PUBLIC SESSION

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10:33 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:33 a.m.]

CHAIR VERLON JOHNSON: Good morning, everyone, and welcome to our April MACPAC public meeting. It's always great to see my fellow Commissioners, and I also want to take the time to thank the staff for all the work they've done in putting us at this place for these sessions for today and tomorrow. And I also want to thank all of you for joining us virtually. We really appreciate you all being here and being able to stay engaged as well.

We do have a full agenda ahead of us over the next two days, and we'll be discussing several draft recommendations that you'll hear about, very central to Medicaid's future for sure. And we'll also get into exploring some emerging topics that are really shaping how care is delivered and managed across the program too.

I want to just say these are not small topics, and they're not abstract. They have real implications for how states operate their programs, how the federal government supports them in that, how providers deliver care, and how people will experience Medicaid day-to-day.

So I am looking forward to a very thoughtful and

productive discussion, and with that, let's go ahead and get started with our first topic of community engagement.

So, as a reminder, today we're really focused on the chapter and the recommendation. In our previous discussions, as you all recall, as Commissioners, we spent a lot of time in alignment, particularly around getting implementation right, with a focus on coverage, stability, clear guardrails, of course, and minimizing administrative burdens too.

We've also heard some very strong support for principles, along with some thoughtful questions about evaluation, transparency, and implementation. S

So I just want to say that as Janice and Melinda brief us, it would be really helpful to hear your perspective as Commissioners on whether the chapter and the proposed recommendation reflect the spirit of those discussions we've had in the past or if there are modifications and tweaks that we need to make in the meantime.

So, with that, I'll turn it over to Janice and Melinda.

IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS IN

MEDICAID

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

Today, Melinda and I are returning to present the draft chapter and the recommendation for implementing community engagement requirements in Medicaid.

First, we'll cover an overview of the project and some background. Then we'll discuss the Commission's principles for implementing community engagement, or CE, requirements. Then Melinda will review the draft recommendation, and we'll conclude with next steps.

The objective of this work was to identify key policy and operational considerations for states and the Centers for Medicare and Medicaid Services, or CMS, as they implement CE requirements. Our study approach included a literature review, expert panels, and interviews with states, CMS, and other stakeholders.

This past January, we presented four draft principles and a policy option for monitoring and evaluating CE requirements based on our research, which are reflected in our draft chapter.

Now we'll begin with some background on our work.

Before CE requirements in Medicaid were recently federally mandated, some states pursued Section 1115 demonstrations to implement work and CE requirements. Among the demonstrations that proceeded far enough, the projected and observed coverage losses were substantial.

Research on these demonstrations found that lack of beneficiary awareness, barriers to employment, and administrative challenges were common reasons beneficiaries did not report compliance. Studies have also found significant administrative costs associated with these policies.

The 2025 Budget Reconciliation Act requires states to implement CE requirements for non-pregnant, non-dually eligible individuals age 19 to 64 who are eligible for the Adult Expansion Group or a Section 1115 waiver providing minimum essential coverage.

To gain and keep coverage, individuals must work or volunteer for at least 80 hours in a given month or go to school at least half time.

The law identifies certain mandatory exceptions and gives states the option to provide short-term hardship exceptions.

The law also outlines several key implementation dates for states and CMS. CMS must publish the interim final rule by June 1, 2026, and states must implement CE requirements by January 1, 2027. States also have the option to implement earlier, or they can request to implement within a certain period after the deadline with CMS approval.

Now we'll review the Commission's principles for implementing CE requirements.

The first principle is that CMS should provide timely federal guidance and technical assistance to states. It's important that CMS engage with states early given the tight timeline, and states and other stakeholders emphasized the importance of CMS guidance before the interim final rule is due in June.

Interviewees noted specific areas where guidance is particularly needed, including but not limited to good faith effort exemptions, the definition of medical frailty, and the use of self-attestation.

CMS issued preliminary guidance and has been engaging with states through state-only forums and providing support with information technology or IT

solutions.

The second principle we identified is that CMS and states should ensure that eligible individuals can gain and maintain coverage. Stakeholders emphasized that using ex parte processes to identify exceptions and verify compliance can minimize beneficiary reporting and reduce coverage loss.

States can use several data sources to determine exceptions and compliance, but accessing timely data can be challenging and expensive.

Stakeholders also noted that self-attestation will be important, especially where data are limited.

We also heard about the importance of states coordinating with managed care organizations and other community partners to raise beneficiary awareness and help individuals navigate new reporting requirements.

The third principle that emerged from our research is that CMS and states should prioritize efficiency when procuring, updating, and operating Medicaid IT systems. Medicaid IT system changes related to implementing CE requirements will likely be costly and time intensive.

The short implementation timeline limits the extent to which states will be able to automate processes and competitively procure systems vendors. Our research found that automation would require greater initial investment but could reduce workload and resources needed for training caseworkers.

Stakeholders also suggested several ways CMS could support state procurement and facilitate state access to Equifax's The Work Number.

In the chapter, we note that CMS is encouraging state and health IT vendors to participate in the General Services Administration schedule to streamline procurement.

The fourth and final principle is that CMS and states should use timely monitoring and evaluation data to inform policy and operations. Stakeholders emphasized the importance of monitoring eligibility and enrollment changes upon CE requirement implementation to identify and address issues that may contribute to coverage loss, and they suggested several new metrics that are noted in the draft chapter.

We also heard from stakeholders the need to conduct independent evaluations to assess if CE

requirements are meeting the goals of improving health and increasing employment, particularly given expected administrative costs.

I will now pass it to Melinda to discuss the draft recommendation.

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

In January, Commissioners discussed a policy option for monitoring and evaluating CE requirements, which reflects input gathered from our stakeholder interviews. That policy option is presented in the draft chapter as a recommendation, which reads as follows: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services, CMS, to develop a transparent plan for monitoring and evaluating community engagement requirements in Medicaid that provides insight into how such policies affect eligibility and enrollment, health status, employment, state and federal administrative spending, and the attainment of other identified policy goals. CMS should identify new metrics for state reporting as needed and build upon existing data collection activities to minimize administrative burden.

Additionally, CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision-making.

As Janice noted, our research highlights the importance of monitoring changes in eligibility and enrollment following CE implementation. CMS has the authority to collect and publish data for program monitoring and has used this authority in the past in response to major policy changes, such as the public health emergency unwinding.

CMS has indicated that they are working on a monitoring plan, though it's unclear at this point if those plans or resulting state reporting will be made public. With input from states, beneficiaries, and other stakeholders, CMS should develop and make public a monitoring plan that includes new, meaningful metrics for tracking changes in eligibility and enrollment associated with CE. In developing this plan, CMS should consider building on existing reporting mechanisms to collect new data while minimizing state reporting burden. CMS should further ensure that state reporting is made available to the public on a monthly basis.

Our research also underscores the need for evaluation to understand if CE requirements are meeting stated policy goals in addition to assessing state and federal administrative spending. To date, CMS has not indicated that it has plans to evaluate CE requirements.

States can choose to conduct their own evaluations, though it's unclear how many will do so, and state-led evaluations may be limited by competing priorities and fiscal pressures.

CMS has experience leading federal evaluations and should draw upon that experience as well as stakeholder input when developing an evaluation plan for CE.

In addition to carrying out and making public the results of a full-scale, multi-year evaluation, CMS should also prioritize rapid-cycle evaluation reports that provide timely, actionable insights to support continuous improvement. These reports could, for example, document key features of state approaches, provide insight into the experience of individuals subject to CE requirements, and examine the downstream effects on providers and managed care organizations.

We are awaiting an estimate from the

Congressional Budget Office concerning how this recommendation may affect federal direct spending. For states, the recommendation would result in additional reporting, which could support states' own monitoring and program improvement efforts.

We anticipate that there will be no direct effect on enrollees, though the recommendation could help safeguard coverage for eligible individuals by enhancing state and federal monitoring of eligibility and enrollment trends that might signal barriers to gaining or maintaining coverage. We anticipate that the recommendation will have no direct effect on plans or providers.

Commissioners will have an opportunity to vote on the recommendation during their public meeting next month once we have an assessment of the recommendation's potential effects on federal direct spending. If the recommendation is approved, we will include it in the chapter for the Commission's June report.

For the discussion today, we welcome your feedback on the content and tone of the chapter, so we can take that back and incorporate your input as we finalize the chapter in the coming weeks.

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

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

I think the chapter, from our perspective, is very well done, and I think it really does reflect a lot of our prior discussions.

I am interested, though, from your perspectives, if it really hits the mark on what you all want to focus on, as well as if you have any recommendations around the recommendation.

So, with that, let me go ahead and see who has some thoughts on that in the room as Commissioners. Right now, I see Tim Hill.

COMMISSIONER TIMOTHY HILL: Thanks, Verlon.

I thought the chapter was really well done, kind of covering a broad breadth and getting into the issues that, quite frankly, are quite divisive to understand how this policy is going to work. So I think you guys did a really good job.

My only thought is on the recommendation itself -- and I get hung up on evaluating community engagement

requirements. I'm just not sure. For me, it's really about evaluating sort of the implementation and operationalization of those requirements, and so making it clear that I think what we want here is for CMS, both on a national and, I would say, also on a state level, to have an understanding about how the role -- evaluating how the implementation has occurred, what did it cost, what did it save, as well as kind of the implications of the requirements themselves.

Maybe it's splitting hairs, and that's what you intended, but as I read it, it just didn't feel fulsome enough to me to kind of cover that whole gambit. But nice job. I thought it was a good job.

CHAIR VERLON JOHNSON: Thank you, Tim.

Heidi.

COMMISSIONER HEIDI ALLEN: Thank you.

I think that this was a very well-written chapter with a lot of nuance and background. So kudos to the staff, and I hope it's going to be very useful for Congress.

I recognize that we can't measure health of people who've left the program, that that would be -- you

know, that would require -- that's something that could be done in evaluation, looking at increases of use of emergency departments and hospitalizations by the uninsured. But it isn't likely something that will be at the tip of the finger of Medicaid agencies.

But I do think that it's important to measure health for people who churn, so people who leave the program because they are unable to document their work but then return after a period of coverage loss. So I really do think it's important that we measure how long they're uninsured in the interim and then their health status when they return.

Thank you.

COMMISSIONER HEIDI ALLEN: Thank you, Heidi.

Doug.

COMMISSIONER DOUG BROWN: Thank you.

Again, same comments that Tim had relative to -- and Heidi about the great job you guys did on this chapter.

I have a concern about the health status in the recommendation here. Fully support monitoring policies around eligibility, enrollment, the burden on states, the dollars spent on the program, et cetera.

I'm concerned that the health status, we're adding another layer of work that perhaps states are already reporting and all the reporting that they already do around individuals in their Medicaid program. But the real concern here is when people leave the program, they join -- they would become uninsured, underinsured. They would go to commercial programs. There's no way to track that, and I think a recommendation that requires the states to try to track those folks once they've left the program and check health status, in that regard, I think it goes beyond what we can make in the recommendation here.

So I have a concern about including health status in the recommendation. The rest of the policy looks very good to me. Thank you.

CHAIR VERLON JOHNSON: Thank you. So, from that perspective, you mean actually removing the health status as part of the language completely. Okay. Thank you for that.

John?

COMMISSIONER JOHN McCARTHY: This was just more of a clarification for the chapter. In the recommendation, right before the paragraph, right before it would say -- or

the document says CMS -- policy or operational adjustments and to assess where the requirements further the stated goals of improving health and increasing employment. We say stated goals of improving health and increasing employment.

Now, I know for the 1115 waivers that were in there, that was often a stated goal. But I don't -- and I could have missed it, but I didn't see in H.R. 1 where there is such a stated goal.

I also haven't gone through the legislative record to see if in any time of the introduction of the bill that there was discussions on that.

So, you know, my question is, is that actually somewhere a stated goal of Congress for this one that, you know -- and if it is, we should probably link to it, you know, have a reference to it on that one.

Thanks.

CHAIR VERLON JOHNSON: All right. Does anyone want to respond to that?

MELINDA BECKER ROACH: Just to say, we appreciate that feedback, John, and we can go back and tighten up some of the references and make sure that we're pulling in

something from the legislative record that speaks to that.

CHAIR VERLON JOHNSON: All right. Thank you.

Angelo and then Dennis.

COMMISSIONER ANGELO GIARDINO: Again, wonderfully written chapter and I think really informative, gave a beautiful overview of a lot of nuance.

I guess I just want to pick up on one of the points that Commissioner Allen made. Certainly, from the public health unwinding, we learned a lot around folks that should not have been disenrolled who got enrolled, and I think that was a big concern, just because that's not the point of unwinding the public health emergency. It wasn't to knock people off that should have been on it. Just there were administrative disenrollments.

So I think with a very objective, clear-eyed review of the literature that emerged from the Arkansas experience, it was -- I think it was something like 70 percent of the people that were disenrolled technically should not have been disenrolled, but they couldn't comply with the implementation, to Commissioner Hill's point.

So I would be particularly interested in putting a fine point on the fact that the evaluation really does

need to track the disenrolled individuals and then some assessment of was that an administrative disenrollment that disenrolled someone who technically was still eligible, and then I would love to understand the impact to their health, because I do not believe that the stated intention of community engagement is to willy-nilly disenroll people. It is to put work requirements in place or volunteer requirements in place or student requirements in place.

So there's a group that should be disenrolled because they're not complying. There's a group that get disenrolled because there may be barriers or maybe the implementation isn't ideal.

And then what's the impact on their health? Because I think that's one of the costs of the program, that people who are legitimately eligible for Medicaid get disenrolled because of an implementation issue, not because they're not complying with the stated objective of the mandate. So that would be something I'd be really interested in, because if that's a large group and their health is harmed, the program could -- in a non-polarized, non-divisive way, could be determined to have been a failure.

If there aren't people that get disenrolled inappropriately, then, you know, this is just a policy option, and the elected officials are implementing their will.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Angelo.

Dennis?

COMMISSIONER DENNIS HEAPHY: Thanks.

I agree with the comments that have been made, and just a question for Angelo in terms of tracking harm. Are you saying use the information we learned from the unwinding to do that? There is a system in place that we can use to track harm. I just want to make sure. Okay. Yeah. Because there seems to be some lack of clarity on whether or not it can be done in a practical way by states.

My concern, actually, is the frailty populations and tracking how states are actually implementing the frailty waivers, see if we can find best practices there.

CHAIR VERLON JOHNSON: Carolyn?

COMMISSIONER CAROLYN INGRAM: Thank you.

I had one question -- thank you for putting this piece together -- and then a couple of comments.

On the section around Equifax and gaining information, you have a nice table that talks about how states are able to get data about work information and then what Equifax offers, and I noted that Equifax doesn't capture certain types of non-traditional -- what I'll call non-traditional employment, like gig worker-type activities.

Did we get a chance to look at other platforms that do capture that that are available or have any information on that that we could add?

JANICE LLANOS-VELAZQUEZ: What came up during our research on gig work specifically was using the income verification as a service or now Emmy that CMS provides. So it would be some sort of like consent-based application where the beneficiary could consent to sharing their income.

Is there anything else that came up?

MELINDA BECKER ROACH: No. I think that's right, and it may be important to remember that the bulk of our interviews were conducted last summer. And so there may be some newer resources out there that we haven't highlighted. It's something I think we could maybe -- well, we could

potentially -- you know, if there are other options for states, we could consider, you know, noting that in the chapter if you think that's helpful.

COMMISSIONER CAROLYN INGRAM: Yeah, that would be helpful. I think there are some other options now, and that's a good point. When we first started this work, those maybe didn't quite exist or we didn't know about them yet. And I can get that information to you if you'd like.

