 Patti?

8 COMMISSIONER KILLINGSWORTH: So, can we go to
9 slide 21? I just want to be sure that I understand the
10 data, because what my brain always tries to do is to total
11 everything up. So, I would expect that these are -- we
12 talk about it being a percent of the total, right? So, I
13 would expect that each of the HCBS users is a proportion of
14 total users and expenditures is a proportion of total
15 expenditures, but the math doesn't work for me, right? So,
16 can you just explain to me what this slide -- how this
17 slide is depicting this information?

18 In the first example, 24.5 percent of what and
19 52.1 percent of what?

20 MS. LLANOS-VELAZQUEZ: Right. So, the
21 subpopulations aren't mutually exclusive. So, when you sum
22 the percentages, it's going to be greater than 100 percent.

1 And so, it's 24.5 percent of all HCBS users for I/DD or
2 ASD. And, you know, for example, like, those beneficiaries
3 could also be in the mental illness, SED, or SUD, so that
4 24.5 percent and the 41.2 percent have overlap. So,
5 they're not mutually exclusive groups, which is why we kind
6 of presented them as separate bars. Does that make sense?

7 COMMISSIONER KILLINGSWORTH: Kind of. It's just
8 really hard to get a sense of what it really looks like
9 then, right? Because I've got 52.1 percent of expenditures
10 being I/DD and 47.4 percent being in the mental illness
11 category. I have no idea sort of what percentage of that
12 is kind of overlap. It just I'm struggling to kind of make
13 sense of it in terms of what it actually means.

14 Maybe I can have an offline conversation with you
15 about that to see if there's a different way, maybe, that
16 we could sort of tease out the details.

17 John, I do think you're right on the
18 administrative services kind of being the explanation on
19 case management. I think especially under managed care, we
20 don't see those services. Case management typically
21 provided as a waiver or HCBS benefit, it's provided as
22 administrative function of the health plans. Sometimes

1 that happens outside of managed care as well.

2 And then, Mike, I think you were also right that
3 the round-the-clock is more like residential kinds of
4 benefits, whereas in-home services are personal care
5 services in the taxonomy code.

6 So many places that we could go with this data,
7 and I want to understand it, make sure that I understand it
8 better before I offer some thoughts about that.

9 CHAIR JOHNSON: Thanks, Patty.

10 Heidi?

11 COMMISSIONER ALLEN: I'm super excited about
12 this. I know it takes a lot of effort to work with the
13 files and make them suitable for rigorous analysis, and I'm
14 just so glad that that investment in time and energy has
15 been made, and then now I think we're going to benefit from
16 it for the next several years.

17 I was really interested. I mean, one of the
18 things that I always notice when I look at data like this
19 is that Medicaid really is serving people who have great
20 disadvantage, and the money is being spent exactly where
21 you would expect it to be spent. So that to me is
22 reflective of Medicaid doing its job, and in particular, I

1 think of the rights of people to not live in institutions
2 and moving from institutional care to the community
3 environment, the least restrictive environment. You see
4 that in the round-the-clock care that people need and are
5 using, and so I think that that's a really interesting
6 subpopulation for comparison, because if you require round-
7 the-clock home- and community-based services, that means
8 without that you would be living in an institution.

9 And so, I think it would be really interesting to
10 see for that population, looking at kind of all the
11 services that they're receiving and comparing that to the
12 cost of people who are in institutional care, because if
13 the numbers are even close, then obviously, the benefit is
14 the least restrictive environment. I mean that's in law.

15 I'd like to understand the mental health,
16 substance use disorder, and SED population more. I'm
17 curious, is this like group homes? What kind of care are
18 these folks receiving in home- and community-based
19 services? I think that's just really kind of something
20 that would be great to understand more since it's such a
21 significant amount of expenditures and participation.

22 I'm wondering if we can observe PACE in this

1 data, because I think that was one of the things when we
2 had the PACE conversation. It was such a beneficiary,
3 beloved program that families and consumers seemed to
4 really love. But there were some questions. Like, nobody
5 really knew what the economics of it were, and so if we can
6 look under the hood of that, that would be great.

7 Then I'm just reflecting on the race-ethnicity
8 slide, and kind of two things come forward to me, a story
9 of advantage and disadvantage, advantage in that you see
10 that whites are disproportionately receiving home- and
11 community-based services and disadvantage that you see the
12 impact of HIV/AIDS on the Black non-Hispanic population.

13 I think that when we collect data on
14 race/ethnicity, it's important for us to kind of think how
15 we can take that further to interpret why it is that you
16 see disproportionality.

17 Some things, we know from epidemiology of who has
18 what disease burden and plays out here, but some of it is
19 not as clear, like why whites would be disproportionately
20 more likely to be receiving home- and community-based
21 services.

22 So that's my thoughts. I'm very excited about

1 this data source and the work that you guys are doing.

2 CHAIR JOHNSON: Thank you, Heidi.

3 Dennis?

4 COMMISSIONER HEAPHY: Thank you. This is great,
5 really great data, but it raised more questions for me.

6 Michael asked about the round-the-clock. I
7 actually looked online to try to find out. It still
8 confused me. What does this mean?

9 And I also was, as I looked at the data, trying
10 to better understand by state, the level of HCBS provided
11 to folks, because we know the distribution of access to
12 HCBS varies by state. And so, what is that variation
13 across the states? Is the data available for that, or is
14 that just beyond the scope of what you're able to do?

15 MS. LLANOS-VELAZQUEZ: Yeah, we have state-level
16 data.

17 COMMISSIONER HEAPHY: Right.

18 MS. LLANOS-VELAZQUEZ: Yeah. So, when you're
19 saying the level of HCBS, are you -- like, can you define
20 that a little more?

21 COMMISSIONER HEAPHY: Sure. So, in one state,
22 personal care kind of services might be 20 hours a week,

1 when in another state, it might be 60 hours a week. And
2 so, when we're looking at distribution of access to HCBS,
3 what does that actually look like? Is that helpful? Can
4 you get down that deep?

5 MS. LLANOS-VELAZQUEZ: Yeah, that's helpful.
6 Thank you.

7 COMMISSIONER HEAPHY: Okay.

8 And one other question. I just can't remember it
9 right now, but I'll get back to the question. It's more
10 about, like, going down to the data to, like, what does all
11 this mean? And that's what I'm trying to figure out.

12 Also, with the race and ethnicity data, what does
13 that actually mean in terms of why aren't folks getting
14 access to these services, especially in light of COVID. We
15 saw what happened there.

16 CHAIR JOHNSON: Yeah. Thanks, Dennis.

17 Any other thoughts or questions?

18 [No response.]

19 CHAIR JOHNSON: All right. Anytime we get more
20 information, we want more information. We have more
21 questions. But I think you have some good questions and
22 some good thoughts to kind of move us forward a little bit

1 more on this, and I'm just excited that we have this
2 dataset to help us with our future projects. So, thank you
3 both for all you're doing to make sure this is happening.
4 We appreciate it.