And then that brings me to, I guess, two points, and one big one is the cost. In our recommendation, we do have looking, I think, there at the cost. But one of my colleagues pointed out maybe looking at cost effectiveness might be the language we want to think about in terms of how much money states are putting forward just to implement this, and does that make sense and balance out, you know, the goal, the policy goal that was there?

In your documents, you pointed out that North Carolina's costs alone for Equifax was, like, doubled or something like that. And from talking to some folks in some states, I think some of them are just looking at those costs tripling because Equifax is raising those rates quite a bit, and so that's just one aspect of this program. You

know, there's obviously building out the IT systems. There's obviously other costs that come.

Which brings me to the second piece around cost, which I would call maybe more rate issues, that I'm wondering if there's some way we can weave into the recommendation that both CMS and MACPAC, frankly, should continue to look at those rate issues. What I'm talking about is the effects on our provider system across states that really rely on these resources to be able to provide care.

So if you think about hospital systems in rural communities that are lower income, most of their -- a lot of their folks coming in are going to be on Medicaid in some way. Might be fine. You know, those folks might be out there finding jobs. They may not, though, and they may fall off the program.

It then creates kind of more uncompensated care in those systems for both hospitals, but also provider groups in rural communities that rely a lot on Medicaid because there's just not resources in those communities.

So I'm wondering if there's something -- and that does filter down even to managed care organizations as

well, who are having to pay those providers more money in order for them to keep open. So I'm wondering if there's something we can do in terms of weaving in that issue around rates and what the effects of this policy change have on providers, especially those in rural communities, managed care companies, and the other groups that are primarily serving these populations.

And I'll pause there. Thanks.

CHAIR VERLON JOHNSON: Thank you.

Michael?

COMMISSIONER MICHAEL NARDONE: Thank you for this chapter. I thought you did a really good job of kind of bringing in the evidence from, you know, both the unwinding as well as prior state efforts to implement community work experience, because I think that -- you know, I think we all share the desire that in implementing this, people who are meeting the work requirements are not inadvertently thrown off of coverage. And some of the barriers that we're experiencing in some of those states, I think it's really important and points to the need, I think, for a really good evaluation and monitoring. I'm separating out monitoring from evaluation in terms of both how the policy

is implemented.

I mean, it's clear that we're on a really tight time frame, and some of the experiences, it does take time for these programs to be set up. So I think kind of having that information is really going to be critical to ensure that, you know, there are not any unintended consequences of this policy or to minimize the unintended consequences of these policies. So I appreciate that.

And I think it's -- I guess I want to respond to what Tim said earlier -- because I wanted to be sure I understood where you were going with your comments, Tim -- because I think it is important if we're doing evaluation, that we're looking beyond, like, how states monitored -- how states implemented the program, because there are a lot of aspects of this, right? Does -- I think it'd be good to know. What are the implications for the health ecosystem by implementation of these policies?

Carolyn mentioned impact on managed care organizations, also safety-net providers. I mean, what are some of the implications there? Those are longer-term things that aren't going to be -- you know, you're not going to find that out as you're monitoring.

I think you also want to understand what's the longer-term impact for individuals. Does it help kind of with, you know, getting employed? Does it help with what the goals, I think, are of the policies to basically provide a ladder to additional employment, more employment, better employment? So I think there's a difference between the monitoring and the evaluation piece. I think the evaluation piece, which is longer term, I think needs to take into account some of those aspects.

So I just want to make sure that we're kind of -- that I'm thinking about this the same way, that I didn't misinterpret something you said, Tim.

COMMISSIONER TIMOTHY HILL: [Speaking off microphone.]

COMMISSIONER MICHAEL NARDONE: I totally understand you, Tim.

And then the other thing I -- you know, the other thing that I'm impressed with is, given the -- and, you know, we're -- I know we're going to -- I know we're going to make this recommendation, and we're going to continue to monitor. I mean, I'm just impressed by the compressed time frame that we're under, right? We're saying in the chapter

that there needs to be -- you know, we put in place these new IT proposals that are going to hopefully streamline things for states. There are discussions that are going on between states and CMS. So I would -- you know, that I'm not privy to those discussions.

But I would hope that we would continue to monitor and understand, for instance, some of the provisions that are being made around the IT to help streamline this process, because my experience with making IT changes has been it takes quite a bit of time to make IT changes. And we really are under a very short window here. So I just want to -- I think that's an area where we really have to follow, like, does this -- I'm not familiar with the GSA streamline process. Are states taking advantage of that? Are they taking advantage of the IT vendors that have been kind of made available to potentially provide discounts to providers? Are the APDs being prioritized, and are they getting through in an expedited way to have states be able to get this up and running by January 1st?

So I just think even in the interim, in the intervening six months or until when this policy goes live, I think there's a lot of things that I hope we're kind of

following up on. And you can present -- we can have further discussion at these meetings about them.

Thank you.

CHAIR VERLON JOHNSON: Thanks, Mike.

Heidi?

COMMISSIONER HEIDI ALLEN: Sorry to jump in again, but this has been a stimulating conversation.

I do think that that difference between monitoring and evaluation is so important, and it's really explained well in the chapter. But it isn't necessarily as clear in the draft recommendation, which might be where there's been some concerns about monitoring health.

I think that in monitoring and what states have access to, they are able to monitor people who churn, and they're able to monitor things like use of preventive services that we would hope everybody would get on Medicaid every year. They're able to monitor things like ED visits when people re-enroll in ambulatory care-sensitive hospitalizations. So there is some things that they can do to monitor.

Then there's this broader evaluation, which is a little bit, probably, out of their scope, which is what

happens when people leave. Were they actually eligible? Should they have left? Did they get new insurance? And then what happened to their health? That is something that seems probably -- it would be even better if that was led by CMS, because you could have a multistate effort to kind of look at the overall policy. So I just wanted to note those things.

Then the last thing is the one thing I didn't see in the chapter that I think could strengthen it is bringing in the literature on administrative burden and disenrollment. We talk about minimizing administrative burden in multiple places, but there's been really great research over the last few years -- I would say over the last decade -- on how increasing administrative burden can lead to disenrollment among eligible populations, and just bringing that literature in there, I think would be helpful.

Thank you.

CHAIR VERLON JOHNSON: Thank you.

Any other thoughts, questions, clarifications?

[No response.]

CHAIR VERLON JOHNSON: Okay. So just so we know,

I just want to make sure that you all have what you need in terms of moving forward. It sounds like from the draft recommendation, we did get at least three potential word changes or modifications around implementation. Operationalizing, I think came from Tim. And then we have had some back-and-forth around health status in terms of how that can be viewed. Doug's recommendation was taking it out, but I'm hearing from others that there is some data around that, at least from a long-term perspective, and that may be a way you may look at that one for sure. And then to Carolyn's point, a little bit more around the cost effectiveness.

It also seems that there were some conversations around potentially modifying the chapter or providing more background for some of those same issues.

But are there additional questions that you all have or clarification that may be helpful as we go back?

MELINDA BECKER ROACH: No. I don't think so. I think we have what we need. Thank you very much.

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

All right. So now we're going to move to our

next topic on state and federal tools to ensuring accountability of Medicaid managed care plans. So for this session, we're again going to focus on the chapter and the recommendations, but the lens is probably a little bit different than the previous one. In our prior discussions, there's been some broad agreement that states have a range of tools available, but the challenge isn't really the absence of tools, but more so how effectively they're being used.

So I know we spent a lot of conversations around data challenges, how fragmented it is and inconsistent. So, as our team starts to walk through this chapter and recommendations, it'll again be very helpful to hear from the Commissioners, your perspective on whether this work meaningfully improves our ability to assess performance and drive accountability.

So, with that, I will turn it over to Holly and Chris.

STATE AND FEDERAL TOOLS FOR ENSURING ACCOUNTABILITY OF MEDICAID MANAGED CARE PLANS

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

Today, Chris and I are going to present the draft chapter and two policy recommendations for state and federal tools for ensuring accountability of Medicaid managed care plans.

First, we'll start with a background on Medicaid managed care accountability and briefly review the challenges in oversight and accountability identified in our study. Then we will walk through the two recommendations, including the rationales and implications that will be up for Commissioner vote tomorrow, and then we'll conclude with next steps.

As a reminder, managed care is the predominant Medicaid delivery system in most states. Almost three quarters of Medicaid beneficiaries are enrolled in a comprehensive, full-risk managed care organization, or MCO, and managed care capitation payments account for more than half of Medicaid benefits spending in fiscal year 2024.

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

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

We found that CMS has broad authority to oversee managed care programs but limited tools to address specific deficiencies. We found that the Managed Care Program Annual Report, or MCPAR, data available from CMS is inconsistent and incomplete, which limits the usability for oversight. From our analysis, MCPAR reporting appears to undercount the actual use of accountability actions, and state variance in MCPAR reporting reflects unclear definitions of what should be reported.

Finally, we found that states need better tools and guidance to assess plan performance across multiple data sources. Although managed care plans are required to report performance data across a variety of sources, such as MCPARs, external quality reviews, and the forthcoming quality rating system, or QRS, these data are not always available in a centralized, publicly available location,

nor provided in a format that is conducive for analysis that links across plans and states.

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

The first recommendation states: The Secretary of the U.S. Department of Health and Human Services should direct CMS to provide guidance on the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance that should be reported on the sanctioned sections of the managed care program annual report pursuant to 42 CFR 438.66(e)(2)(viii).

Under this option, CMS would provide clarification and guidance on which types of accountability tools should be reported on the MCPARs and how to report them consistently.

This guidance could be provided through updated MCPAR instructions, technical assistance resources, or a combination of these approaches.

Specifically, CMS should clarify reporting

requirements for liquidated damages, informal interventions that states may be using before escalating to formal sanctions, and other accountability actions that are in response to plan noncompliance.

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

However, as identified in our analysis, states are likely reporting incomplete or inconsistent data, and it is not clear that states share the same definitions of sanctions and informal interventions. For an example, one state reported liquidated damages in their own compliance action report for the state but did not report them on the MCPAR.

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

The goal of this recommendation is not to

document every communication between the state and managed care plan, but to capture notable communications and interventions in response to a lapse in plan performance. As such, CMS should determine a threshold for reporting informal interventions. For example, CMS could exclude routine monitoring calls from reporting.

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

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

For this recommendation, the Congressional Budget Office, or CBO, does not estimate any change in federal direct spending.

The recommendation may result in increased administrative effort for CMS, such as developing and disseminating updated instructions, data definitions, and

reporting templates through technical assistance materials, MCPAR instruction updates, or sub-regulatory guidance.

For states, they already collect information on their accountability actions and are required to submit this information on MCPARs. The primary change would be more specific guidance on what and how to report, rather than requiring states to collect new information.

However, some states may need to adjust their internal tracking systems or processes to ensure they are capturing and reporting all the required information consistently.

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

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

Finally, providers would benefit from having complete and publicly accessible information on plan performance to inform their choices of which plan to contract with.

Policy Recommendation 2 states that the Secretary of the U.S. Department of Health and Human Services should direct CMS to develop a publicly available database on managed care performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans.

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

National experts noted that the MCPAR is a good first step in collecting plan-level data, but that understanding plan performance across states remains

difficult. They suggested that CMS could do more to help state Medicaid agencies better understand managed care performance in other states, such as a comprehensive, up-to-date database or dashboard that would allow states to understand what performance looks like across the country.

CMS recently developed a Medicaid Data Collection Tool, MDCT, to collect data required to monitor, manage, and review the managed care programs for each state, which includes a web portal that states use to submit the MCPARs, their network adequacy and access assurance reports, and their medical loss ratio reports. This database is not available to the public, but CMS could build upon the structure to develop a comprehensive, public-facing database or dashboard for states and enrollees.

In our March 2025 report to Congress, the Commission made recommendations on external quality review, including the need to reduce areas of duplication with other federal quality and oversight reporting requirements and to create more usable reports that identify key takeaways on plan performance. This option would build upon those prior recommendations by combining the information across the different federal reports on managed

care quality and oversight.

For this recommendation, CBO does not estimate any change in federal direct spending.

For states, this recommendation would provide a more complete picture of plan performance. They could use this information to procure high-performing plans and implement more effective accountability provisions in contracts.

Access to better comparative data would help states benchmark their programs' performance compared to other states in terms of outcomes and compliance. This type of comparison could help states identify gaps in their oversight practices or identify emerging compliance issues in other states.

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

For enrollees, performance data that are publicly available and readily accessible can improve their ability to make informed decisions during plan selection, and improved plan performance resulting from more effective

state oversight could lead to better access to care and quality of services.

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

Finally, similarly to the first one, providers would benefit from having complete and publicly accessible information on plan performance to inform their choices of plans to contract with.

To summarize, these two recommendations seek to improve the usability of managed care performance data and provide states with additional tools to assist in overseeing plan performance. The Commission will vote on the two recommendations tomorrow, and we are currently working to finalize a chapter for the June report to Congress. The Commission will also continue to monitor the maturation of MCPAR reporting, the implementation of QRS in 2028, and other developments related to Medicaid managed care oversight and accountability.

And with that, I'll turn it back to the Commission Chair. Thank you.

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

All right. So let's pause and open it up to the Commissioners and see what reactions you have to the chapter and the recommendations.

With that, we'll turn to Jami.

COMMISSIONER JAMI SNYDER: Thanks again for this work.

Can we go back to the slide with the first recommendation? So I think the first recommendation points to the need for CMS to provide guidance on the types of accountability actions that should be reported. But I know a part of the issue is consistency in reporting. So I wondered if we could weave that language into the actual recommendations, so not only providing guidance on the type of accountability actions but also guidance on how to report those actions in a consistent manner. I'd just like to see that in the actual recommendation. Thanks.

CHAIR VERLON JOHNSON: Thank you, Jami.

Mike and then Patti.

COMMISSIONER MICHAEL NARDONE: Hi. Thank you for this work.

I think my concern, which maybe is kind of a project for a future effort, is that we're looking -- when you talk about tools of ensuring quality, this is really tools of enforcement, which is separate and apart from the tools that states use day-to-day to manage their managed care programs.

I guess what I think is important is for us to understand what are the procedures that states have in place to do that, because some of the information -- I mean, one of the concerns I have about the MCPARs data and the QRS data is that it's so far down the line from -- I mean, it's old, right? It's two years old. You're managing that program on a day-to-day basis. You're managing on a monthly basis, a quarterly basis.

The HEDIS measures are at least going to be two years old, three years old by the time that they're reported nationally, just because of the way you do the benchmarking. So I think it's really important to recognize that states have those systems in place.

I guess I really reacted -- I reacted very

strongly as a former Medicaid director when it said states have a problem -- states struggle to manage data, right? I understand the point, which is that because of the many sources that are available at the federal level, that it's not always easy to use. But I have to tell you, when I was Medicaid director, I was managing data, right? And we had tools in place to understand what were the good performing plans, what were the lesser performing plans, what were the things we had to do, and I don't see that reflected, really, in this chapter. I'd hope that might be something that we think about as we're going forward with this work.

So that was kind of my -- I guess my major reaction. I don't necessarily have an issue with the recommendations. I think Jami's addition is good.

I mean, I think given where MCPARs is, it's very appropriate to be continuing to provide guidance to states around how to use that tool so that it's actually useful. But I do think that there has to be some acknowledgment that states are managing -- they are -- many of the states have sophisticated tools for trying to do this on a real-time basis that maybe isn't reflected in enforcement actions, and maybe we'll get to more of it when you're

talking about informal. But there are things in place that states are doing and I think should be acknowledged.

CHAIR VERLON JOHNSON: Thank you, Mike.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Tagging onto that, really, like Mike, I agree in general with the recommendation. I appreciate, Mike, the way that you parsed that out.

My primary concern -- and maybe we can just call this out a bit more in the chapter -- is that we don't want to create a chilling effect on those ongoing state oversight efforts that Mike talked about, not addressing a potential issue because public reporting would be required, or adding administrative burden by really requiring that you document and report every single little thing that you do.

But we are trying to just ensure consistency in terms of the types of actions that should be reported and how those are reported, to reinforce Jami's distinction, again, in order to ensure that there's transparency in health plan accountability and how data is being used to drive ongoing program improvements.

CHAIR VERLON JOHNSON: Thank you, Patti.

Doug and then Anne.

COMMISSIONER DOUG BROWN: I'm not opposed to the recommendation. I am concerned about the variability in state enforcement.

Some states penalize their MCOs frequently. Other states will take other actions, lettering and whatnot, that may not show up on a report. So I think there has to be some way to gauge or stratify the states, the ones that are more active in using liquidated damages, for example.

There's also variability in the scope of similar services offered from state to state. So a drug utilization review (DUR) program in one state may have much different requirements than DUR program in another state. In one state, you may see lots of liquidated damages because they didn't meet all the different requirements there versus another state that has a different set of recommendations or a different set of criteria that they're kind of being measured against. So there is variability there, and I think some way you have to tease that out in the reporting.

I don't know that we need to change the recommendation. It's just an observation that as we begin to make these outputs public, you need to stratify that a little bit or take that into consideration, maybe provide a response, like a response from MCOs so that they can kind of respond back and comment on the reason that they suffered liquidated damages, for example.

Thank you.

CHAIR VERLON JOHNSON: Thanks, Doug, for that.

Anne and then John.

COMMISSIONER ANNE KARL: This is sparked by what Mike had said, where I think maybe that one distinction is just that there are different audiences. So Mike was saying like, well, I don't feel like it's fair to say that states are struggling with data. They have a lot of different pieces of data. They're pulling it together. They're doing that monitoring. And I think I read the materials as more pointing toward like other people outside of the state. So nobody can start to monitor if you're a stakeholder in the state that wants to see how the plans are doing or if you're another state that's about to offer a contract to that player and you want to understand how

effective they are or not. So maybe that's the difference is that like the state itself may be doing a fabulous job monitoring, but it's just too opaque because of the complexity of the data. So does that sound right?

CHAIR VERLON JOHNSON: Thank you.

John and then Sonja.

COMMISSIONER JOHN McCARTHY: Anne actually just kind of took my comment, because I was going to say, you know, if you're looking at this from the standpoint of a state like Mike said, I think it doesn't really get into all the work, the great work that states are doing to do these things.

However, if you're from the outside, if you're the federal government, you're like, hey, how are we monitoring these things? It's probably hard to do because it's all, you know, different, different places. So I think there is a little bit of that.

I think the reason I would support these is -- especially the second recommendation is -- well, I support the first one too, but then the second one is, you know, we need more transparency. We already see that CMS has moved to release all of the claims data, right? So people can

download claims data and look for things. To me, it's better aligning the data so that anybody can take a look at it and maybe find something out there that you wouldn't be able to see.

Again, it's not that it is for real-time monitoring, right? As Mike said, the data could be two years old, but it's, are there patterns out there that's something that can be used then for later decisions around policy to say, hey, we need to change this or move in a different direction?

Because one of the things we didn't talk about in this chapter for monitoring is HEDIS measures. You can just look at HEDIS measures, which are done across all Medicaid managed care plans and see where the plans fall in every state on this. Now, there's other contributing factors in there, but, I mean, that's probably -- if you're a state, the thing that you look at the most is how does your plan's HEDIS measures compare to the other plans in your state's HEDIS measures for -- really just get the outcomes, but as a measure.

CHAIR VERLON JOHNSON: Thank you, John.

Sonja?

COMMISSIONER SONJA BJORK: Thanks.

I'm really glad that we're going to promote transparency like we like to do, because these recommendations are going to help with clarity and the idea of technical assistance so that everybody's reporting on the same things and understanding what they're supposed to be reporting.

But I just want to follow up on my fellow Commissioners' comments about data delays, and I think that simply highlights the importance of the informal tools, because none of the states are waiting two years until they talk to their health plans if something goes awry. So those tools are really important. There's letters, there's meetings, in addition to fines, but corrective action plans can be really effective, and it just has to be taken into account as we look at this whole picture.

I'm very in favor of this idea of making sure that everybody understands what the reporting template is and what it requires and is practicing sending in their data so that we can see across the whole country what's going on.

So that's it. Thank you.

CHAIR VERLON JOHNSON: Thank you. Good perspective. Appreciate that.

Let's go to April and then Mike.

COMMISSIONER APRIL HARTMAN: Oh, there we go. One of the comments I just wanted to say from the provider point of view is this -- I appreciate all the work that's being done, and this information does need to be publicly available. A lot of times, a group of providers may bring a complaint about a managed care organization to the attention of the SSA, and then you don't hear anything else. So you have no idea what's being done, because it's nowhere can you find anything. So it just keeps being brought back again and again because you're not sure what's happening or what they're supposed to be doing.

But if we can get this publicly reported, I think providers and members and everybody also help make the managed care organizations more accountable, because now they know what they're supposed to be doing, and there can be an increased demand for that responsibility.

So I think the key thing to this is the need for the data to be available to people in a way that we can see what's happening and what has been the results of what we

reported. Thank you.

CHAIR VERLON JOHNSON: Thank you.

Mike?

COMMISSIONER MICHAEL NARDONE: Yeah. I was just going to say, kind of in response to Anne and John, that I don't disagree with what they're saying. I think to the extent, though, that what we're saying in the chapter is this is going help states manage their Medicaid program, I think maybe we need to make a distinction in the chapter itself around kind of what we're referring to.

You know, to a great extent when you're in that position, you're not evaluating how well does Health Plan A do in Minnesota or another state. You're really looking at what is that state doing, what is that MCO doing in my state, and you can't -- you know, to some degree, that's your main focus, right? I mean, this information can help you in that effort, but I just think it has to be clear.

Just so you don't think I'm totally crabby about this chapter, I want to just say thank you for putting it -- I appreciated the discussion around QRS, which I think was added. You know, I think that, you know, that's something that, you know, going forward does have the

potential to really standardize a lot of the information that we have on MCOs across the country.

It's getting to the point where you have 16 measures that you can evaluate health plans on across the country, and so I think that that's going to be something that as we continue our work, we're going to want to continue to look at as a valuable resource.

CHAIR VERLON JOHNSON: Thank you.

Dennis.

COMMISSIONER DENNIS HEAPHY: One, this system was said before that this data be usable by plan members to make choices over which MCOs they participate in, and so as we're looking at this and looking at what should be presented transparently, how is this going to help people make decisions about their health care providers and the plan they choose? I think there's a framework to use when putting this forward. When making choices about what should be shared, is this going to help make decisions, people make decisions, as well as the state, but for consumers to make decisions?

CHAIR VERLON JOHNSON: Thank you, Dennis. Good point to bring in that point of view, too, for sure.

Anyone else? Mike, are you coming back to us again?

Okay. You've said your piece. All right. Well, we appreciate the piece you said for sure.

All right. So this is the very helpful, I will echo, like my fellow Commissioners, that I think that the chapter did a strong job of really laying out the landscape and the challenge we've been discussing before, particularly around data fragmentation and usability. I, like many of you, feel that the recommendations are really directionally in the right direction for sure, really about making sure that our data is more accessible and connected as we look at this.

I think that the only thing for me is the hope is whether these changes actually change how states and CMS use this information, or we may in future iterations need to think about how can we push a little bit further.

But job well done. I will echo those comments, too.

So do you all have everything you need to kind of move forward and we'll come back and vote on this?

HOLLY SALTRELLI: Thanks for the comments.

CHAIR VERLON JOHNSON: Thank you.

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

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chair.

We've got Linn and Ava coming to join us to bring back the work that's been taking place over the last couple of years as they've walked this Commission through both the background of Medicaid and how children and youth transition to adult, identifying the pathways, benefits that impact them, and the requirements as they go through redetermination now as adults.

They've surveyed states' key findings, input from us as Commissioners, and so they have the draft chapter that we all had a chance to preview, and they've got six recommendations. And they're seeking our thoughts as we bring these to a vote tomorrow to refine those recommendations based on the Commissioners' feedback today.

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

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

* AVA WILLIAMS: Good morning, Commissioners. Linn

and I are excited to present our draft chapter and recommendations for children and youth with special health care needs from child to adult -- children and youth with special health care needs transitions from child to adult Medicaid coverage.

I will be presenting an abbreviated version of what is in our chapter, including an overview of the transition process and states' roles in supporting the transition of coverage. The full chapter will be available in our June report to Congress.

I will then present the first two recommendations, their rationales, and implications. Linn will then present the rest of our recommendations before going over next steps.

This figure should look familiar to you, but as a reminder, this figure shows that there are several transitions children and youth with special health care needs may go through between the ages of 18 and 26, including the Medicaid and SSI age 18 redeterminations as well as waiver transitions. Additionally, the SSI redetermination and waiver transitions can affect the Medicaid eligibility pathway a beneficiary is enrolled in.

There are a number of federal Medicaid requirements related to the transitions I discussed in the prior slide, but I will focus on a few key requirements and state flexibilities that are important context for our recommendations.

For example, states are required to first attempt to confirm ongoing eligibility on an ex parte basis before requesting additional information from a beneficiary, and states also have the flexibility to ease coverage transitions through different policy decisions such as extending child eligibility to age 21.

In this figure, we summarize the four key challenges that beneficiaries experience with the transition to adult Medicaid and how these challenges are addressed by the six recommendations we will discuss next.

Based on our findings from this work, we have developed six recommendations to improve coverage transitions for children and youth with special health care needs. Our recommendations specify a minimum children and youth with special health care needs population that is used across all recommendations. So rather than reading the population for each recommendation, I'll remind you all

of it now.

The minimum population includes children who are enrolled in Medicaid through SSI-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to amend 42 CFR 435.919(b)(6) to require states to send a notice a minimum of 60 days in advance of children and youth with special health care needs aging out of child Medicaid eligibility to inform them that the renewal process has been initiated.

Research demonstrates that beneficiaries and families need advanced notice of the upcoming transition from child to adult Medicaid so that they are aware and can prepare for the next steps needed to maintain Medicaid coverage as an adult. Without adequate time to prepare, beneficiaries may not complete the redetermination process

within allotted time.

Currently, there is no federal requirement for state Medicaid agencies to notify beneficiaries that they are initiating the redetermination process, but many states initiate the redetermination process between 60 and 90 days prior to the end of the eligibility period.

So states should provide beneficiaries with a minimum of 60 days' advance notice of their upcoming redetermination to ensure they have sufficient time to prepare for their transition. Sixty days is meant to be a minimum, and states may want to consider sending a notice as early as a year in advance as done by SSA, the Social Security Administration, in advance of the SSI enrollees' age 18 redetermination.

CBO estimates this recommendation would not have a direct effect on federal Medicaid spending. However, CMS would have to commit time and resources should they issue guidance related to this new requirement. States that do not already send beneficiaries a notice of their upcoming redetermination may have increased administrative burden to identify this children and youth with special health care needs population and target notices.

Enrollees will receive an advance notice and have more time to prepare for their upcoming redetermination. Plans may have fewer beneficiaries experiencing disruptions and coverage. Lastly, providers and transition coordinators may have more advanced notice of the upcoming redetermination.

State Medicaid agencies should provide children and youth with special health care needs who are aging out of child Medicaid eligibility with a minimum of 30 days to respond to requests for information to complete Medicaid redeterminations in accordance with 42 CFR 435.919(c)(1).

Research demonstrates that many beneficiaries and their families have challenges with responding to requests for information within the time they are given, which may lead to loss or gaps in coverage among children and youth with special health care needs aging out of child Medicaid.

Some advocates shared that beneficiaries may receive their notice too late to respond within the required time frame. So states that do not already provide beneficiaries with a minimum of 30 days to respond to requests for information should implement this minimum response time to ensure beneficiaries have adequate time to

gather any requested information.

CBO estimates this recommendation would not have a direct effect on federal Medicaid spending. States will have some administrative burden to revise notice procedures to accommodate the 30-day response time. Enrollees will have more time to submit the required information. Plans may have fewer beneficiaries experience disruptions in coverage and care, and lastly, providers may have more time to send beneficiaries' requested medical records.

Now I'll turn it over to Linn.

* LINN JENNINGS: Thanks, Ava.

Recommendation 3 reads: To ensure the accuracy of information provided by the Social Security Administration to Medicaid beneficiaries enrolled in SSI-related eligibility pathways who are being notified that they're losing eligibility for SSI, the Secretary of the U.S. Department of Health and Human Services through the Centers for Medicare and Medicaid Services should coordinate with SSA to review and update model notice language pertaining to Medicaid and SSA's program operations manual system manual paragraphs. The model language should clearly indicate that the individual may

retain their Medicaid coverage while the state Medicaid agency takes steps to redetermine the individual on a new basis of eligibility. Additionally, the model language should describe in general terms the steps the individual needs to follow to complete the Medicaid redetermination that are specific to 1634 SSI criteria in 209(b) states.

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

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

Currently, there are no federal Medicaid or SSA requirements for SSA and CMS to coordinate on SSA notice language that are sent out to beneficiaries who lose SSI.

So based on these findings, CMS should coordinate with SSA to review and develop model SSI notice language

about how a loss of SSI affects Medicaid eligibility so that beneficiaries are aware that their Medicaid coverage is not immediately terminated.

We are awaiting an estimate from CBO on federal direct spending. For states, they may need to provide input on notice language to ensure that the language is accurate and clarifies the effect of a loss of SSI on Medicaid coverage.

For beneficiaries, they may have a better understanding of the effect of their losing SSI on Medicaid eligibility and the steps they need to take to retain their Medicaid coverage. For plans and providers, they may have fewer beneficiaries who are experiencing disruptions in their coverage.

Moving on to Recommendation 4. State Medicaid agencies should implement the optional Medicaid eligibility pathway for children and youth with special health care needs up to age 21 who are not otherwise eligible for and enrolled in the mandatory coverage or optional full Medicaid coverage under the state plan 42 CFR 435.222 and 42 CFR 435.223.

This recommendation is intended to ease the

transition from child to adult Medicaid coverage for children and youth with special health care needs and improve their coverage stability when to adulthood.

Children and youth with special health care needs can have complex medical conditions and therefore rely on specialized pediatric care and continue to need these specialized services as adults. So maintaining coverage stability is even more important for them in maintaining continuity of care during this transitional period.

Delaying the transition to adult Medicaid coverage is one of many approaches state Medicaid agencies can take to improve coverage stability for children and youth with special health care needs and can benefit families in two primary ways.

First, delaying this coverage transition would ensure that children and youth in special health care needs and their families, including those who may not continue to be eligible for Medicaid as an adult, have coverage stability while navigating multiple transitions that occur between ages 18 and 21.

Second, the extended eligibility can act as a bridge between child and adult coverage by providing

families with more time to complete transition steps that can directly affect an individual's ability to meet adult Medicaid eligibility criteria, such as applying to SSI.

In considering this recommendation, the Commission weighed several factors that states should consider when implementing this optional pathway. First, this optional pathway provides states with a number of flexibilities in how the pathway is designed, including determining whether to extend eligibility up to age 20 or 21, the eligibility criteria, and population scope. So, in implementation, states should consider how to design this extended pathway in a way that best meets the needs of their beneficiaries who are at risk of becoming uninsured at age 19.

Second, some Commissioners raised concerns about the state fiscal impact of expanding coverage to individuals who may otherwise disenroll, and that with this recommendation, states will need to consider their state budget implications when designing the pathway, especially as they are balancing other state priorities.

In response to these concerns, there was also some discussion of the state fiscal impact of covering

health care costs for those who are uninsured who lose Medicaid after aging out of child Medicaid, especially for those with complex medical conditions who would be at an increased risk of ED use for missed care, and estimates of public funding sources for uncompensated care suggest that state and local governments fund about 35.9 percent of these costs.