5 All right. So next up, we're going to have
6 findings from our technical expert panel on HCBS payment
7 policies. This is going to be our last session this
8 morning focused on HCBS, and so Katherine Rogers, our
9 Deputy Director, and Emma Liebman, our Senior Analyst, will
10 be making their way up to talk to us about the findings
11 that they have.

12 [Pause.]

13 **### FINDINGS FROM A TECHNICAL EXPERT PANEL ON**
14 **MEDICAID PAYMENT POLICIES TO SUPPORT THE HOME-**
15 **AND COMMUNITY-BASED SERVICES (HCBS) WORKFORCE**

16 * MS. LIEBMAN: Hi, everyone. It's great to be
17 here. This is both mine and Katherine's first time
18 presenting, so we're excited. Well, I'll speak for myself,
19 but I think we're both excited.

20 Today Katherine and I will be presenting the
21 latest installment of our work on payment approaches to
22 promote the HCBS workforce. This presentation builds off

1 work that kicked off during the November 2023 Commission
2 meeting, and our former colleagues Rob Nelb and Asmaa
3 Albaroudi last spoke to the Commission on this topic in
4 March of this year.

5 And then this fall, Katherine and I held a
6 technical expert panel, or TEP, on HCBS payment, and we'll
7 use this session to share the findings from the TEP and
8 trace the through line in terms of the findings from our
9 previous work as well.

10 Our goal for the conversation today is to discuss
11 next steps for this work, including potential policy
12 options, and we're really looking forward to hearing from
13 the Commissioners about our findings and where they may
14 lead us.

15 So, with that, I'll pass it over to Katherine.

16 * MS. ROGERS: Thanks, Emma.

17 So, to start, just a quick overview of what we'll
18 go over today. We'll provide some policy background on the
19 foundation for this work, including discussion of the HCBS
20 workforce, how Medicaid HCBS is authorized and paid for,
21 and how Medicaid programs set HCBS payment rates. After
22 that, I will turn it back over to Emma, who will go through

1 all that prior work that MACPAC has completed in HCBS
2 payment, which was presented in last year's analytic cycle,
3 and we'll cover the policy issues examined and discussed in
4 that TEP in September. At the end, we'll facilitate some
5 discussion with all of you about the best path forward,
6 next steps.

7 So we'll start with the HCBS workforce. As you
8 all know, Medicaid is the primary payer of formal LTSS in
9 the nation. According to a 2024 MACPAC analysis, some of
10 which you just saw, in calendar year 2021, total federal
11 and state Medicaid spending on HCBS was \$84 billion, as
12 they mentioned, accounting for 55 percent of all Medicaid
13 spending on LTSS and about 18 percent of Medicaid
14 expenditures.

15 The workforce supporting HCBS programs is
16 diverse, serving people across all those LTSS
17 subpopulations and assisting Medicaid beneficiaries with a
18 wide range of services and supports, also as discussed in
19 the last presentation. This includes performance of
20 activities of daily living and including a growing number
21 of independent providers working in self-directed models,
22 like you heard about yesterday.

1 HCBS workers also work in a range of settings,
2 including group homes, assisted living facilities,
3 individuals' homes, and more.

4 All states have reported shortages in some corner
5 or multiple corners of their HCBS program. And while HCBS
6 workforce challenges predated the COVID-19 public health
7 emergency, there's widespread evidence that significantly
8 exacerbated these challenges.

9 HCBS is, of course, delivered differently in
10 different states. There are a number of different
11 authorities under which state Medicaid programs can design,
12 deliver, and pay for LTSS in home- and community-based
13 settings. These authorities all intersect with states' use
14 of Medicaid managed care as well, since HCBS is delivered
15 through both fee-for-service and managed care delivery
16 systems, depending on the state jurisdiction.

17 The intersection of delivery systems, HCBS
18 authorities, self-direction, provider types, and payment
19 rates means payment for HCBS may look different state to
20 state, and it is fairly complex.

21 A note that our focus here today is primarily on
22 fee-for-service payment policy, as that is set by states

1 and providers are paid directly by states, but it's
2 important to understand that fee-for-service payment policy
3 has downstream effects to both managed care provider
4 payments and self-directed provider payments, through
5 budget-setting processes, for example.

6 States also feel the effects of cross-program
7 shifts; for example, workforce shifting from an agency
8 model to a self-directed model. So we can't ignore the
9 entire HCBS payment ecosystem as we go here.

10 While payment rate models and rates themselves
11 vary across service types, for example, day programs versus
12 personal care aides, those models generally, like other
13 Medicaid services, rely on several key components of the
14 service model and data on those inputs. Many LTSS or
15 labor-driven service delivery, and so worker salaries or
16 wages, often comprise usually the largest share of payment
17 rates. These may also be governed by local or other laws
18 regarding minimum wages overall or within a sector.

19 Other employee-related expenses, such as training
20 or benefits, comprise another component, and these may vary
21 based on the provider, provider type, or setting.

22 HCBS providers have program-wide expenditures,

1 such as transportation, program support, administrative
2 support, including medical records management, compliance,
3 incident reporting, and more.

4 Providers obviously make independent decisions
5 about their own agency policy, though the May 2024 Medicaid
6 access rule established a reporting requirement and a
7 standard for certain HCBS to ensure at least 80 percent of
8 Medicaid payment rates were directed to worker wages and
9 compensation.

10 From a policy perspective, the requirements for
11 formal rate reviews vary. Only 1915(c) actually specifies
12 the periodicity required for the rate review from the
13 federal side. There are no requirements specified for the
14 type of rate review, the content of the rate review, for
15 any HCBS authority.

16 Throughout today's presentation and this work,
17 we'll use a few terms we'd like to clarify here that fall
18 under that umbrella of rate review. When we talk about
19 rate studies, we are talking about comprehensive data-
20 driven evaluations of the payment rate that may result in
21 changes to the fundamental method used to pay for that
22 service or group of services. This may look like the

1 comprehensive work that's conducted at the very outset of
2 implementing a new service and setting a payment rate
3 method in the first instance.

4 States also employ methods for updating rates
5 without fundamentally changing the methodology through
6 indexing or rebasing, and in indexing, we're talking about
7 linking the payment rate to some trend factor, such as a
8 wage standard. In rebasing, we're talking about
9 periodically recalculating the rate without changing the
10 methodology but using new data, such as cost reports or new
11 wage data.

12 Before we zoom in a bit more on the work that
13 we've done across this project, a brief refresher on
14 MACPAC's Provider Payment Framework. This framework is a
15 starting point for assessing how Medicaid payment policies,
16 including here in this project for HCBS, can be used to
17 address the goals of the Medicaid program. In this
18 context, we are focused specifically on how payment can
19 impact access to HCBS.

20 Medicaid statutory objectives for provider
21 payments include economy, a measure of what is spent,
22 efficiency, how what is spent drives what is achieved among

1 the goals of care, and access and quality are measures of
2 what we can obtain from those provider payments.

3 In order to promote access and quality, states
4 can improve payment rates or find ways to achieve more
5 efficiency; that is, obtain more value for the expenditure.