We are awaiting an estimate from CBO on the federal direct spending for this recommendation.

For states, they have the flexibility to determine the eligibility criteria for this optional pathway, and the state's budget implications are dependent on how broadly or narrowly the state decides to define these criteria.

For beneficiaries who would otherwise disenroll at age 19, they would now have an additional pathway to remaining Medicaid eligible, and for plans and providers, they may have fewer beneficiaries who are experiencing disruptions in coverage.

Recommendation 5 reads: To ensure children and youth with special health care needs receive a full 12-month continuous eligibility CE period in their final year

of child Medicaid eligibility, Congress should amend section 1902(e)(12) of the Social Security Act to require states to provide children and youth with special health care needs with a 12-month CE period that lasts a full 12 months from the date of the eligibility determination, even if the CE period -- if during the CE period, an individual reaches the upper age limit for the eligibility pathway by which they are eligible for Medicaid. This 12-month CE period should apply to all children and youth with special health care needs who receive coverage from a mandatory or optional child eligibility pathway, including optional pathways covering youth above age 18.

Findings from our T-MSIS analysis indicate that about 17.6 percent of transition-age youth enrolled in disability-related pathways disenroll when aging out of child eligibility, and of those who disenroll, about one-third churn back onto Medicaid within 12 months.

Gaps in coverage, even for short periods, are associated with delays in receipt of care and an increase in unmet health needs and a risk of hospitalization.

Beginning in 2024, states are required to provide 12-month CE for all children under age 19 in response to

research that showed that CE reduces rates of churn and improves access to care and short- and long-term health outcomes for children.

With the current requirement, beneficiaries remain continuously eligible for 12 months up to age 19 and must be redetermined prior to the beneficiary turning 19, even if this occurs before the end of the full 12-month continuous eligibility period.

In considering this recommendation, the Commission discussed the importance of continuity of coverage for children and youth with special health care needs who are transitioning to adulthood and navigating multiple simultaneous program transitions between ages 18 and 21, and discussed how providing 12-month continuous eligibility in this final year of child eligibility could reduce beneficiary and family burden.

Further, there was discussion of the importance of expanding the 12-month continuous eligibility period to those enrolled in state optional pathways that extend child eligibility up to age 21.

We are awaiting an estimate from CBO on the federal direct spending of this recommendation.

For states, this will affect Medicaid spending, as states would be required to provide children and youth with special health care needs with 12 months of continuous eligibility through the end of the child eligibility pathway's upper age limit. For beneficiaries, they may experience a decrease in administrative burden in the final 12 months prior to aging out of child Medicaid, and for plans and providers, to the extent that this improves continuity of coverage during this period, they may have beneficiaries experiencing fewer disruptions in coverage.

Moving to Recommendation 6, which reads: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to issue guidance to the states on existing authorities for supporting children and youth with special health care needs with Medicaid redeterminations and transitioning to adult Medicaid coverage. The guidance should address authorities to cover case management transition planning for child-only Section 1915(c) home- and community-based services waivers and the state optional pathway to cover children up to age 21.

Currently, there's no CMS guidance on existing

authorities to support children and youth with special health care needs with their Medicaid redetermination, and states need guidance on using existing authorities to provide children and youth with special health care needs with improved support during this transition period.

In the development of this guidance, CMS should address authorities states can use to provide children and youth with special health care needs with a dedicated case manager or care coordinator to support them with this Medicaid redetermination, transition planning procedures states can include in state age-limited Section 1915(c) HCBS waivers to support beneficiaries and their families with this redetermination process, and state implementation of the state optional pathway to extend child eligibility up to age 21.

Implications. CBO does not estimate a direct effect on spending for this recommendation. States will have greater clarity on the available existing authorities to support children and youth with special health care needs in transitioning to adult Medicaid. For beneficiaries, they may experience improved support during this transition period. For plans, there may be

administrative effort for plans to develop payment policy and guidance for providers supporting beneficiaries with this redetermination, and for providers, they may engage in supporting children and youth with special health care needs with the transition to adult Medicaid coverage.

So we welcome Commissioner feedback on the draft chapter and recommendation language, rationale, and implications, and will return in May for the vote on all six recommendations, and the chapter will be published in the June report to Congress.

With that, I'll turn it back to the Vice Chair.

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

Again, we're looking to have the draft chapter completed for our June report, and this will be, again, brought back in our May meeting, voting on these recommendations.

Prior to turning over to the Commission, I just, again, want to say a personal thank-you and how I'm in support of these recommendations. Being a parent of two children that have gone through this transition, with one unique in mental behavioral health and one unique in both

physical and developmental delay, knowing there are different pathways and the different responses, as well as having that done in two different states, I really appreciate the recommendation because it provides both some continuity and consistency in that pathway, particularly for the families as they're going through that process, just reflecting on my own time. There's so many other things happening in those lives of those children into adulthood, that having some of these recommendations in place would be extremely supportive in making sure that transition, that commitment, consistency of care is important. So thank you on behalf of being a Commissioner, but more importantly, being a parent of a couple of children that this would impact. So thank you.

With that, we'll go to our Commissioners. Angelo.

COMMISSIONER ANGELO GIARDINO: First, I want to thank you for really taking on a super complicated topic and really educating us about all the different nuances.

The health care transition from pediatric to adult care is really a complicated, chaotic time for all children, and then children with special health care needs

find specific challenges, primarily because they have special health care needs, and their families and their supporters are helping them with those. It just so happens that as they chronologically get older, then the programs they're entitled to or qualify for change. So it adds a level of complexity.

I think I'm so compelled by the testimony that we have received from Got Transition and Peggy McManus and Dr. Patience White, and then we received some written communication as well from them from the last meeting.

And I think what really strikes me is that gaps in coverage create gaps in health care that create gaps in health. Therefore, this really vulnerable population does require us to be very thoughtful, and I think you've really helped us try to strike a balance between the programmatic needs and the needs of these people.

I'm particularly concerned about the population that will churn, because the programmatic stuff doesn't quite align with their notifications and whatnot. Then that gap in coverage that may occur affects a gap in health care that may occur, which then affects their health. And that change in health may or may not be remediable.

So, if you have a setback, it may or may not be something that you can recover from. It may or may not be something that then once you get the health care back, because your coverage got straightened out.

So I think whenever I think of something clinically where the downside is significant impact on health, I think we have to be particularly careful.

So I think the fact that you have six recommendations just is emblematic of how complicated this is, and I think you've really helped us recognize that there's a number of these youth who are transitioning from pediatrics to adult that get caught in the middle. While there's no perfect solution, you have suggested some reasonable interim steps to improve that problem where gaps in coverage will create gaps in health care, which then will create gaps in health.

So I just want to commend you on putting together six really thoughtful, balanced, reasonable recommendations, and I speak in support of those. So thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Angelo.

We have Anne, Mike, John, then Heidi.

COMMISSIONER ANNE KARL: I just want to echo the thanks for such an excellent set of materials, and I think it's really thorough. And it's such a complex topic. So it's walked through really carefully, and I appreciate that.

I just wanted to express some hesitation about Recommendation No. 5, and the reason for that is -- I completely agree with everything that Angelo said about wanting to reduce gaps in coverage, and I think my concern is that it's going to lead to different -- kids getting treated differently just based on happenstance. So, if everyone's eligibility is tied to the month of their birthday, I think there's more clarity. I think then also every child is getting the same coverage.

I worry with the extending CE, so you always get 12 months, that it just will happen, right, that there'll be two children who have the same exact birthday. One of them happens to get redetermined late in the year, right before their birthday. That's going to mean they're going to get almost another full year of coverage compared to someone who gets redetermined shortly after their birthday, which means they're going to get less in terms of coverage.

So it's that piece that I just keep a little stuck on, that it just feels like some kids are going to get a windfall, some kids are not, and that that feels sort of not quite right to me. If we feel like the extending the length of coverage is so important, then we should focus on extending the length of coverage for all kids who meet the children and youth with special health care needs, as opposed to differentiating based on just when their redetermination happens to fall relative to their birthday.

VICE CHAIR ROBERT DUNCAN: Thank you, Anne.

Mike, John, then Heidi.

COMMISSIONER MICHAEL NARDONE: Yes, thank you, and thank you for this work.

I wanted to just ask a couple of more technical questions, more specific, understand the recommendations, make sure I understand them.

On Recommendation No. 1 where we say 60 days prior, I'm wondering, when does that clock start? Because I'm just -- maybe I don't understand the SSA process enough. Is it when the child turns 18, and then the SSI clock starts redetermination? Or is it when they get a notice, there's a notice that they are not eligible under

the adult status, and then they have their Medicaid -- I'm thinking about a 1634 state where, you know, they haven't had any real contact with Medicaid, and now they're going to get a notice, right? I'm just trying to understand what the expectation is.

I mean, I fully agree that there should be this notice. I'm just trying to understand where that begins.

AVA WILLIAMS: I'm sorry. Are you talking about Recommendation --

COMMISSIONER MICHAEL NARDONE: One.

AVA WILLIAMS: One?

COMMISSIONER MICHAEL NARDONE: Yeah, 60 days. I'm just wondering when does it -- 60 days prior to what?

AVA WILLIAMS: The beneficiary's eligibility period.

COMMISSIONER MICHAEL NARDONE: Would that be when they turn 19?

AVA WILLIAMS: Yes. Depending on the upper age limit for the pathway, but yes, it's normally 19.

COMMISSIONER MICHAEL NARDONE: Okay. So it would always be 60 days before 19, or could it be earlier than that if someone was determined ineligible?

AVA WILLIAMS: For SSI?

COMMISSIONER MICHAEL NARDONE: This is not going to be a standard process for everybody, right? Not everybody is going to get redetermined by age 19, right? It's going to be like rolling.

AVA WILLIAMS: Yeah.

COMMISSIONER MICHAEL NARDONE: So I'm wondering, what is the expectation from the state, and will they know? I mean, how will they know that, I guess?

AVA WILLIAMS: I will say that SSI age 18 redetermination is required to happen at least a year after the child turns 18, right? And then if the child is determined ineligible, SSA will send a notification to the state Medicaid agency that this child is no longer eligible, which prompts the agency to conduct a redetermination.

If it's a 1634 state, yes, there might be some issues that the state does not have enough information for this. So they would reach out to the beneficiary to collect more information to do the redetermination.

I will say I don't exactly know when that would happen, but I guess with this requirement, it would have to

happen at least 60 days before the end of the age limit. Let's just say age 19.

Am I answering your question?

COMMISSIONER MICHAEL NARDONE: I'm just a little confused about when, and I just -- the only reason I'm -- I'm not trying to -- I mean, I think it's great to get this advance notice. I'm just trying to be clear on when the state will be expected to provide that information, and it seems like there are a lot of different scenarios here, right? I know we can't necessarily address all of them, but I'm just trying to understand in my mind when that notification would go out.

LINN JENNINGS: Yeah. So because of the continuous eligibility requirement, if you lost SSI before age 19, you would actually -- you would continue to be eligible, because that's not a -- like, you would continue to be eligible through 19. And so I think -- my understanding of speaking to states is that there is -- there's like -- the redetermination happens before they turn 19, because that's the cutoff. That's when their continuous eligibility requirement would cut off, and so because of that, it would be 60 days before they turn 19.

Regardless if they lose SSI, you know, at 18 years and six months, they're still entitled, like, to the remainder of that continuous eligibility period.

So I think it, in general, I think would be fairly consistent across states, because that's the -- like, the cutoff.

COMMISSIONER MICHAEL NARDONE: I wonder if they're -- I mean, I -- maybe I'm the only one who's confused by that, but I just think maybe some clarity around what that means, not necessarily in the recommendation, but maybe in the text.

And then I wanted to just be clear, and this is more about how the recommendation is written. When I look at the recommendations, 5.1 through 5.4 are really narrowly focused on -- or more narrowly focused than 5 and 6, right? And we use the same kind of tag information about who the CYSHCNs are, the children with health care special needs, and I wonder if that needs to be reflected in the actual draft language, right? Because the last two apply to all kids with special needs, right, not just kids who are transitioning to -- you know, as adults and are transitioning to non-SSI-related pathways when they reach

age 19.

AVA WILLIAMS: [Speaking off microphone.]

COMMISSIONER MICHAEL NARDONE: Yes. I want to make sure I understand. Those are much broader, right, than 1 through 4? Because 1 through 4 is really tied to people who are getting -- potentially losing coverage, right?

LINN JENNINGS: So I think in all of the recommendations, we still have the same kind of minimum population.

COMMISSIONER MICHAEL NARDONE: Right.

LINN JENNINGS: think kind of like the intention behind some of the recommendations, for example, with Recommendation 4, would be those who would disenroll, but the kind of minimum population that we are focusing on, I think, is consistent between the recommendations, if I'm understanding.

COMMISSIONER MICHAEL NARDONE: Okay.

LINN JENNINGS: But there is kind of like a difference in kind of who would be kind of target, right? With Recommendation 4, you would have to be not eligible for any other mandatory or optional pathway at 19 to be

eligible for that optional pathway. But we're still in our kind of definition of who we think states should be and how they're implementing that. One of the considerations should be this, children and youth with special health care needs population in particular.

COMMISSIONER MICHAEL NARDONE: Okay.

LINN JENNINGS: I don't know if that is helpful.

COMMISSIONER MICHAEL NARDONE: I'll just take that it's more limited -- the population is more limited in 1 through 4 than it is in 5 through 6. The languages -- the tag language or the ending language or how you describe the population is the same, but as long as it's clear in the text, I guess I can live with it.

Those are my questions.

LINN JENNINGS: And we can make sure as we're looking through our rationale to kind of ensure that that part is clear in terms of who it would be kind of targeting.

VICE CHAIR ROBERT DUNCAN: Thank you, Linn, and thank you, Mike.

We have John, Heidi, Dennis, and Patti.

COMMISSIONER JOHN McCARTHY: I know this is kind

of late in the game, but looking at this chapter of where it ended up, I was wondering if we would consider changing this one slightly to be children and youth with special health care needs eligibility transitions to adult coverage, because really, the chapter right now, five of the recommendations really focus on eligibility transitions.

In the beginning, we talked a little bit about outside of the eligibility transitions, the actual -- what can be done around the transitions. I know six hits at that just a little bit, but I think we've lost so much in that one. So, like, talking about the things of, you know, paying two providers -- so when you're transitioning from one provider to another and you have to have two doctors meet with one another, just even getting them to meet, and then paying both of them for that meeting time and how that meeting time is -- there's no code to bill right now.

I know we talk about doing other casement, but we've, you know -- and I can't totally speak to this one. Probably Angelo can speak to it better or Bob can speak to it better. In my opinion, we kind of -- that part of the transitions, which I thought we started with, is kind of

missing from this chapter in our recommendation. So I was just wondering if there would be any thought to -- and all the eligibility stuff is super important, right? Because if you don't have eligibility, none of the other stuff matters. But is that something that we should be thinking about breaking apart?

Let me say it differently. My recommendation would be making this whole chapter just on those eligibility transitions that we could then later on go back and look at when somebody does transition, what are those things in the program that we can do better around those handoffs and making those transitions happen?

Thanks.

VICE CHAIR ROBERT DUNCAN: Do you want to respond, Linn?

LINN JENNINGS: Yeah. I think we can go back kind of and speak as a team to kind of figure out how we might want to frame the chapter.

I think to kind of those provider issues, I think that a lot of those were really highlighted in the first chapter, focusing on the, like, transition of care. And I think in kind of developing this chapter, we didn't want to

do too much repeating of what was already in that first chapter and try to have a little bit of a through line.

But I agree that this is really focused on that eligibility transition, whereas those provider handoffs and those pieces really, I think, were further emphasized in the first chapter in last year's June report to Congress.

VICE CHAIR ROBERT DUNCAN: Thank you, Linn. Thank you, John.

Heidi, Dennis, then Patti.

COMMISSIONER HEIDI ALLEN: Yes. Thank you for all this work, and you can tell that it's complicated because all of us are still, after having read it, going like, oh my gosh, it's so much. But you did a really, really good job in trying to lay it out clearly.

I also found the public comment from Got Transitions helpful to me in my thinking of these recommendations, and there were a couple things that I wanted to raise that they had suggested.

One, in Recommendation 1, they had suggested making people aware of benefits that they could be losing in the 60-day notice.

Then in Recommendation 2, they flagged that 30

days is often not enough time to get updated information from providers and specifically subspecialists, and I wondered if there's any connection between Recommendation 1 and Recommendation 2, like if part of the 60-day notice could also be these are the things that we're going to require you to provide us, could help buy that time.

I don't know if that's a question they have. I'm not sure if that would fit in there.

But also, with Recommendation 2, they mentioned, is it possible to have an exemption when you can't get in to see a provider? And this really speaks to me because I've been on a 10-month waiting list for my child to get an updated neuro-psych eval, and they just simply won't. It's like 10 months. They're just like, sorry, that's what it is.

And I can imagine if I had this eligibility hanging over my head, the helplessness that I would feel when they're simply -- and I have good private insurance that usually has better access to subspecialty providers. What kind of bind we're putting families in if they simply cannot get in to see a particular behavioral health provider to get an updated assessment and time for the 30

days? So is 30 days the right amount of time?

I think that we've already submitted something to the CBO to say, what's the cost of that? But maybe we could consider having some kind of exemption if the family can demonstrate that they are just simply unable to get into the provider to get the assessment that's required, or is it possible to include in Recommendation 1 that that information be requested 60 days in advance?

LINN JENNINGS: Just quickly respond to that. So I think we probably can, I think, think about adding more to the rationale in Rec 1.

Regarding the 30 days, I think I just wanted to note that that development came through -- or the reason we had it as like a 30 days was that's what was included in the 2024 E&E rule, and there was evidence that that was kind of a good amount of time to manage burden of, like, the administrative burden, but also beneficiary burden.

But we take your comment, and we'll think about how we can include that.

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

Dennis, Patti, then Doug.

COMMISSIONER DENNIS HEAPHY: Thanks, and thank you for moving the needle and pushing for the 12-month coverage for folks and that 19 -- turning 19.

I'm wondering, what's it going to take? What can you do? What kind of evidence would you need to move the needle even further to ensure all the folks are covered to 21? The reason I raise that is because in draft Recommendation 5.6, it talks about providing the ongoing coverage of cases management. And so if you're providing something for the kids at age 21, why not provide it all for the kids until they're 21?

It's like the 19, it's fantastic. It's a Band-Aid. But what we really need is coverage for the folks turned 21, and so what kind of evidence do we need to collect to maybe move us in that direction? So I just raise that.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

We'll go to Patti, Doug, and then we'll wrap up and get ready for public comment.

COMMISSIONER PATTI KILLINGSWORTH: Thank you both. Clearly lots of interest in this topic because it is such a vulnerable population who experiences just

inordinate challenges.

I think we're dealing with two fundamentally different sets of recommendations. One of them is really aimed more at operational kinds of issues, how kids within the current processes of eligibility processes, really the things that they have to do and making some accommodations for them to be able to do those things in order to have their eligibility re-verified. So I think those accommodations are reasonable, and we should absolutely make those and probably more than that.

The second issue -- and this is what I feel like we haven't just laid out in the chapter maybe as clearly as I would like -- is that there is fundamental misalignment in Medicaid federal policy around benefits and eligibility for kids. So benefits continue to 21. Eligibility is sort of all over the place, depending on what eligibility category that you're in.

Even though if we go all the way back to 1965 when Medicaid was created primarily to serve pregnant women, children, and people with disabilities, these are kids who have disabilities by virtue of the definition that we've assigned, and yet for some portion of them, when they

hit whatever that eligibility line is, there is no adult eligibility pathway for them. I feel like that's primarily -- it is primarily who we're serving with recommendation 5.5 -- no, 6, the one that's really about the state plan eligibility category.

Even the continuous eligibility one, a little bit, I feel like is more targeted to this population. And I've used the phrase frequently, "We are kicking the can down the road," right? With either one of these options, we are giving kids another year of eligibility. Maybe we're getting them all the way to age 21, at which point there's still a cliff for them. Their disabilities didn't go away, but these are, by definition, kids who don't qualify in this particular recommendation. They don't qualify in another existing adult eligibility pathway. They are coming off the rolls, right? It's not a technical issue. It's not a procedural issue. It's a -- we don't have an eligibility pathway for them.

So I'm still thinking about kind of the mechanisms that we're choosing here and some of the issues that other Commissioners have raised. Are these the right ways to try to at least chink away at the issue and make

some progress for them to keep them coverage as long as we can, recognizing that those things will have costs associated with them? And we have yet to see what those costs actually are.

But I don't want us to miss pointing out that this -- it's an issue bigger than we have the tools to solve at the moment, and it's one that extends beyond their childhood years, whatever you want to number that at, whether it's 18, 19, 21, whatever it is. These kids don't have coverage when they become adults, and that's a problem.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

Doug, you're done? All right.

Madam Chairwoman, I'll turn it back over to you for public comment.

CHAIR VERLON JOHNSON: All right. Thank you for that last discussion. Very fruitful.

All right. So we invite our virtual participants to raise their hand on Zoom if you'd like to offer comments. When you do, please make sure you're introducing yourself and the organization you represent. We also ask

that you keep your comments to three minutes or less.

All right. We have one. Peggy, the floor is yours. Peggy McManus, you can offer your comment now.

PUBLIC COMMENT

* DR. PEGGY McMANUS: Yes. Can you hear me?

CHAIR VERLON JOHNSON: We can hear you now, yes. Please go ahead.

DR. PEGGY McMANUS: Okay, great. Thank you.

I'm Peggy McManus with the Got Transition Program, and I really commend MACPAC and the Commissioners for all their due diligence on this challenging issue.

I wanted to comment on two things in particular, the issue about this benefits and eligibility and how they're oftentimes quite intertwined. Families and young people are not aware of the eligibility changes. They're also not aware of the benefit changes.

To the extent that in the first recommendation, there could be some inclusion of informing people about the changes in the loss of EPSDT, I think that would be really important.

Another comment I had was about the question about, you know, what is the time point at which the 60

days kicks in? SSI, SSA has a provision called Section 301 that allows a young person who has been receiving special ed and who does not graduate from high school can continue on SSI if they're in an approved program, like a vocational program, and thus be able to retain their SSI and also retain their Medicaid. And I just wanted to make certain that that Section 301 be looked at, because I think people oftentimes are not aware of that.

Again, I think that the issues came up about, like, you know, the handoff from one provider to the next and whether or not that should be, you know, in the transitions in care in the future or here. I do think it's transitions in care. Again, should you -- we're very steeped in this stuff, but I'm happy to comment on that later.

But, again, I thank you for this important work.

And just one shout-out, just to acknowledge how important plain language is, especially for this population who has little or no experience in moving from one insurance eligibility pathway to another or from one plan to the next. So making it as simple as possible would be really important.

Thank you.

CHAIR VERLON JOHNSON: Thank you, Peggy.

Any additional comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. So hearing none or seeing none, I do want to remind you that if you have additional comments at any time, you can submit those on the MACPAC website.

And now we will take a lunch break, and we'll return at 1:30 p.m. Eastern. Thank you.

* [Whereupon, at 12:22 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.)

AFTERNOON SESSION

[1:31 p.m.]

CHAIR VERLON JOHNSON: All right. Welcome back to -- after lunch. Hope everyone had a nice lunch. We're going to kick off our afternoon sessions focused on automation and Medicaid prior authorization.

I'm just going to say from the onset that I'm really excited about this one. Like, you guys know how I feel about this. I think this is the area where we're really seeing some real momentum and not just in Medicaid, but really across the whole broader health care ecosystem. So the use of automation AI has a potential, as I think we've talked about several times, to really fundamentally change how prior authorization works, right? Improving timeliness, reducing administrative burden, and really creating a better experience for both providers and beneficiaries.

So I'm going to turn it now over to our analysts. We have Patrick and Katherine to really walk us through the chapter and recommendations. So the floor is yours.

AUTOMATION IN MEDICAID PRIOR AUTHORIZATION (PA): DRAFT RECOMMENDATIONS

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

This afternoon, Patrick and I will present recommendations derived from our research on automation in the Medicaid prior authorization process and developed from the policy options we brought to our meeting last month.

I'll keep the background matter pretty brief today, but I'll recap a couple key features of this work. I'll review our key findings and the policy principles we also shared last month, and then I'll turn it over to Patrick, who will present our draft recommendation language, the rationale for each of the four recommendations, and the implications for stakeholders.

We undertook this work as an outgrowth of some prior work on authorization denials and appeals that culminated in a 2024 report chapter. In this work, we've sought to understand the extent to which Medicaid programs, either in managed care or fee-for-service, are using automation in the prior authorization or PA process.

We've defined automation within this work as the use of technological tools, such as algorithms or artificial intelligence, AI, both defined on this slide, to

supplement or replace human action or decision-making. The work has involved a literature review, policy scans at the federal and state levels, and stakeholder interviews with representatives from states, health plans, beneficiary advocates, providers, and technology vendors.

With that, I'll summarize our notable findings.

First, we found that states and managed care plans are deploying AI and algorithms in Medicaid PA and have found a variety of uses for these tools. In our interviews, all states and managed care plan respondents reported some form of automation within their PA process, most often rules-based algorithms using clinical criteria to determine medical necessity.

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

Next, we found that states and the federal government have limited visibility into managed care plans' use of automation in Medicaid PA. States may leverage their existing contracts or oversight activities for

managed care plans to identify uses of automation, but not all states do so.

Respondents reported that managed care plans may disclose or demonstrate automation technologies, but typically, this was happening on a voluntary or ad hoc basis.

Current federal policy neither prescribes nor prohibits specific uses of automation in PA. There are currently no Medicaid fee-for-service or managed care requirements in either statute or regulation that specifically regulate, guide, or monitor the use of automation in PA. Some states, however, have passed legislation regulating payers' use of automation in care decisions.

Similarly, we found some states' managed care plans and IT vendors have established formal AI governance structures to monitor and guide the use of automation in PA. We also found that automated PA processes could present potential risks to Medicaid beneficiaries, providers, and payers.

Stakeholders raised concerns that automated PA systems could make incorrect determinations due to

technical issues such as data bias or programming errors. Stakeholders also raised concerns about the complexity of AI and protections for proprietary software that could limit transparency into PA decisions.

Finally, limited federal guidance on automation may be impacting the adoption of automation tools in Medicaid PA. Some stakeholders acknowledge that they are reluctant to implement automation in the absence of federal regulations and that variation in state laws could create an uneven regulatory environment that can be difficult to navigate.

Our findings revealed a couple key challenges that I'll cover next.

First, there is limited transparency into how automated PA systems work and their impact on cost and access to care. Stakeholders representing beneficiaries and providers said they have little visibility into how automation is being used, how these tools make PA decisions, and the approval and denial rates for such systems. Stakeholders noted that the highly complex nature of AI limits understanding of how and why PA decisions are made.

CMS and states have existing oversight mechanisms such as the External Quality Review Process, or EQR, and the Managed Care Program Annual Reports, or MCPARs, and state contracting authorities that could provide insight into the use of automation, but respondents in our interviews did not report using these or any other newly developed mechanisms to conduct routine oversight specific to managed care plans' use of automation.

Limited transparency can reduce states and CMS's ability to oversee those potential risks of automation, and limited transparency into automation systems also prevents states and federal governments from monitoring those technical issues, such as data bias or programming flaws.

There is limited federal guidance regarding automation in PA, and the state guidance varies. Federal and state policy govern Medicaid managed care and fee-for-service prior authorization. Automation has spread rapidly in recent years, and these policies do not directly regulate, guide, or monitor its use in the PA process.

Language in federal Medicaid managed care regulations does require oversight of adverse decisions, similar to the regulations for the Medicare Advantage

Program. This language is silent on automation specifically, and fee-for-service regulations do not impose the same requirement.

Stakeholders representing states and managed care plans stated that the absence of federal guidance makes many states and managed care plans reluctant to implement automation tools or worried that action they do take may be disrupted by federal action in the future or require reworks of action that has been taken.

Variation in state laws may create additional compliance burdens for those implementing automation.

And with that, I'll briefly recap the principles we shared in the March session.

First, automation in Medicaid PA offers administrative efficiencies for payers and providers, which can improve the timeliness of approvals, the beneficiary experience, and access to care. These efficiencies can reduce costs for both payers and providers and reduce approval times for beneficiaries. When contemplating the potential risks of automation use, it's important to consider these benefits.

Second, transparency and disclosure are important

tools in documenting and assessing the use of automation, including the nature of emerging risks. It's difficult to oversee automation if its use is not disclosed or known.

With limited transparency, states and the federal government are less able to monitor for those potential risks posed by automation tools, including inaccurate coding, data bias, and more.

And finally, due to the evolving nature of automation technologies and their increasing application, ongoing reevaluation of the oversight policy framework in Medicaid PA is warranted. Automation technology is improving in its functionality and quickly expanding.

Given this rapid evolution, some of the risks identified now by stakeholders may fade while new risks may emerge. This warrants ongoing data collection, evaluation, and reassessment.

And with that, I'll turn it over to Patrick, who will present our draft recommendations.

* PATRICK JONES: Thank you, Katherine.

This next section of the presentation will present draft recommendations that address the findings and challenges Katherine just detailed.

These next two slides visually map our findings to the draft recommendations, just for your reference. I'll go into greater detail about how each draft recommendation addresses these findings in the presentation in the subsequent slides.

Okay. So moving into Recommendation 1. Recommendation 1 clarifies the role of human oversight in PA decisions in Medicaid managed care. It recommends that the Centers for Medicare and Medicaid Services should issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that the language at 42 CFR 438.210(b)(3) requires an individual with appropriate expertise to review and authorize all decisions to deny service authorizations, including those proposed by automated systems.

This guidance should clarify further that, one, adverse determinations may not be made by automation tools alone. Two, adverse determinations must be made based on determinations of individual medical necessity. And three, all existing regulatory requirements related to adverse determinations apply, whether or not automation is used in the process of issuing an authorization decision.

So current regulations do not offer clear direction on automation and PA. Regulatory text suggests that a human must review adverse decisions but does not explicitly bar automated systems from doing so.

This recommendation's guidance would clarify that a human reviewer with expertise must review all PA decisions, including those involving automated systems. Human oversight safeguards against the potential risks of automation, such as bias in AI-based tools or programming errors in rules-based algorithms. Human reviewers can use their expertise to identify and correct when automated systems make incorrect adverse decisions.

There is a consensus among stakeholders that this is a common and appropriate safeguard. In interviews, managed care plans, IT vendors, and states reported that they already have a human-in-the-loop policy for adverse decisions.

Furthermore, this recommendation creates consistency across states. Some states have passed laws requiring a human-in-the-loop for adverse PA decisions, while others have not. This guidance would clarify that this is a requirement across states, reducing some of the

regulatory variation that poses a barrier to the adoption of automation.

So moving into the implications for Recommendation 1, MACPAC has asked CBO to estimate draft recommendations' impact on federal spending, but we have not yet received estimates. So, for the impact on states, this recommendation will have a minimal impact on states.

States will be responsible for ensuring managed care plans' compliance with these requirements and may need to adjust their oversight processes to do so. This may require additional administrative spending by states.

This recommendation may provide enrollees with additional protection from incorrect adverse determinations, which can improve access to care and reduce administrative burdens for beneficiaries.