6 Now I'll turn it back over to Emma to continue
7 with the background on MACPAC's prior work and the findings
8 from our TEP.

9 MS. LIEBMAN: Great. Thank you, Katherine.

10 So I will begin with the study approaches and
11 then get into the findings from our past work.

12 During our last Commission cycle, our colleagues
13 contracted with Milliman to develop a compendium of payment
14 policies for HCBS provided under the Section 1915(c) waiver
15 authority, which was then published in January of this
16 year. And then, in an effort to better understand payment
17 strategies that states are pursuing to improve HCBS rate
18 setting, our colleagues also worked with Milliman to
19 conduct interviews with national experts as well as
20 stakeholders in five states.

21 Through the Section 1915(c) compendium, we
22 learned that states have flexibility to define HCBS

1 services, and as a result, service definitions vary
2 significantly across programs and states. For example, our
3 colleagues investigated three broad HCBS taxonomy
4 categories that account for the majority of HCBS spending.
5 Those include home-based services, day services, and round-
6 the-clock care. And the compendium identified 253 unique
7 state-defined services that fit into these three taxonomy
8 categories.

9 We also learned that many states use rate studies
10 to develop and update rates, but there's significant
11 variation in the way that states use this tool. For
12 example, states vary in how comprehensive their rate
13 studies are, so whether they're reviewing services from one
14 waiver or state plan or looking across the board, and how
15 frequently they take on these studies.

16 As we know, there's no CMS requirement around
17 rate studies and few requirements around rate reviews or
18 updates more broadly. So many states don't use rate
19 studies at all or regularly review and update their HCBS
20 rates.

21 States also vary in the extent to which they
22 publicly document their rate study process or results, with

1 some states publishing formal rate study reports and others
2 having very little external documentation.

3 The compendium also shows that even when states
4 do conduct rate studies, they do not always implement the
5 study recommendations.

6 And then the final key takeaway from the
7 compendium was that HCBS worker wages tend to make up the
8 largest component of the HCBS payment rate, and states tend
9 to rely on several data sources to develop wage
10 assumptions, most notably Bureau of Labor Statistics Data,
11 or BLS data. However, BLS data does not have a
12 classification for HCBS workers. So states use other BLS
13 categories as proxies for HCBS workers.

14 Moving on to our interview findings, our
15 colleagues found that rate setting is the primary strategy
16 that states use to address HCBS workforce challenges. When
17 designing and updating rates, the national and state
18 stakeholders we interviewed stressed the importance of
19 comprehensive data-driven and aligned rate assumptions and
20 regularly updating rates to account for a changing policy
21 environment using tools like rate studies, indexing, and
22 rebasing.

1 In particular, the interviewees discussed the
2 fact that there is significant variability in rate
3 assumptions that can incentivize workers to switch to
4 higher-paying services, which can create access challenges.

5 Interviewees identified rate studies as an
6 important mechanism for ensuring that rates are designed in
7 an aligned manner and include all of the relevant inputs to
8 promote adequate workforce participation. However, the
9 interviewees also identified some of the drawbacks of rate
10 studies, including how resource-intensive they can be.

11 They also resurfaced the point that rate study
12 recommendations are not always implemented, largely due to
13 budget constraints.

14 Finally, the interviews also covered potential
15 non-financial strategies for promoting the HCBS workforce,
16 such as workforce training and credentialing programs,
17 public campaigns to encourage workforce participation, and
18 promoting the use of family caregivers to supplement the
19 HCBS workforce.

20 Overall, though, the interviewees did not share
21 much evidence regarding the effectiveness of these
22 strategies.

1 Moving on to our most recent phase of work on
2 this topic, I'll now run through the approach and findings
3 from our technical expert panel.

4 Similar to our previous work, we contracted with
5 Milliman to help us home in on some of the most promising
6 payment strategies that states may consider when setting
7 HCBS rates and how those rates may be developed and updated
8 over time. We also carved out some space to consider
9 payment strategies beyond rate setting.

10 We held our TEP in September with participation
11 from CMS officials, plan associations, actuaries, and
12 consumer representatives, and overall, as was mentioned
13 earlier, many of our findings corroborated and built upon
14 what we learned from our previous work on this topic.

15 Over the course of the next few slides, I'll
16 review the key findings from the TEP.

17 Our first key finding was the importance of
18 comprehensive rate assumptions. Today HCBS wage
19 assumptions and rates may not reflect the full range of
20 inputs necessary to provide care to beneficiaries. For
21 example, the rates may not include the professional skills
22 and responsibilities that one type of HCBS worker provides

1 versus another. They may also not reflect the time that
2 HCBS workers spend conducting program activities beyond the
3 direct provision of care, such as completing incident
4 reports or progress notes. And rates may also not reflect
5 variations in patient acuity or additional costs associated
6 with providing care to certain beneficiaries, such as
7 translation services or travel needed to reach rural
8 beneficiaries.

9 The TEP participants identified several
10 strategies that states may use to ensure that these inputs
11 are included in the rates, such as productivity
12 adjustments, local payment rate adjustments, or code
13 modifiers.

14 The next key finding, which mirrors findings from
15 our previous work, is the importance of aligned rate
16 assumptions. There is significant variation in payment
17 rates across HCBS delivery models, programs, and geographic
18 regions, meaning that rates for the same or similar
19 services may differ from one model to the next.

20 Wages may also differ due to underlying rate
21 differences or minimum wage variations across states and
22 counties.

1 As we discussed earlier, these rate variations
2 can lead HCBS workers to participate in models or programs
3 that offer the highest wage, which can create access
4 challenges.

5 TEP participants also noted that incentives based
6 on rate variations extend beyond HCBS into the LTSS system
7 more broadly and emphasized the importance of considering
8 rebalancing efforts in the rate-setting approach.

9 TEP participants, like our previous interviewees,
10 encourage states to use alignment and variation
11 strategically to incentivize adequate workforce
12 participation according to beneficiary need.

13 In considering how to achieve comprehensive and
14 aligned rates, TEP participants identified the importance
15 of strong data. As we discussed earlier today, HCBS
16 service definitions and the way that these services are
17 reported varies across states and HCBS programs. Without
18 clarity about what each service entails and how services
19 differ from one another, it's really challenging to build
20 or fund appropriate rates.

21 TEP participants also discussed the lack of a
22 single reliable data source for HCBS worker wages across

1 states and HCBS programs, which surfaced during the
2 compendium findings as well.

3 Again, without timely and accurate base data from
4 CMS or at the state level, it's challenging to build
5 appropriate wage components into the payment rates.

6 The 2024 Medicaid access rule, among several
7 relevant provisions, requires public reporting of direct
8 care worker compensation and hourly rates for key HCBS
9 services. So this rule may improve HCBS data transparency
10 and standardization. However, the impact of the rule is
11 yet to be seen, and there may be further opportunities for
12 CMS to improve data, including around service definitions
13 and wage assumptions.