This recommendation may have some impact on managed care plans. Stakeholders report that human oversight mechanisms are already common. So most plans are already in compliance with the guidance. Plans that do not have these mechanisms in place will need to implement them, which may require implementing new IT functions or human reviewers, which may create costs for those plans.

Finally, this recommendation will have a minimal impact on providers. Human oversight may reduce the number of incorrect adverse determinations, which in turn could reduce administrative spending on PA appeals.

Recommendation 2 aligns fee-for-service PA regulations and managed care regulations with regards to human oversight of PA decisions. It recommends that the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to amend the regulations at 42 CFR 440.230 to provide that, in fee-for-service Medicaid programs, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollees' medical, behavioral health, or long-term services and supports needs.

Consistent with Recommendation 1, this recommendation requires that an individual with appropriate expertise make all adverse determinations, and that determinations must consider enrollees' specific needs. CMS could clarify in the preamble to the proposed

regulation that these requirements apply to automated PA systems.

Like Recommendation 1, Recommendation 2 would help mitigate risks posed by automation by ensuring human oversight of automated PA determinations. Interviewees said that automation is limited in fee-for-service compared to managed care, but we found no evidence that the standards for oversight should differ. Instead, these same risks may arise in both delivery systems.

Furthermore, if issued together, Recommendations 1 and 2 would create alignment between managed care and fee-for-service Medicaid programs.

Recommendation 2 also addresses the absence of federal guidance and variation in state approaches to automation. These regulatory changes would create a consistency for the utilization management entities and IT vendors that serve fee-for-service Medicaid programs.

Finally, Recommendations 1 and 2, issued together or separately, would increase Medicaid alignment with Medicare Advantage regulations concerning automation.

Recommendation 2 may impose additional administrative costs on states. In interviews, state

representatives reported that their fee-for-service programs require human review of PA decisions, but we do not have evidence that all states do the same. Given this, some states may need to update their PA systems to include human review, which may impose costs.

Like Recommendation 1, Recommendation 2 may provide enrollees with additional protection from incorrect adverse determinations and may reduce administrative burdens for providers. This recommendation would not have an impact on managed care plans, as it applies only to fee-for-service Medicaid programs.

Our next pair of recommendations concern transparency in the use of automated PA systems.

Recommendation 3 aims to enhance states' ability to monitor and conduct oversight of managed care plans' use of automation and PA. It recommends that the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans specifying ways in which existing regulatory oversight processes, including the external quality review process and mandated plan reporting required

for Managed Care Program Annual Reports, can be used to create effective oversight of managed care plans' use of automation and utilization management.

This guidance would describe how states can use existing oversight tools such as managed care readiness reviews, external quality reviews, and managed care program annual reports to oversee managed care plans' use of automation.

It can also recommend states mandate reporting or other activities to gather information on automation. Information gathered can focus on how plans use automation and its impacts on the program and do not necessarily need to collect proprietary information on technology or coverage criteria.

This recommendation addresses the finding that states have limited insight into managed care plans' use of automation and PA. States reported that they do not have formalized mechanisms for monitoring automation. Some reported that they lack the time and resources to develop such mechanisms and stated that federal guidance can reduce this barrier.

Recommendation 3 also complements and builds upon

existing MACPAC recommendations issued in 2024 and 2023 on managed care oversight and would complement recommendations the commission is currently considering regarding managed care accountability.

Recommendation 3 will have some impacts on states. This recommendation would not mandate that states conduct any additional oversight or monitoring activities. States would be free to conduct them in a manner that fits within their administrative and financial capacities, but some states may choose to invest additional resources into these activities.

States utilizing this guidance should benefit from the additional information these activities provide. Some managed care plans may incur additional administrative costs in order to comply with state-determined requirements, but this would vary by state.

This recommendation does not directly impact providers or beneficiaries. These groups may experience downstream effects if the additional reporting and oversight specific to automation in PA identifies potential issues that lead to changes in PA criteria or processes.

Recommendation 4 speaks to states directly. It

recommends that state Medicaid agencies should amend their Medicaid managed care plan contracts, on a timeline that is practical to require disclosure or other reporting of the use of automation in plans' coverage and authorization processes described at 42 CFR 438.210. Disclosure should facilitate state visibility into the applications of automation tools and other meaningful elements of automation, such as plans' protocols for testing, evaluation, and oversight. To the extent possible, states should modify existing reporting requirements or existing oversight processes to minimize additional administrative burden.

In interviews, states reported little newly imposed oversight specific to automation in managed care, which limits their visibility into plans' use of automation in PA. States hold unique authority to impose contract standards for plan performance and reporting, such as requiring that plans report if and how they use automation in the PA process.

Recommendation 4, if followed by states, increases transparency by using existing mechanisms to conduct oversight of managed care plans' use of automation

in PA.

As with Recommendation 3, states may need to invest additional resources to conduct these activities, but states would be free to do so in a way that matches their current capacities. State costs could be eased by the issuance of CMS guidance per Recommendation 3. Furthermore, states should benefit from the additional information obtained through these activities.

In states that adopt this recommendation, managed care plans may incur additional administrative costs to comply with state requirements, and as with Recommendation 3, this recommendation does not directly impact providers or beneficiaries but may result in downstream impacts as a result of changes to PA criteria or processes.

So this concludes our presentation of the draft recommendations for automation and Medicaid PA. During Commissioner discussion, we would appreciate your feedback on the proposed recommendations, including feedback on the framing or wording, as well as the rationale or implications.

For the May meeting, we will present a draft report chapter that reflects Commissioner input. We ask

for your feedback on the following questions. One, are there outstanding questions about the recommendations that staff can answer? And two, are there other factors for staff to consider while refining the recommendation language, rationale, and the implications or other content for the draft chapter?

And with that, I will hand it over to Verlon for the Commissioner discussion.

CHAIR VERLON JOHNSON: Thank you so much, Patrick and Katherine. That was very, very helpful. I mean, as we look at this topic of AI automation, we know that it's coming, right, whether we're ready or not for it. I appreciate that we as a Commission are really thinking about how we can help states help to shape that and not just react to it. So I'm really excited about this conversation.

The recommendations to me feel very thoughtful and measured, particularly in reinforcing the role of the clinical oversight, that human-in-the-loop -- or human-in-the-lead, as I like to call it, because it also helps us to really figure out, too, the value of automation. So I really appreciate that.

Let me see what the rest of our Commissioners are thinking and comments that they have around the recommendations in the chapter. So let's see. Bob Duncan, Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Chair.

You actually brought into the conversation what I wanted to mention as I read the recommendations, which, again, I thought were fantastic. It talked about human-in-the-loop. You know, at the last meeting, we talked about human-led, and I just want to make sure. You know, my concern is how far that human is in that loop versus being brought in sooner. So that's just something I think we've got to think through and I'd like to call out, because I don't want everybody jumping through a million hoops before they get to a human that can make sense out of it.

CHAIR VERLON JOHNSON: Great point.

Tim?

COMMISSIONER TIM HILL: So I hate to contradict the Deputy, but let me go in a different direction in the loop.

Help me understand in the recommendation, when you're talking about adverse determinations having to be

kind of reviewed by a human, like, there's a lot of stuff where we say no that is, you know, "never events" or, you know, limbs that are amputated that have already been -- like, where does that start? There's a lot of claims processing processes that are automated that result in adverse determinations. Are we saying that we've got to expand the review there, or are we only talking about certain types, whether it's prior authorization specifically as opposed to other claims processing edits that have to be reviewed by a human? Does that make sense?

KATHERINE ROGERS: I think we're happy to take this back and think more about it.

In contemplating sort of the life cycle of utilization management -- and there are many, many stages of that, right? From prior authorization, there are other things that happen throughout claims adjudication, post payment, et cetera.

The language that's referenced in Recommendations 1 and 2 that's already in existing Medicaid managed care regulations pertains to the prior authorization process and so seeing that clearly circumscribed there, but there's no shortage of other interesting questions to consider.

COMMISSIONER TIMOTHY HILL: And that makes sense to kind of bound it that way. Got it.

CHAIR VERLON JOHNSON: All right. Thank you.

April?

COMMISSIONER APRIL HARTMAN: A couple things. I appreciate your use of the appropriate expertise rather than human-in-the-loop, because I can tell you there's been many times I've talked to someone who had less expertise than myself when trying to get a prior approval through. So I would encourage the use of that term rather than "human-in-the-loop" throughout the paper, because I think it's really important to define that this needs to be someone with an expertise that can adequately answer the question that you're asking.

One thing that kind of stood out to me as a provider of this, I really like that someone with expertise has to look at any adverse decision. I would kind of like to see something that says "and require an explanation of why," you know, because sometimes we'll get, oh, they've been denied this. And you're like, why? And then, like, you finally talk to someone. You're on the phone, on hold forever, and they say, oh, they need an x-ray first. Well,

just tell me that. I could have done that and then resubmitted it. It's helpful to have an explanation of why that adverse determination was done. So I don't know where that comes to play in this, but to get a denial with no explanation, no matter who's looked at it, is not helpful.

KATHERINE ROGERS: Just one note on that, and I think we can elaborate on this in the chapter perhaps. But some of the requirements of the interoperability rule that was finalized in 2024 and effective this year imposes certain requirements on denial notices and the reason for denial. So we can take that back and make sure that that's covered. Thank you.

COMMISSIONER APRIL HARTMAN: Thank you.

CHAIR VERLON JOHNSON: Thank you.

Doug?

COMMISSIONER DOUG BROWN: Thank you.

On Recommendation 2, where it talks about -- I guess I'm concerned with "any decision to deny in any amount, duration, or scope that is less than requested, an individual," et cetera, et cetera, has to approve that. And I'm fine with that, but I'm concerned that when it's referenced to Section 440.230 -- and in that section, it

already says the plan must specify the amount, duration, and scope of each service that it provides for. So just because someone makes a request that could far exceed what is already in the plan, what the plan pays for -- and I know pharmacy is excluded. There's great examples I could use with pharmacy, but pharmacy is excluded from this section. Specifically, drugs are excluded from this section.

But there could be situations where it's an error in writing and an error in the request, because it far exceeds what the plan already pays for.

A response, as to Tim said, like, just here the parameters of the program for what we cover, right? That should be it. I don't know that you need a human being to then call on every one of those that are outside the plan and say, you know, this is why it got denied, and this is the service that it got denied for, because you wanted six x-rays when we pay for two x-rays, whatever the case is, particular condition. So some concern about that language that any denial, an exception to that, trying to kind of link it back to the statute that you're trying to modify.

Thanks.

KATHERINE ROGERS: I'll not only right now -- and I don't need to keep chiming in on every comment, but the language in Recommendation 2 is intended to mirror the recommendation -- or I'm sorry -- the language that's already in the Medicaid managed care regulations to create that parity that Patrick mentioned or alignment.

We can take this back. I think this does go back to Tim's point about there's sort of a very broad continuum of utilization management pieces, of which PA is one, and so we can think about how we address that in the chapter.

CHAIR VERLON JOHNSON: Thank you.

Sonja?

COMMISSIONER SONJA BJORK: Thank you.

I wanted to follow up on Commissioner Hartman's comment about the importance of the contents of the notice, and if you're going to take that back and look into it, just being aware of the NCQA standards that are pretty specific about who has to get notified and what it should say in the notice, including a requirement that it should be said in plain language so that regular people can understand what's going on.

So some states require all the health plans to

have NCQA accreditation, and some do not. But it gets confusing if there's different rules by different regulators or different standards. So I just want to advocate for looking at the NCQA standard and trying to find alignment.

Thanks.

CHAIR VERLON JOHNSON: Thank you.

Dennis and then Carolyn.

COMMISSIONER DENNIS HEAPHY: Thanks.

Appreciate that you have the human looking at the adverse decision. But I'm wondering, if I'm a provider and I'm looking at this information and it says that it was already denied, is that denial already going to be in my head? So is there a way to, like, blind the provider so that they don't know whether it was denied by AI or not -- or some algorithm or not, so that they're actually making it on their own decision rather than based on what was denied? I think you can go either way.

But my other concern is if they do have access to the AI information or the automated information, will they have all the information they need? Because this is a proprietary information that plans have. So it's kind of

like mounting an appeal. Do we have all the information we need to mount an appropriate appeal if the information used to determine your denial was proprietary? So will that human, if they're going to have access to the AI information, will they have access to all the information, the proprietary information as well, so they can actually really delve into how that decision was made?

CHAIR VERLON JOHNSON: Thank you, Dennis.

COMMISSIONER DENNIS HEAPHY: That's one of the biggest concerns the community has is not being able to mount an appropriate appeal.

CHAIR VERLON JOHNSON: Thank you.

Carolyn?

COMMISSIONER CAROYLN INGRAM: Thank you.

I wanted to ask just one clarifying question, back to -- I think it was Commissioner Hill's comment on Recommendation 1 around adverse determinations.

So I went to look at the CFR section, and I don't see it in here. So maybe you guys can explain to me. If there's a denial for a service -- and I think mostly of drugs, for example. If somebody wants a brand-name drug, but the generic drug is just as good or qualifies and they

deny the brand name, but they substitute in or allow the generic, are you still asking in that section or in that case, that type of scenario that it has to be reviewed by a human person? And I don't know if those things are automated or not. Maybe Doug does or Commissioner Brown does. But I'm trying to figure out, in those cases, where you're really not denying a service overall, you're still providing the service, is that considered an adverse determination?

And I couldn't find it in the CFR section that we were -- that's in here, but maybe you all could clarify that somewhere in the documents or something in the writing.

KATHERINE ROGERS: So like a clear definition of what partially denied?

COMMISSIONER CAROLYN INGRAM: Well, or what do we mean by adverse determination exactly

KATHERINE ROGERS: Okay.

COMMISSIONER CAROLYN INGRAM: Do we mean we just say, no, it's a full-on denial, or do we mean any adverse determination? So if you're given something like -- we'll say RTC days. Somebody wants to assign somebody to be in

an RTC for three months, and the MCO says, no, sorry, you only really need to be there two months -- or drugs, you don't need that brand name. I'll just use Adderall, and you could have the generic Adderall. What do we really mean by adverse determination?

To me, if we're stepping down something and it's still covered and you're still getting that benefit, that's not a full-on denial. So do we need to clarify that language of adverse determination to say a denial, like you're not getting care? I'm sure I'm guessing somewhere in the CFR that's defined. I don't know. Anyway, if we could clarify that.

Thank you.

CHAIR VERLON JOHNSON: Thank you. Good call-out, Carolyn.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Not an attorney, but having been involved in litigation pertaining to this issue, I will tell you that adverse determination includes even an approval that is less than the duration or intensity of a service that was requested. So a partial approval is an adverse determination from a Medicaid

perspective. But please feel free to look that up and dig into it.

I think the nuance that both Doug and Tim brought up, which maybe we could easily clarify, is around whether a benefit is covered on the front end or not, and I think that simple language -- also, having litigated on this particular issue or been involved in litigation on this particular issue -- is that in order for -- you don't even get to medical necessity if a benefit isn't covered. So the real issue is we're looking at medical-necessity determinations of covered benefits, obviously, which is based on the benefits that that person is eligible for, maybe different if it's a child versus an adult, all the things that go along with that. But just simply by calling out covered service or covered benefit, it may address this nuance.

We would not want an individual to review -- to have to review something that's clearly outside the scope of a covered benefit.

CHAIR VERLON JOHNSON: Thank you, Patti.

PATRICK JONES: Patti, thank you.

CHAIR VERLON JOHNSON: That's helpful.

Mike?

COMMISSIONER MICHAEL NARDONE: Just to kind of -- because my head went to the pharmacy denials that happened, maybe because someone is requesting a medication, but it isn't -- like, it's too soon from the past prescription, so that, you know, there's -- you can only -- there's only a window where you could apply. To me, that's -- if it gets denied, that's an adverse decision.