14 Moving to the next finding, consistent with our
15 earlier findings, the TEP participants emphasized rate
16 studies as an effective tool for building rates, as well as
17 identified some of the challenges associated with this
18 tool. Namely, rate studies require significant time and
19 energy inputs from a variety of stakeholders, including
20 providers, legislators, Medicaid agency staff, et cetera,
21 which can create a real administrative burden.

22 As we discussed before, budget constraints may

1 also mean that even when rate studies are conducted, their
2 recommendations may not be implemented. And then on the
3 flip side, tight budgets might mean that implementing rate
4 recommendations leads to unintended consequences, such as
5 implementing utilization limits or program wait lists.

6 With all of that in mind, TEP participants
7 encouraged CMS or states to identify the right cadence for
8 rate studies that balances their benefits and drawbacks.
9 For example, some participants suggested staggering the use
10 of rate studies across HCBS services to reduce
11 administrative and financial burdens. However, other
12 participants emphasized that rates should be updated in
13 tandem, given the interconnectedness of the HCBS system.

14 TEP participants pointed to indexing and rebasing
15 as less burdensome tools for ensuring that HCBS rates are
16 updated over time but noted that budget constraints may
17 still affect the ability to implement rate updates.

18 Additionally, because indexing and rebasing do
19 not update the rate methodology, they run the risk of
20 locking in outdated rate structures. For that reason, TEP
21 participants agreed that indexing and rebasing are tools
22 that CMS could require or states could opt to use in tandem

1 with or in the interim between rate studies rather than
2 instead of rate studies.

3 Finally, the TEP discussed payment strategies
4 beyond rate-setting approaches, such as wage add-ons,
5 covering technology to promote remote care, value-based
6 payment approaches, and state-directed payments.
7 Generally, the strategies that states have adopted to date
8 have relied on enhanced funding through the American Rescue
9 Plan Act, which is running out in the next few months. So
10 we'll have to monitor to determine whether these strategies
11 will continue to be funded out of state budgets.
12 Additionally, states offered mixed opinions when it came to
13 success of these strategies.

14 So having discussed our key findings, we'll now
15 move on to the next steps for this work.

16 Overall, we'd like to use the rest of the time to
17 hear from the Commissioners about how we may use TEP
18 findings to inform MACPAC's future work in this area,
19 including potential policy options. We've laid out five
20 specific questions for the Commissioners' consideration
21 today.

22 For the first and second question, as we

1 discussed, only HCBS programs operated through Section
2 1915(c) waiver authority are required to review their
3 rates, and as a result, many states do not regularly review
4 or update their HCBS rates.

5 Additionally, even where rate reviews are
6 required, there are few specifications regarding what
7 constitutes an adequate rate review.

8 With that in mind, we'd like to discuss whether
9 more HCBS authorities should be required to conduct rate
10 reviews with some baseline frequency and what rate review
11 requirements might look like, including what could be made
12 public in terms of rate review methodology and outcomes.
13 For example, given the various benefits and challenges of
14 rate studies, indexing, and rebasing, how should these
15 mechanisms fit into rate requirements?

16 Moving to the third question, we discussed that
17 HCBS payment rates and wage components may not reflect the
18 full extent of HCBS worker contributions, which has
19 implications in terms of workforce participation. We'd
20 appreciate Commissioner input on whether there's a role for
21 CMS to support states to ensure comprehensive wage
22 assumptions.

1 Next, for question 4, lack of alignment across
2 rates can lead HCBS workers to be paid different rates for
3 the same or similar services, and lack of consistent
4 service definitions across HCBS programs complicates this
5 issue. We're hoping to discuss the role of CMS or states
6 to improve rate alignment where appropriate, including
7 potentially by supporting more consistent service
8 definitions across programs.

9 And finally, we've heard repeatedly that states
10 lack clear and consistent wage data on which to build HCBS
11 payment rates. We'd like to discuss the role for CMS,
12 Congress, or states in promoting and maintaining sufficient
13 wage data.

14 As we move forward on these main findings, there
15 are also a couple of areas that we're planning to continue
16 to monitor, namely whether states continue to finance
17 payment strategies adopted through ARPA funding, any
18 further evidence on the impact of non-rate-setting
19 strategies to promote the HCBS workforce, and finally, the
20 effects of payment adequacy and reporting requirements
21 included in the access rule on HCBS data transparency and
22 standardization.

1 So, with that, I will turn it back to our Chair
2 and look forward to hearing the Commission's thoughts on
3 our findings as well as the five questions posed here.

4 CHAIR JOHNSON: Thank you so much, Katherine and
5 Emma. Great job for your first time up for sure.

6 All right. So let's keep it on the slide, and
7 let's see if we have any feedback from the Commissioners,
8 obviously on the entire presentation, but also on these
9 five questions that they're asking us.

10 Heidi.

11 COMMISSIONER ALLEN: So thank you for this work,
12 and I am looking forward to discussing potential policy
13 options.

14 We've been talking about this issue for multiple
15 years, and the thing that always just rises to the top to
16 me is this is not a career that people would counsel their
17 children into. And as long as that's the case, we're
18 always going to have a workforce issue for the rates that
19 people are paid, the wages that they're paid. They could
20 do jobs that are just so much less physically and
21 emotionally demanding and require less skill.

22 And so why would you lift somebody up and down

1 multiple times a day versus be a greeter at Walmart? It's
2 just if you're making the same money, and I think that we
3 constantly struggle with that. So I think of other
4 difficult jobs that we've invested in as a society to make
5 them worthy of people wanting to do that, like teachers.
6 Teaching is a job that people want to encourage their kids
7 to, but it comes with really good benefits. So the
8 salaries are not as high as you would get if you're a
9 physician or a lawyer, but you're going to have a really
10 good middle-class, stable career. And I think that this is
11 a difficult middle-class, stable career for people.

12 And just listening to Robert testify yesterday
13 about the people who work for him and who have worked with
14 him for years can't take sick leave, they don't have
15 vacation time, they can't take family leave or paternity or
16 maternity leave, they don't get retirement benefits, they
17 don't get vacations, they don't have health insurance. And
18 I just feel like we could continue to kind of demand that
19 home- and community-based service agencies try to funnel
20 more money to employees, and that definitely seems worth
21 doing.

22 But I wonder if there's any other way that the

1 state would want to say we need to invest in this workforce
2 by giving them a career pathway and thinking about that. I
3 mean, I know it's a total wild idea, but thinking of the
4 potential pathway for public employees, for people to go
5 into it as a long-time career. You know, it does feel like
6 sometimes we just have to do big thinking, and with the
7 aging of the population and more people wanting to stay
8 home -- and we certainly don't want the aging of the
9 population to mean that more people have to spend down to
10 go into institutional care -- we have to figure out a way
11 to make this a career that people would want to go into and
12 that would be sustainable for an American family.

13 And so I know we're working around the margins
14 here of like what exists, but I do think that framing to
15 Congress, you know, that it is time for big-picture
16 thinking. It is time for us to think about, you know, the
17 fact that we need this workforce in place more and more
18 every year, and it's going to require some definite action.

19 CHAIR JOHNSON: Thank you, Heidi.

20 Patti?

21 COMMISSIONER KILLINGSWORTH: This is a
22 challenging topic, and I agree that it's a really, really

1 important topic, probably one of the, if not the, most
2 significant challenge facing states in delivering home- and
3 community-based services.

4 I want us to be careful that we stay in our lane
5 and that we -- you know, our role is to think about
6 recommendations that would help to ensure the adequacy of
7 funding and payment for the services, including the payment
8 to the direct care workforce, without kind of becoming
9 overly prescriptive and, you know, starting to suggest, for
10 example, that services should -- that states should use the
11 same service definitions and they should all pay the same
12 way. And I think that may be stepping beyond the scope of
13 our statutory responsibility.

14 Completely agree that we need a -- that we need
15 more transparent, accountable reporting of both payments
16 and costs for these services that can help to enable a
17 complete understanding of whether Medicaid payment is
18 adequate for these services. I think that needs to be a
19 data-informed approach that just currently doesn't exist,
20 right, because we don't know what the workforce is paid,
21 and so some sort of way of gathering that information, I
22 believe, at a state level, because it is states that are

1 responsible, you know, for setting the rates or for
2 informing that process when we're talking about managed
3 care reimbursement. I just think that has to happen at a
4 state level.

5 I do think it's important that there is a
6 consistent approach across long-term services and supports
7 broadly as it relates to nursing facilities as well as HCBS
8 programs, providers, and populations because they share a
9 common workforce. They share common workforce challenges,
10 and the last thing that we would want to do is sort of
11 favor one over the other and create access issues in
12 another area of the Medicaid program.

13 Completely agree that we -- so Heidi talked about
14 sort of this, you know, kind of the challenge of this, the
15 nature of the work and kind of the way that it's set up,
16 but there's a bigger problem we haven't talked about. And
17 it's sort of like it's the reality of the demographics of
18 an aging population, where if you look at the population of
19 people projected to turn 65, projected to turn 85, those
20 numbers are going up, up, up. Those are the people most
21 likely to need long-term services and supports. By the
22 way, people with disabilities living longer and longer, all

1 good things, but then if you look at the demographics of
2 the workforce age population, the age of people who would
3 be most likely to deliver these services, it's kind of
4 flat, right? So we have this practical issue of we don't
5 have enough people, and it doesn't matter what you pay
6 them. We don't have enough people to deliver all of the
7 supports that individuals need. We don't have enough
8 people to staff restaurants. We don't have enough people,
9 right?

10 I mean, we're seeing it kind of everywhere, but I
11 think it's acute because of the nature of these particular
12 services that are provided and how critically important
13 they are for people's needs to be met on a day-to-day
14 basis.

15 I agree with Heidi that the notion of career
16 pathways is really, really important for this workforce so
17 that it's not a dead-end job, if you will. We have the
18 ability to sort of draw people into the field and help them
19 feel like it is something that allows them promotional
20 kinds of opportunities.

21 I do think there's opportunities for expanded
22 scope of practice for the direct care workforce to really

1 encompass things like medication administration and the
2 performance of routine health care tasks, things that sort
3 of elevate that role and then would come with, hopefully,
4 commensurate increases in pay because it would be a more
5 cost-effective way of meeting those kind of routine needs
6 when they're in the home.

7 But I think as a practical matter, we do also
8 have to look beyond workforce solutions to alternative ways
9 of ensuring that people have access to the supports they
10 need. We talked a little bit about remote supports. There
11 are all kinds of assistive technologies, but we cannot --
12 no matter how we set reimbursement for this workforce, we
13 are not going to solve what is a fundamental demographic
14 challenge in this country.

15 We are going to have to look to alternative ways
16 in addition to, right? So we need to look at the adequacy
17 of payment, but we also need to recognize this is not a
18 solution -- or this is not a problem that will be solved
19 through a single solution related to paying the workforce
20 more. It's much bigger than that.

21 CHAIR JOHNSON: Thanks, Patti.

22 It seems like a lot of forums we talk; we hear a

1 lot about the career pathways, and I'm just curious too.
2 Have we seen that work? Have we seen examples of how
3 states have utilized that tool to get more people involved
4 in the series? Just things to think about.

5 Dennis?

6 COMMISSIONER HEAPHY: Thank you.

7 I agree with much of what Patti said and also
8 Heidi, but I do think we need some standard definitions
9 across states of what it means to be a direct service
10 worker. There's a person, like a personal care attendant,
11 providing direct services in the home versus a homemaker
12 versus -- I don't know -- and versus someone who's working
13 in a day hab. So, like, having definitions, I think, would
14 be really helpful. So there's some standardization at
15 least for the collection of data.

16 I also think that it would be helpful to have
17 some data on the variation in wages across the state --
18 across the country, because we get some sense of what the
19 variation looks like, understanding that, you know, there
20 are variations in income across different states as well.
21 But I think I would love to see more data on what people
22 are actually getting paid.

1 And the third thing is Medicaid. A lot of the
2 folks that either don't have insurance or they're on
3 Medicaid, and actually increasing the income would cause
4 harm to those folks. And so how do -- you can capture some
5 of that data and say, you know, where might it be -- how
6 are we going to make sure that those folks don't get harmed
7 and they're not going to lose their medical insurance
8 because their payment rate is going to go over what
9 Medicaid allows? So those are a couple of thoughts I had.

10 Thank you. That was really great.

11 It's a crisis. I know that Patti talked about
12 it. We really are in a crisis. So we should find every
13 way to address this.

14 And states are really overburdened, and so is
15 there a role for others to help states with their payments?

16 Thanks.

17 CHAIR JOHNSON: Thank you, Dennis.

18 Tricia?

19 COMMISSIONER BROOKS: Building on what Dennis was
20 saying about variation by state of payment rates, I'd be
21 interested to compare that to the penetration of HCBS
22 services compared to institutional to see if we can

1 illustrate the correlation between payment and how far you
2 can get in serving your population in the community.

3 The other thing that was the first thought I
4 wanted to share; I know that Pam is a caregiver herself.
5 She's obviously very sophisticated and experienced in that
6 work, but I would love to hear from a panel of caregivers
7 themselves. I'd like to hear the challenges and the hopes
8 that they would have in doing that work and what the
9 barriers are. I think that would be very interesting.

10 Thank you.

11 CHAIR JOHNSON: Thank you. That's a great
12 suggestion, Tricia.

13 Jami?

14 COMMISSIONER SNYDER: Thanks so much for this
15 work.

16 I had a question actually on slide 18. You
17 talked a little bit about some of the payment strategies
18 that states have employed using Rescue Plan Act dollars.
19 It sounds like the TEP had a bit of discussion around state
20 efforts to extend some of those strategies or financing
21 efforts. Can you provide any more detail? I'm just
22 curious because we are coming to that, sort of that end

1 point on March 31st of 2025 when the funds either need to
2 be used or they're no longer available to states, what
3 states are doing to make those payment strategies and
4 financing efforts available beyond that time.