I guess I'm just wondering. I think we just need some clarity around pharmacy in particular, but I guess it does also apply in other areas.

I heard you say that you didn't think pharmacy was included.

KATHERINE ROGERS: It's excluded from this section, and it's in Chapter 431.60(b)(6). That's where the -- that's where the drugs are addressed. But in 440.230 is where it says -- it talks about prior authorizations requested for items and services excluding drugs, and then drugs are in another section. But I didn't read the other section to do prior authorizations and things like that for drugs.

And I think, Carolyn, to your thing, they used to

track those as approvals, changes, and denials. So your Adderall example with brand and generic, it's approve, change, or deny, and then the denials would have to be escalated the appropriate way.

COMMISSIONER MICHAEL NARDONE: I had some other questions, too. I wanted to ask, in terms of the recommendation around inclusion of this information in MACPAR and some of the other tools, does this -- on one hand, you say state flexibility. Are we saying that in the rationale? And I'm wondering, are we saying that the guidance would not be a requirement, but it would be how they could possibly use MACPARs? Is that what the -- I just want to be clear on what the recommendation is.

PATRICK JONES: Yes, that's correct. It wouldn't mandate any reporting.

COMMISSIONER MICHAEL NARDONE: Okay. So it'd be up to states to -- so the guidance would basically be saying this is a tool you could use if you choose to.

PATRICK JONES: Yes. Correct.

COMMISSIONER MICHAEL NARDONE: All right. Then the only other -- in writing the -- you mentioned something, Patrick, that I think was important that we had

talked about at the last time I think we had this meeting, was around how does this policy align with Medicare Part D -- not Part D -- Medicare Advantage. So I just would recommend that when we're writing this up as a chapter, that these -- one of the things, I think we don't want to create a system where we have here's the Medicaid, here's the Medicaid rules, here's the Medicare Advantage rules. You're trying to be like -- you know, you're trying to get away from fragmentation. So it seems to me that should be something we highlight in describing these recommendation.

And then I just want to be like -- we've developed three principles. The principle that really comes out in our recommendations is the transparency piece. So I guess maybe future work or maybe understanding how do these pieces fit into the idea of encouragement of the use of -- facilitation of the use of AI as well as a nimble structure for like making changes, because like -- AI is happening, and we're always behind, right? And so how do we kind of keep that framework going?

Maybe it's just talking about the fact that there is this -- you know, kind of putting in the context of trying to come up with a solution that is shared across the

federal government, at least. I mean, there are a lot of ways you go with it, but I think you want to tie back to the principles. The transparency piece comes through loud and clear. I'm not sure the other two do.

CHAIR VERLON JOHNSON: Thank you, Mike.

Jenny and then Adrienne.

COMMISSIONER JENNIFER GERSTORFF: I just wanted to expand on one of Commissioner Hartman's comments. In Recommendation 1, where we discussed the appropriate person with applicable expertise, that was something that stood out to me in the chapter, especially because you mentioned in part of the research that the use of automation shows an increased likelihood of denials. So that fact suggests maybe someone will lean more on what the AI has suggested. But if you have someone who is credentialed for making certain decisions, then that credential is very serious. You can lose your credential. So just being very clear about credentialed review of certain things and expanding on that definition of applicable expertise.

CHAIR VERLON JOHNSON: Thank you.

Adrienne?

COMMISSIONER ADRIENNE McFADDEN: So I was

debating whether or not to speak up, because I think Patti essentially said everything, I wanted to say around the coverage piece, but just wanted to emphasize I think maybe it would be helpful in the materials that -- it talks about adverse determinations. I'm wondering if it would be helpful just to be more specific around adverse determinations based on medical necessity, because there are administrative denials for many different reasons. If that gets brought into all of this, it will just complicate things. I think that's where having an expert in the field to be involved in this makes the most sense is when we're talking about medical necessity-related denials.

CHAIR VERLON JOHNSON: Thank you for that.

And then Jami.

COMMISSIONER JAMI SNYDER: I actually have a question for Doug. I'm sorry to catch you off guard, but I'm just curious.

So I appreciate that you brought up that the regulatory reference in the chapter and in the recommendations does not include drugs. Is your suggestion that it be included, or was it just a point of --

COMMISSIONER DOUG BROWN: No. Because I think to

maybe Carolyn's point, there are so many changes and denials in pharmacy, that that process is already well established in states. There are lots of changes that go on when requests are made for preferred products or for non-preferred products, and there's automation in those systems that looks back in patient history for trial and failure of other products, and if so, it automatically will allow the prior authorization to go through. And the drug will be paid at the pharmacy level, or it'll be denied, and it will get circled back to the physician and close the loop that way.

I think that system is already pretty well established, but there are so many prior authorizations in there, that it would overwhelm a program if you had to verbally call every single time, made the state call on every denial that went through or every change.

COMMISSIONER JAMI SNYDER: Yeah. I'm in agreement. I just want to make sure we clarified for the MACPAC team.

CHAIR VERLON JOHNSON: All right. Thank you.

Dennis?

COMMISSIONER DENNIS HEAPHY: In terms of the

denial versus the modification, that for someone who needs 15 or 20 hours of PCA and they give them 15, that means they're going to figure out what to do if they can't go to the bathroom. That's a denial. It may seem like they're modifying that, but that means that person has to figure out how they're going to get to the bathroom during enough hours, PCA hours. If someone gets a wheelchair and it's not the wheelchair they requested, that could mean -- like for me, it means I wouldn't be able to use my elevator. That wheelchair is just going to sit there and not be used? So the modifications can also very much be a denial in every sense of the word, because a person can't use that piece of equipment.

I think something else we need to bring to the conversation is how SDOH impacts the need for especially LTSS, because the interaction between where a person lives -- they live in an accessible apartment, and they need assistance to go to the store or whatever it may be. AI may not understand that the person can't leave their apartment if they need that assistance with that IADL. It's very nuanced and very much a person's -- really human person-centered approach that's needed with a lot of this

stuff.

I agree with you that AI can really streamline and do this. For instance, with using AI to determine if something's an administrative denial, that should be the first thing it does. Then if it's an administrative denial, then just spit that out and get that administrative process fixed.

When it comes to other things, it's so much more nuanced. Thank you for putting in the human expertise. But I do think that for LTSS, the person needs to have expertise in -- and you do have that in one area, HCBS and independent living principles and also SAMHSA-defined recovery principles, because it's really important that decisions be guided by those things as well.

CHAIR VERLON JOHNSON: Thank you, Dennis. That should call those out for sure.

April?

COMMISSIONER APRIL HARTMAN: I just had one clarification, I guess. When we say that these adverse determinations have to be reviewed by someone with the right expertise, we're not talking about a phone call. We're just talking about they have to review it and give

you a response, right? Because in my experience with prior approvals, the way it works is you get a response. If you don't agree with it, you may ask -- I mean, you request something. You may get a denial. You then can -- it'll tell you why sometimes, like maybe I didn't give enough information or something was missing. And then someone reviews it and tells me approved or denied. If it's still denied, then I have an opportunity for a peer-to-peer conference. Then I talk to somebody.

But this, when we say an expert in the loop, we're not talking that they have to talk to me right away, just that they need to set eyes on why this was denied and make sure that's appropriate, right?

KATHERINE ROGERS: I happen to have the rule right here, so hopefully -- this is the Medicaid managed care rule. It requires that the Medicaid managed care contract require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and support needs. So it doesn't

necessarily address the process by which, but that the decision is made by.

Going back to a point Mike made earlier about the alignment with the Medicare Advantage rule, I believe that the Medicare Advantage rule, which is not applicable here, but just to note says that before the decision is issued. And so this is the language in the Medicaid managed care rule, though.

COMMISSIONER APRIL HARTMAN: Okay. Thank you.

CHAIR VERLON JOHNSON: Thank you.

John?

COMMISSIONER JOHN McCARTHY: I promise I was trying not to talk on this one.

What I know I'm getting hung up on, and I think some of us are getting hung up on, is the fact that we're dealing two different things at the same time. One is just we're expressing our -- probably -- and I'll just say for myself -- personal frustrations with the prior authorization process, whether or not AI is being used. But just I think what's coming out a little bit is just the prior authorization process in general, whether or not we're using AI, we're saying we want a human involved in it

to do it. There needs to be something there.

The second part then is this chapter was focused on using AI in these things, and so how is that different? I think the discussion that people are bringing up is excellent points, and we probably want to say something. So I was trying to figure out, is there a way to navigate this to break it down into specific areas?

Our recommendations are just so gigantically broad, which I get why they are, but then it makes it hard because it's like all these discussions we're having. Well, wait a second. How does this apply to drugs versus HCBS services versus physician services? So it's almost like should we try to break it down and say we're going to make this recommendation for -- we're going to exclude drugs, or we're going to make this recommendation just for HCBS services first to find out what comes out through there?

Because then Recommendation 3, I think is probably one of the most important, but I think it gets lost in there, because what we're really trying to do is measure how well automation is improving or not improving the prior authorization process. I don't know if we're

getting at it with what we've written there.

So it's almost like what are the measurements -- what are the specific measurements? I don't even know how to evaluate if PAs are improving things or not improving things. So I was trying to think of, do we have to think about that more of what is it we want to look at? Just because the number of prior authorizations denials goes up doesn't mean that's a bad thing. I mean -- because we've talked about it. If they go down, that also doesn't mean they're a bad thing. So it's almost like, what else do we need in there?

So my suggestion was, do we need to, in our recommendations, limit it? I totally get what you're trying to do, but it's almost like a pilot project. We look at it from a standpoint of, just looking at this group, we apply it to that because -- you know, Dennis's examples were excellent. I was just thinking through the standpoint of durable medical equipment and the request for a wheelchair and all the specialty items that a person needs to make a wheelchair functional for them to be able to live their life independently. Yeah, if you just ran that through, not even AI, but just a regular algorithm,

probably would deny most of the things a person needs, right? So how does that get involved in that type of a thing?

Anyway, I know it's not a great solution there, but maybe we should think about narrowing the scope a little bit on this one.

CHAIR VERLON JOHNSON: Thanks, John.

Any thoughts on that one, Katherine?

KATHERINE ROGERS: I think a couple of the clarifications that folks have asked for are relatively easier for us to address things like the medical decisions subject to a medical necessity review, limiting -- you know, we're talking about things that are within the coverage criteria, et cetera. So a few of those, I think, are -- and I think also the scope of the regulations that we're -- are even at -- I can't think of the right word, but like at stake here that we're talking about 438 and 440, so we can put those outer bounds on them too.

I 100 percent agree that the range of things for which PA is required in state Medicaid programs is diverse, and they're -- just based on my own experience in the long-term care world, are very -- you know, the processes are

distinct for prior authorization in different spaces. So we'll take that part back. That's a little more complicated, but the rest of it, I think we can include definitions for things in a chapter and things like that that would be helpful to address some of those.

CHAIR VERLON JOHNSON: Thank you.

Yes. Who was that? Mike.

COMMISSIONER MICHAEL NARDONE: I just wanted to respond to John and Katherine's point. I mean, I think one of the issues here, right, is I think to say do it as a pilot, the problem is I think right now, most of the processes -- maybe I'm making a generalization here, but most of the processes that use AI do have a human-in-a-loop process. I thought that was one of the things that we identified in some of the research and evaluation.

So one of the problems is if you kind of then look to narrow the scope, that might mean that those things that were used, the human-in-a-loop, would not be part of our recommendation. As you were talking, John, that's what I was struggling with a little bit because it is -- I mean, I think it is used more broadly where you have human-in-a-loop, and now if you say, well, we only recommend it for --

or this is our proposal to just do it in LTSS, I think then that leaves this whole body where human-in-a-loop is generally being deployed. And wouldn't you want to support that?

CHAIR VERLON JOHNSON: Okay. April?

COMMISSIONER APRIL HARTMAN: I just want to say, I don't think we need to narrow it, kind of piggyback on that. I almost think it needs to be broader. There's very distinct -- when it comes to medical necessity, there's very distinct clinical practice guidelines and things that need to be in place for something to happen.

If someone needs their tonsils out, we know the rules as physicians. We know what Medicaid requires, that they need to be 11, that you need to have tried these other things. And you only get it earlier if it's whatever, because usually they outgrow it. There's specific guidelines that go along with things that I think can be built in.

Actually, AI could probably be expanded to be more -- I mean, it might actually help rather than hurt. So I think we need to embrace AI in the prior authorization process. We just need to be clear about it, that this AI

algorithm is based on clear clinical practice guidelines and evidence-based necessity of what makes this necessary. If someone is submitting a request and they can document those things, then it should be approved easily, right?

So I think that AI, like, we need to embrace that, and I think it can be helpful.

CHAIR VERLON JOHNSON: Thank you, April.

Dennis?

COMMISSIONER DENNIS HEAPHY: Yeah, I'll come back to what John was saying. Like, how do we measure the value of AI? Like, how are we going to measure the quality of how AI is being used? Is it based on dollars saved, or is there a way to track increased or decreased use, hospitalizations, things like that? Like, what are we going to use to actually determine the value and the quality of AI in this process, in these processes? I don't know how to do that.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Any other thoughts or comments, questions, concerns?

COMMISSIONER DENNIS HEAPHY: I will say just that the concern is that a lot of folks will measure success

based on how much earnings they are able to get out of the denials, and that's a concern that folks have, is that these denials are just going to be in favor of the insurance companies.

CHAIR VERLON JOHNSON: So having more transparency around that would be helpful.

COMMISSIONER DENNIS HEAPHY: Exactly.

CHAIR VERLON JOHNSON: I agree with doing that one.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: Dennis, I would just say that one of the easy ways to think about value is the speed with which we are able to get people approvals, right? So if you just look at the sheer volume of things that can be auto-approved and then you can draw from that the benefit and a beneficiary not waiting and a provider not having to go back and provide additional information or whatever the case may be, that's one very simple way to say if we're not using those systems, it's going to be a lot slower for everybody, and it's going to cost a lot more money to administer.

But then beyond that, I do think we have to find

ways to make sure that what we're doing is actually adding value on balance.

COMMISSIONER DENNIS HEAPHY: Exactly. For administrative denials, I think it would wipe out the time for administrative denials. I think that's fantastic if using AI will reduce the amount of time it takes for administrative denials to be addressed. That would be fantastic.

CHAIR VERLON JOHNSON: Thank you. Anyone else?

[No response.]

CHAIR VERLON JOHNSON: All right. So it sounds like, then, we have some opportunity for greater clarity in the chapter, for sure. I think you all have those notes pretty well. Sounds like that the recommendations are, for the most part -- people are comfortable with where they landed. Is that what I'm getting a sense of? Okay. With maybe a couple of tweaks, for sure.

I'm just going to say, again, you know, AI is here. Prior authorization is very important for us. So I love what April said, which is we just have to do this, right, essentially, right, that we need to be a little bit more broader in this. So I do love the recommendations as

they're written, but definitely want to make sure that we're capturing all the thoughts from our fellow Commissioners, too, as well.

So, with that, I'm going to turn it over to -- or is it – oh, it's me again. Okay. Oh, my gosh. Again, you guys have me. All right.

So we are going to talk about PACE and the role of the state Medicaid agency, for sure. Obviously, PACE has been around for a number of different years, has been known to deliver some high-quality care, integrated care. But as we've heard and as we've talked about, there are still opportunities, of course, to improve how oversight is structured around that and how responsibilities can be shared between states and the federal government.

So we are going to turn it over to Michelle and Brian to walk us through their findings and the chapter and all the other great things.

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

* BRIAN O'GARA: All right. Good afternoon, Commissioners.

So today, Michelle and I will be presenting some draft policy options for our forthcoming chapter on exploring the role of the state Medicaid agency and the Program of All-Inclusive Care for the Elderly, or PACE.

So we'll start with a quick summary of findings. We'll spend most of today's time discussing the three policy options, and we'll wrap up with some next steps.