5 MS. LIEBMAN: Anecdotally, we heard from some
6 states that there is an interest in continuing, and we
7 heard that from some CMS leadership as well. But we don't
8 have any specifics in terms of what states will be capable
9 of.

10 I think there is some data about state intentions
11 to continue some of the strategies adopted during ARPA. I
12 don't have that in front of me at this moment, but I can
13 get back to you on that.

14 However, I think it's still kind of yet to be
15 determined in terms of whether states will really be able
16 to follow through on those intentions.

17 COMMISSIONER SNYDER: Yeah, I guess given that
18 the deadline is looming, I think that's something that
19 might be interesting for a panel presentation over the
20 course of the next couple of months, looking not only at
21 what states are doing to extend some of the financing and
22 payment strategies, but also how states used Rescue Plan

1 Act funding to extend non-financial strategies to address
2 the kind of workforce concerns. Have we sponsored that
3 type of panel?

4 EXECUTIVE DIRECTOR MASSEY: Just as a reminder,
5 we have HCBS ARPA monitoring as an ongoing activity. We
6 did have the panel last analytic cycle where we reviewed
7 what efforts were being done at a federal and a state level
8 about evaluating the investments made. We are still
9 monitoring those activities, and we do plan on wrapping up
10 the monitoring once states complete the run out of those
11 funds, but we can take it under advisement.

12 COMMISSIONER SNYDER: Okay, great. Thank you.

13 CHAIR JOHNSON: Thank you.

14 Carolyn?

15 COMMISSIONER INGRAM: Thank you.

16 Thanks for continuing to put this together and
17 bring it to us.

18 A couple of questions I had, just back to
19 comments that I think my colleagues have had around, you
20 know, states are very strapped. The system is very
21 strapped. Are there other ideas or things that we can look
22 at, a little bit to what Jami was talking about, to remove

1 barriers or other tools that are used besides just the
2 rates and the financial reimbursement?

3 And I don't know if that fits under the scope of
4 this, but I'm thinking of things like scholarship programs
5 or some of the items our colleagues brought up about, you
6 know, further training or things like that that help make
7 it easier for people rather than just the financial rate
8 discussion about can we keep just reviewing rates and then
9 find out they're not adequate, but then what is going to
10 happen with that? Are there other tools that can be
11 employed?

12 CHAIR JOHNSON: Thank you, Carolyn.

13 John and then Angelo.

14 COMMISSIONER McCARTHY: A couple of things. One,
15 great work, and this is a super complicated subject.
16 Having been one of the consultants who set rates way before
17 I was Medicaid director and then doing these things and
18 building them from the ground up, it is always difficult to
19 do those and try to hit on those. So I think you hit on
20 almost every topic I would have brought up.

21 There's just a couple, though, that I also wanted
22 to bring up, and that is, one, when designing rates, you

1 can design rates that hit all of those topics that you
2 talked about, right, which you had the different issues
3 around travel or experience, things like that. The issue
4 then becomes the rates become so complex that providers get
5 upset because you'll have a rate chart of like a thousand
6 different rates that you'd have to bill for each person.

7 So just little things, like when a person starts,
8 they might be making -- I'll make it up. I don't know what
9 the numbers are, but they could be making \$12 an hour, but
10 if they're in the job for five years, they might be making
11 \$18 an hour. So how do you have a rate that takes all of
12 that into consideration?

13 There's also the issues you run into around when
14 you're rate setting. As it was talked about, you're
15 setting rates for the I/DD waiver, but the aged waiver
16 isn't doing rate updates, especially around nursing
17 services. Nurses can go to hospitals. Those are really
18 hard rates to set because of all the different places and
19 the fact that you've got more commercial payers in
20 hospitals and some other places. So you're competing with
21 the commercial market also, which we're also starting to
22 see competition for commercial market in just home- and

1 community-based services, right, because many people, as
2 we're aging, are getting HCBS services not through
3 Medicaid, just through private pay.

4 One of the last things is I know a couple of
5 people brought up, they want to see what people are
6 actually paid or cost reports. Cost reports are also a
7 little bit dangerous to work with from the standpoint of
8 you're looking at costs. If you're setting rates off of
9 costs, then there's the incentive to continue to just raise
10 costs. You might say, well, wait a second, the rates don't
11 cover it.

12 But I'll just give you examples of when I was
13 doing this, and you would have two entities. One is a
14 nonprofit who can do fundraising. So when we were looking
15 at cost reports, we couldn't figure it out. Their costs
16 were twice that of other entities, and we were like, how
17 can they be staying in business? Well, it's because they
18 did fundraising, and so do you take those costs that are
19 twice as high and average it into the rates, but then
20 you're underpaying them but overpaying other people? So
21 again, it's very complicated in some of these things.

22 I think the questions you have are good questions

1 for us to take a look at, but it is a very complex subject
2 when we get into some of these, and it will be interesting
3 to see what our recommendations are.

4 COMMISSIONER GIARDINO: Again, thank you for the
5 work.

6 I wonder if -- you know, looking at some of your
7 questions, you've talked about CMS and Congress. I wonder
8 if we can also look at other entities in the federal
9 government that may be commenting on some of this. Like,
10 this workforce issue is certainly related to Medicaid, but
11 it's a much bigger issue than Medicaid, and I think Patti
12 was referencing some of that.

13 I don't know. I assume it's the Department of
14 Labor, the Department of Commerce. I mean, there's other
15 entities that I think are looking at workforce issues, and
16 I wonder what the key drivers are to Heidi's point of
17 making this a middle-class career.

18 There are experts in how the workforce works, and
19 I don't think that's a domain of Medicaid. So can the
20 federal government help us so that we could be efficient
21 here? So what are the three, five, seven things that you
22 have to do to make a career pathway?

1 And we might have a little role in Medicaid to
2 suggest something related to the rates, but there are many,
3 many other domains related to the workforce. I'm sure
4 you're aware in mental health, for example, many of the
5 states are coming up with different pathways for licensure
6 and approving people to work in mental health because
7 there's such a crisis there.

8 But I would just encourage us to look to the
9 federal government, which you're part of and we're part of,
10 and see what else they're doing because I suspect there's
11 like a 30-page report from the Department of Labor in how
12 to fix one of these frontline positions. So if you could
13 just look at that, that would be helpful.

14 CHAIR JOHNSON: Thank you, Angelo.

15 Dennis?

16 COMMISSIONER HEAPHY: Thanks.

17 I'd also like to see what percentage of folks are
18 full-time versus part-time. I don't know if you can access
19 that data or not, but I think that makes a difference. And
20 I think that's it.

21 CHAIR JOHNSON: All right. Thank you.

22 All right. Any other follow-up questions from

1 anyone else?

2 [No response.]

3 CHAIR JOHNSON: Okay. All right. Well, thank
4 you both again for this great session. We appreciate it.

5 MS. ROGERS: Thank you.

6 MS. LIEBMAN: Thank you.

7 CHAIR JOHNSON: Okay. So you know the holidays
8 are upon us when you get your MACStats. So really looking
9 forward to Asher and Chris walking us through some of the
10 highlights.

11 **### HIGHLIGHTS FROM THE 2024 EDITION OF MACSTATS**

12 * MR. WANG: Hi. Good morning, Commissioners.

13 Today I'll be presenting on our key findings from
14 the 2024 edition of MACStats, our Medicaid and CHIP data
15 book. This year's MACStats is scheduled for release next
16 Wednesday, December 18th, and for members of the public, we
17 will have MACStats both compiled as the published book and
18 separated into individual tables on our websites. Most of
19 the tables will have both Excel and PDF versions for your
20 convenience.

21 MACStats is our regularly updated end-of-the-year
22 publication that compiles a broad range of Medicaid and

1 CHIP statistics from multiple data sources, including
2 census, enrollment, survey, and national- and state-level
3 administrative data.

4 Listed on the slide above are the six sections of
5 MACStats. Key statistics of this year's MACStats show
6 similar results to last year. These key statistics focus
7 on Medicaid and CHIP enrollment spending compared to other
8 payers, Medicaid's share of state budgets and more.

9 In fiscal year 2023, over 32 percent of the U.S.
10 population was enrolled in Medicaid or CHIP at some point
11 during the year. Looking at the state-funded portion of
12 state budgets, Medicaid was a smaller proportion compared
13 to elementary and secondary school education. Medicaid and
14 CHIP combined were a smaller share of national health
15 expenditures when compared with Medicare as well.

16 And moving on to the trends in Medicaid and CHIP
17 enrollment over time, we can see the impact of policy
18 responses and the unwinding. Compared to July 2013,
19 Medicaid and CHIP enrollment was around 38 percent higher
20 in July 2024. Most of this increase happened during the
21 initial years after the bulk of the ACA expansion.

22 Enrollment in Medicaid and CHIP had peaked during

1 the continuous coverage requirement, and most recently, as
2 states began to redetermine eligibility for beneficiaries
3 following the end of the continuous enrollment requirement,
4 the number of Medicaid and CHIP enrollees have
5 significantly declined.

6 From July 2023 to July 2024, enrollment in
7 Medicaid and CHIP decreased by around 14 percent, or 12.5
8 million enrollees. This follows a 2 percent increase in
9 Medicaid and CHIP enrollment from July 2022 to July 2023.

10 Looking further into growth trends, this graph
11 shows growth trends in Medicaid enrollment and spending.
12 Overall, spending and enrollment have had complementary
13 trends, both rising and falling in tandem. The trends
14 reflect policy changes and economic conditions, such as
15 economic recessions and policies to expand and preserve
16 Medicaid coverage.

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

1 smaller share of the federal budget than Medicare.

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

9 We also looked at various characteristics of
10 program enrollment and spending. As of July 2022, nearly
11 three-quarters of enrollees were enrolled in comprehensive
12 managed care, and this accounted for over 50 percent of
13 Medicaid benefit spending.

14 LTSS users accounted for only 4.8 percent of
15 Medicaid enrollees but almost 30 percent of all Medicaid
16 spending. That is, \$219 billion was spent on services for
17 these 4.5 million enrollees. I will note that this
18 estimate only includes enrollees using LTSS services under
19 fee-for-service arrangements and does not include those
20 receiving LTSS under a managed care arrangement.

21 In fiscal year 2022, the new adult group, which
22 applies to states that have expanded Medicaid, accounted

1 for about 26 percent of Medicaid enrollees and 23 percent
2 of spending.

3 In fiscal year 2023, drug rebates reduced gross
4 spending by about 51 percent. We also saw that in fiscal
5 year 2023, DSH upper payment limit and other types of
6 supplemental payments, such as those made under Section
7 1115 waivers, accounted for over half of fee-for-service
8 payments to hospitals.

9 Total spending for full-year equivalent enrollees
10 across all service categories ranged from \$3,786 for
11 children to \$25,483 for the disabled eligibility group.
12 Spending for managed care capitation payments was the
13 largest service category across all eligibility groups.

14 In 2023, we saw that 35 percent of Medicaid
15 enrollees had annual incomes less than 100 percent of the
16 federal poverty level, and 50 percent had incomes below 138
17 percent of the federal poverty level.

18 As of July 2024, 40 states and D.C. have expanded
19 Medicaid and now cover the new adult group, which is one
20 more state than last year.

21 MACStats also reports on beneficiary health,
22 service use, and access to care using survey data from the

1 National Health Interview Survey and the Medical
2 Expenditure Panel Survey.

3 In 2023, children and adults with Medicaid or
4 CHIP coverage were less likely to be in excellent or very
5 good health than those who have private coverage. Children
6 with Medicaid or CHIP coverage were as likely to report
7 seeing a doctor or having a wellness visit within the past
8 year as those with private coverage and more likely than
9 those who were uninsured. And while most children with
10 Medicaid or CHIP had coverage had a usual source of care,
11 they were less likely to have one compared to children with
12 private insurance.

13 Children and adults with Medicaid or CHIP
14 coverage, we also saw were as likely to report no
15 difficulty reaching their usual medical provider by phone
16 during business hours as those covered by private
17 insurance.

18 And this is our figure notes and sources. Thank
19 you.

20 CHAIR JOHNSON: All right. Thank you very much.

21 All right. Any questions or insights from the
22 Commissioners?

1 Yes.

2 COMMISSIONER GIARDINO: I just want to thank you
3 for MACStats. Many of the people I work with really look
4 forward to the publication of the statistics, and they use
5 it in both their advocacy and academic work. So it's
6 really become an authority in the field. So your effort is
7 really very much appreciated. Thank you.

8 CHAIR JOHNSON: Thanks, Angelo.
9 Patti?

10 COMMISSIONER KILLINGSWORTH: I certainly echo
11 that.

12 I have a quick question about managed care data
13 since in one of the bullets you talked about it not
14 reflecting managed care expenditures. So tell me a little
15 bit about what to expect related to that.

16 MR. WANG: Yeah. So, the LTSS number that we
17 reported was only for fee-for-service. But now that we've
18 done the HCBS data run, we're planning to include the
19 identification of LTSS managed care in our spending. And
20 in the future, we may consider also breaking down the
21 spending distribution of managed care. But it can become
22 difficult when we're accounting for things like directed

1 payments and supplemental payments in managed care. But
2 it's definitely something that we're considering for the
3 future.

4 COMMISSIONER KILLINGSWORTH: Okay. Good. Thank
5 you.

6 CHAIR JOHNSON: That's great. Thank you.

7 Jennifer. Jenny.

8 COMMISSIONER GERSTORFF: I may not be
9 right, but I'm remembering that MACStats in the past has had
10 information on third-party liability coverage. Is that
11 right?

12 MR. PARK: Yeah, that's right. We haven't broken
13 out third-party liability.

14 COMMISSIONER GERSTORFF: Okay. So I was just
15 thinking now that we have T-MSIS data, it gets better all
16 the time, it might be useful to evaluate T-MSIS to see if
17 it's worthwhile to try to summarize that information into
18 charts for MACStats in future years.

19 CHAIR JOHNSON: Thanks, Jenny. Good call-out.
20 Heidi?

21 COMMISSIONER ALLEN: Thank you, Asher and Chris.
22 I love MACStats.

1 Could you in future years consider in that chart
2 that shows the spending in the services over time, have a
3 separate category for duals? I just think that it's
4 important with the aging of the population and the trends
5 of more people receiving long-term services and supports in
6 Medicaid to make clear that that is a shared relationship
7 with the Medicare program. I think that there's a
8 misconception among the public that Medicaid spending is
9 growing so much because of the non-categorically eligible
10 adult population or expansions to children or expansive to
11 postpartum people.

12 But I think it's, as we know, the dual population
13 is a considerable amount of expenditures for the Medicaid
14 budget, and I just feel like if that's reflected -- not
15 that one. It was the -- it was the line graph, that one,
16 yeah -- or the other one, the one that has -- that one
17 right there.

18 Because you can see that like CHIP is so cheap.
19 Look how cheap CHIP is in there, and I think that if you
20 could see Medicaid, that what you would see probably is
21 that relationship.

22 If you said duals there, had Medicare, CHIP, and

1 duals as part of the Medicaid, I think that would be really
2 interesting to see.

3 MR. PARK: I would just want to point out Exhibit
4 21 in MACStats does have like total spending broken out by
5 eligibility group, and it does show it for the dually
6 eligible beneficiaries and would also put a plug in for the
7 Duals Data Book that we publish in conjunction with MedPAC.

8 CHAIR JOHNSON: Tricia?

9 COMMISSIONER BROOKS: I just want to add my
10 kudos. We love MACStats, and I'm just curious if we're
11 going to have a Christmas present in the mail with a hard
12 copy.

13 CHAIR JOHNSON: That's what I heard. It's
14 available next Wednesday, right?

15 [Laughter.]

16 COMMISSIONER BROOKS: Thank you.

17 CHAIR JOHNSON: Okay. Thank you.

18 All right. So with that, Asher, do you want to
19 remind us again how people can access the MACStats?

20 MR. WANG: Yeah. So it's available on our
21 website as both Excel and PDF versions.

22 CHAIR JOHNSON: Very exciting. Thank you again

1 for a great holiday gift.

2 Anyone else before we close it out?

3 [No response.]

4 CHAIR JOHNSON: Okay. Thank you both again.

5 Again, this is obviously very exciting for all of us. So
6 it's a great way to end our meeting today. We appreciate
7 it.

8 So with that, let's go to our public comments.
9 We will open it up. We invite you in the audience to raise
10 your hand if you have any comments to offer. We do ask
11 that you introduce yourself and the organization that you
12 represent, and we also ask that you keep your comments to
13 three minutes or less.

14 So, with that, any comments? We do. We have one
15 from Lindsay Jones.

16 **### PUBLIC COMMENT**

17 * MS. JONES: Hello. Yes. My name is Lindsay
18 Jones. I am a co-chair of the Federal Advocacy Committee
19 with the National Academy of Elder Law Attorneys, also
20 known as NAELA. I am a practicing elder law attorney from
21 just outside Cleveland, Ohio.

22 My comments pertain to the session on timely

1 access to home- and community-based services.

2 So NAELA strongly supports MACPAC's efforts to
3 improve timely access to HCBS, and we want to express
4 appreciation for the great work you're doing on this
5 subject. Improving access to HCBS is one of our core
6 policy priorities, and speeding up the receipt of services
7 is particularly important as part of the overall issue.

8 While we would support a potential recommendation
9 around CMS guidance for provisional plans of care, NAELA's
10 view is that conversations around improving timely access
11 should focus not on the take-up of any specific authority,
12 but rather by addressing the operational and procedural
13 difficulties associated with aligning the financial
14 assessment, functional assessment, and person-centered
15 services plan development.

16 So I'd like to offer Ohio as an example. So we
17 have presumptive eligibility involved with our PASSPORT
18 home- and community-based services program. PASSPORT is a
19 program that offers a maximum of four to six hours of daily
20 in-home care services. So that's the amount of assistance
21 that people can qualify for if they receive those services.

22 Presumptive eligibility as part of that program

1 can offer up to 90 days of those services to be provided to
2 an applicant while their financial eligibility is being
3 determined. However, the applicant must first be
4 determined eligible for all non-financial requirements. So
5 that means that they have to jump through all of the hoops
6 involved of the functional assessment process and the
7 development of a person-centered services plan before any
8 services can actually kick in.

9 The unfortunate reality of that situation is that
10 it can take weeks to complete the non-financial eligibility
11 portion, at which point the financial eligibility
12 determination has typically been completed, and that
13 negates the need for presumptive eligibility in the first
14 place.

15 So what we see in Ohio is often that despite
16 having presumptive eligibility with PASSPORT, it's almost
17 never used. It simply doesn't come into consideration
18 because of the timing concerns involved. So the applicant
19 does not receive services at an earlier point in that
20 process, despite the availability of presumptive
21 eligibility. That means that the gap in service is not
22 addressed for them, and it leaves them in a vulnerable

1 situation, which often results in a period of short-term
2 hospitalization or even long-term institutionalization
3 because they have a period of four to six weeks typically
4 where they have no supports, despite the fact that they
5 were eligible for the same and in need of them.

6 The idea of using provisional plans of care would
7 better address this gap in services by shortening the
8 approval of presumptive eligibility services, typically by
9 two to four weeks. That would allow services to offer that
10 support to allow the applicant to remain in the community
11 while their financial eligibility is determined and a
12 formal person-centered services plan is established. In
13 our view, that short but critical amount of time would
14 assist in avoiding unnecessary institutionalizations and
15 other adverse outcomes.

16 In addition, as some Commissioners and
17 stakeholders have shared, the financial eligibility
18 determination can also be a primary source of delay.
19 Regarding that concern, educating state agencies as to the
20 requirements and state options, allowing for self-
21 attestation by applicants, ex parte reviews and renewals
22 via electronic asset verification systems and electronic

1 service may also be effective.

2 CMS guidance would be a helpful starting point
3 and would lead the way on this issue, but ultimately to
4 make progress, we will require a long-term effort to
5 understand and respond to specific operational
6 considerations and challenges in each state as HCBS
7 programs are incredibly state-specific.

8 Again, we appreciate the opportunity to speak and
9 will be submitting written comments in the coming days. We
10 stand ready to be a resource or connect MACPAC with legal
11 professionals who are on the ground in various states and
12 are assisting HCBS applicants every day.

13 Thank you.

14 CHAIR JOHNSON: Thank you for your comment.

15 Do we have any additional comments?

16 [No response.]

17 CHAIR JOHNSON: All right. Seeing none, I do
18 want to remind you that if you do have additional comments
19 later, you can definitely feel free to submit them to our
20 MACPAC website.

21 And with that, I want to thank you all for
22 attending today's meeting and yesterday's meeting as well.

1 Hope you have a great weekend, and we wish you all a
2 wonderful holiday season. We'll see you in the new year.

3 * [Whereupon, at 11:40 a.m., the meeting was
4 concluded.]

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