So these findings are based on our review of key federal and state oversight documents, which we presented here in January -- or virtually in January, and stakeholder interviews with state Medicaid officials, CMS officials, and PACE experts, which we presented in March.

So our review and interviews revealed several key themes; first, that there's wide variation in how states conduct PACE oversight, including differences in roles, the use of two-way program agreements, and state-specific oversight tools. Second, data collection and reporting are limited and not standardized, making it hard to measure performance consistently across programs; third, that many states face capacity constraints, especially as programs grow; and finally, that coordination between CMS and states is uneven, leading to some duplication and misalignment in

oversight activities.

So based on these findings, along with stakeholder and Commissioner feedback from the first phase of this work, we have developed three policy options to address two key challenges. First, to reduce duplication and improve coordination audits, CMS should update audit protocols and three-way program agreements to support joint federal-state audits. Second, to increase transparency around PACE performance, CMS should publicly release existing performance data. Separately, CMS should also develop a standardized national quality measure set for PACE organizations.

This first policy option directs CMS to update its audit processes and three-way program agreements to support joint federal and state audits of PACE programs, planning together, sharing document requests, and reviewing materials concurrently.

So while federal law requires CMS to work with states, current policy guidance does not clearly define how audit coordination should occur. This option would formalize a process. In practice, joint audits would go beyond simply timing them to occur together to include

shared planning and execution. CMS and states should jointly plan audit scopes, share document requests, hold joint entrance and exit meetings, and review evidence at the same time where appropriate.

Importantly, this policy option does not change current oversight roles. CMS continues overseeing compliance with federal requirements, and states continue to oversee compliance with state-specific requirements.

This option also preserves flexibility for independent audits after performance concerns or corrective action plans, for example, and also allows states to continue auditing more frequently when needed, as we heard from several states that they do audit PACE organizations more frequently than CMS.

So audits are the central oversight tool for both CMS and states for PACE organizations, and CMS and states are already well positioned to share data using existing systems.

So, for example, CMS provides states access to HPMS, or Health Plan Management System, data modules upon request, and could expand sharing of audit results and documentation. Both CMS and states are also required under

federal regulations to promptly share report audit findings with PACE organizations. So communication processes already exist that could be taken advantage of.

Joint audits would reduce duplication and administrative burden by reviewing overlapping requirements at the same time. We also heard from several states that their state-specific requirements closely mirror requirements from CMS.

They would also improve visibility across oversight entities; for example, helping identify issues like enrollment concerns or grievances that may arise under one party's oversight activities more than the other.

Overall, joint audits would support a more shared understanding of program performance while still allowing independent findings when needed.

So we're currently awaiting a federal cost estimate from CBO. For states, greater coordination could reduce duplication and improve access to federal audit findings. For PACE organizations, it could reduce administrative burden and streamline the corrective action processes, and overall, improved coordination could strengthen oversight and help ensure enrollees receive

appropriate care.

The second policy option directs CMS to publish existing PACE performance data, including data submitted through HPMS and enrollee satisfaction data collected by PACE organizations.

This option focuses on making existing data public, not creating new collection requirements. CMS should aggregate data already reported, such as HPMS modules like enrollment, emergency department utilization, grievances appeals, and publish it in a user-friendly format on the CMS website.

CMS should also include participant experience data, like those collected from the I-SAT or the HCBS CAHPS surveys. This approach defers to CMS to select the specific metrics that should be published, but they should address beneficiary outcomes and allow for comparisons across PACE programs and other LTSS programs where applicable.

CMS should also work with states and PACE organizations to standardize the data so that it can be meaningfully compared.

Right now, most PACE performance data are not

publicly available, even though they are routinely collected by PACE organizations, states, and CMS, and this creates a gap compared to other programs like Medicaid-managed care. Making existing data public would help beneficiaries compare options and make more informed decisions. It would also strengthen evaluation by allowing policymakers and researchers to assess outcomes and effectiveness. And for CMS and states, it would make it easier to identify trends, benchmark performance, and address issues more proactively.

For implications, we are also awaiting estimate from CBO on this policy option. States could benefit from better visibility into program performance, especially in states with multiple PACE organizations. Public reporting could also support oversight by making it easier to track trends and compare programs.

For PACE organizations, this creates an opportunity to demonstrate performance strengths and the strengths of the model's design with limited additional burden since it builds on existing reporting requirements. For beneficiaries, greater transparency would help them better understand and compare PACE with other LTSS options.

And now I'll turn it over to Michelle.

* MICHELLE CONWAY: Thanks, Brian.

So this option would direct CMS to develop a standardized national quality measure set for PACE organizations.

We found that states vary in the extent to which they measure and evaluate PACE program performance and outcomes with limited federal reporting requirements and no standardized national PACE quality measures to allow for comparison across and within states or with other programs.

Additionally, quality data for PACE organizations that are collected are not released publicly. As a result, CMS, states, and other stakeholders lack clear, comparable information on PACE organization performance and enrollee health outcomes.

To address these challenges, this policy option would direct CMS to amend regulations in order to create a standardized national PACE quality measurement set that would allow CMS, states, and consumers access clear, comparable information about health outcomes and enrollee satisfaction for Medicaid beneficiaries enrolled in PACE.

Unlike Policy Option 2, which focuses on making

existing data publicly available, this option would establish a new standardized quality measure set for PACE. Helpful examples that CMS might consider in developing this measure set may include Medicare Advantage star ratings or the Medicaid Core Data Set Dashboard. These measure sets present a meaningful set of key health outcome and enrollee experience measures that are easy to navigate on a public-facing CMS website.

The five-star rating system and star ratings, for example, is easily understood, and both star ratings and the Medicaid Core Set include outcome measures that are relevant to their respective populations, so, for example, diabetes measures for the Medicare population and behavioral health measures for the Medicaid adult population.

In the first phase of our PACE work, nearly all stakeholders we interviewed expressed interest in the development of a standardized national PACE quality measure set that would allow for comparisons within and across states. Some states have done their own work on developing PACE-specific quality measures.

In a recent interview with the National PACE

Association, they noted they are conducting ongoing work to develop a standardized measure set and a PACE performance recognition program. However, the absence of a federally required standardized measure set continues to limit CMS's and states' ability to assess program performance consistently, compare outcomes across PACE organizations and states, and identify any systemic quality issues.

CMS is well-positioned to act as a convener to both gather information on existing quality measurement efforts as well as input on a new comprehensive quality approach because of the regular meetings it already hosts with states and PACE organizations, something state and federal officials agreed during our interviews are useful for collaboration and coordination.

Given challenges related to small population size and differences in PACE populations, CMS should also include quality measurement and PACE experts in their work implementing this option. CMS has also undertaken work to create a standardized national HCBS quality measure set, an effort that may hold valuable lessons for development of a PACE quality measure set. The development of an HCBS measure set suggests it's feasible to develop a

standardized measure set even with small population sizes and programs that vary across states.

Based on our findings, we identified the following principles for a national PACE quality measure set. First, the process should be collaborative. CMS should develop the PACE measure set with extensive input from states, PACE organizations, participants and their families or caregivers, quality experts, researchers, and other stakeholders. Because the PACE population is small and has a narrow set of demographic characteristics, yet varies across states and PACE organizations. Gathering meaningful stakeholder feedback on an overall PACE quality measurement approach as well as specific quality measures to include should be a priority for CMS.

Next, the measure set should minimize burden for PACE organizations. Quality measures should be limited to the most meaningful health outcome and enrollee satisfaction measures that reflect stakeholder priorities and the demographics and needs of the PACE population.

Finally, the measure set should prioritize comparability where possible. Both our interview findings and feedback from Commissioners raise the issue of a lack

of ability to compare outcomes across various programs serving dually eligible individuals. While small population size may be a challenge, CMS should prioritize including quality measures that are also used in the Medicaid Core Set or the HCBS Quality Measures Set or in other programs, such as HEDIS and CAHPS measures, to allow for an apples-to-apples comparison where possible.

On implications for federal spending, we are awaiting an estimate from CBO on this. For states, many states already collect a variety of data from PACE organizations that may duplicate existing federal requirements, and creating a standardized national quality measure set could reduce burden for states by creating a clear, comprehensive baseline of reporting that all PACE organizations across all states would be required to submit to CMS. States would no longer need to create their own quality measures to gather information about PACE organization performance.

For PACE organizations, this policy option would likely create some initial burden as they adjust to new reporting requirements. However, our research found PACE provider organizations are generally supportive of

standardized reporting, and as I mentioned, NPA has already undertaken work on this option.

PACE organizations would also benefit from this approach by having an opportunity to demonstrate the value of the care they provide, potentially creating more evidence and opportunities for expansion.

For PACE enrollees, they would likely not see an immediate impact to their day-to-day care. However, over time, with full implementation of this option, enrollees may see improvement in quality of care as PACE organizations are incentivized to improve quality measure outcomes, particularly with public reporting, and prospective PACE enrollees and their family members or caregivers may also benefit with more transparent information about performance and outcomes to inform their choices.

We welcome Commissioner feedback on our policy options and would like feedback in particular on if any of these options should be modified, if there are any rationales or implications you would like to see more fleshed out, or if there are any points or findings that we've shared in the previous few meetings that should be

emphasized in our upcoming chapter.

We will return in May with a draft chapter for the June report to Congress, and if there is support for moving forward with these options, we will include the recommendation language for a vote at the May meeting.

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

CHAIR VERLON JOHNSON: Thank you, Michelle. Thank you, Brian. Very, very helpful.

So, fun fact, my first innovative program when I was at CMS was working on the PACE program. So this is like full -- you know, full circle here for me. And John's not here, but the very first PACE audit I did was in Ohio. Yeah. So this is exciting. I really like the policy options, but I really want to hear from you all first.

So who do we have up for question or thoughts? All right. Mike and then Patti.

COMMISSIONER MICHAEL NARDONE: Thanks a lot for this work, Brian and Michelle.

Generally supportive of the recommendations. I just wanted to ask, in the interviews or as you did your research, was there any consideration given to using the two-way agreement or the three-way agreement as a mechanism

to drive quality performance improvement, you know, or other program goals? Because just thinking to, say, the D-SNP evolution, you know, the SMACs were kind of available. They weren't -- you know, at first, they were not really well used -- or they weren't robustly used, I guess. And then over time, I think those evolved.

I'm wondering if there was any consideration or anybody talk about that in your interviews around could there be a way to use those, that same format, I guess, to basically improve state oversight of the programs.

BRIAN O'GARA: So that didn't come up specifically in interviews. We know that half of the states with PACE do use two-way program agreements. So, to the extent that we would like to see maybe a national standardized set, two-way program agreements, may not be the best avenue there. But for the three-way program agreement, those are used in all states to outline current federal regulatory requirements.

There are appendices where states can make adjustments. Anything can be included in the agreement that all three parties agree to, those being the PACE organization, CMS, and the state Medicaid agency. So that

could potentially be an avenue to introduce new incentives or policies. They would just have to be applied to every three-way program agreement.

COMMISSIONER MICHAEL NARDONE: I was just wondering if there was any benefit. It sounds like in your work, you did detail some states that seemed to be very out front in using those agreements, and I wonder if other programs might benefit from kind of understanding how other states have used those agreements. That's kind of where my thought process went.

And the SMAC, I think, reflecting back, initially, they were pretty perfunctory for a Medicaid director, but I think they evolved over time so that they became a more live document.

CHAIR VERLON JOHNSON: Thank you.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: I'll be brief because I think I'm largely going to echo Mike's comments; one, in gratitude for the work; two, in general support for the recommendations.

In particular, I like the transparency of posting the data that we have now while working toward Policy

Option 3, a standardized quality measure set, which I think is necessary.

I also really like your suggestion, Mike. I do think that the work that was done around SMACs to really help other states see how states were leveraging that agreement to drive improvement in their D-SNP products is a model for what could happen in PACE with these three-way agreements where we pull out things that states are finding particularly valuable and sharing those and allowing them to learn from one another.

CHAIR VERLON JOHNSON: Thank you.

Jami?

COMMISSIONER JAMI SNYDER: Thanks so much for this important work.

I was just going to mention -- and you detailed this in the materials that were supplied to the Commissioners, but just the importance of including in that measure set, measures that capture member experience of care. You talk a lot about that in terms of different tools that are currently used, but just wanted to reiterate the importance of the member perspective, especially for a program like PACE.

CHAIR VERLON JOHNSON: Thank you, Jami.

Any others?

[No response.]

CHAIR VERLON JOHNSON: Okay. Do you have what you need then in terms of the next step? Sounds like you have some good feedback in terms of what you all have put together.

BRIAN O'GARA: Yeah, I think we do.

CHAIR VERLON JOHNSON: Okay. All right. Thank you.

So now we're going to go ahead and move into our public comments. We do invite all audience members to raise your hand on Zoom if you would like to offer comments. Please introduce yourself and the organization you represent, and we do ask that you keep your comments to three minutes or less.

All right. Liz Parry.

PUBLIC COMMENT

* LIZ PARRY: Hi. Good afternoon. My name is Liz Parry, and I represent the National PACE Association, the trade association for more than 200 PACE organizations across the country.

Given that PACE is a three-way partnership among PACE organizations, states, and the federal government, we greatly appreciate the Commission's thoughtful consideration of these policy options and their implications for all three partners.

NPA has heard from both states and PACE organizations about the importance of a collaborative approach to PACE oversight, and as we've noted in previous meetings, variation in state administration and oversight can increase administrative burden for PACE organizations. At the same time, programs are interested in understanding a national variation to identify opportunities for greater alignment between state and federal requirements.

Because CMS and states have previously conducted joint compliance audits, we believe there is merit in reexamining whether enhanced coordination between state and CMS oversight could help reduce duplication and promote greater consistency.

Regarding the second policy option, we agree that leveraging existing data sources is a practical and efficient approach. As an interim step toward the development of a comprehensive national PACE quality

measurement framework, it would be both feasible and valuable for CMS to aggregate and publicly report select data that are already being collected that effectively evaluate program performance.

This approach could help establish greater transparency, support benchmarking across programs, and inform future refinement of standardized quality measures.

Looking ahead, we strongly support the recommendation to develop a standardized national quality measure set for PACE organizations. While PACE already operates under robust federal oversight, including CMS audits, there is a clear opportunity to advance a more uniform, PACE-specific set of performance measures that are meaningful, actionable, person-centered, and tailored to the unique population served while avoiding unnecessary administrative burden.

Overall, we appreciate MACPAC's thoughtful recommendations to improve oversight, coordination, reduce duplicative burden, and advance meaningful quality measurement that reflects the complexity of the PACE population.

We look forward to the Commission's forthcoming

recommendations and welcome the opportunity to continue this dialogue.

Thank you so much.

CHAIR VERLON JOHNSON: Thank you so much.

Camille? Camille Dobson, the floor is yours.

CAMILLE DOBSON: Good afternoon, Commissioners. Can you hear me?

CHAIR VERLON JOHNSON: Yes, we can hear you.

CAMILLE DOBSON: Camille Dobson, Deputy Executive Director of Advancing States. We're the membership association for the state leaders of aging and disability programs across the country that serve both Medicaid and non-Medicaid individuals, older adults, and people with disabilities.

We have been doing a little bit of work on PACE as our members express increasing interest in offering PACE as an option as part of their integrated care delivery system in states, and one of the areas -- and agree with the staff and the folks from the PACE Association. One of the areas where there's a huge gap is data that allows both consumers and the states to understand the quality of the services that are provided by PACE, particularly for those

home- and community-based services that PACE organizations are delivering.

In particular, states that have MLTSS programs really don't have any data to be able to compare the outcomes that their managed care organizations have compared to similar populations that are served by PACE organizations.

So we recommend -- commend the Commission for that recommendation. I would encourage the recommendation to flag looking at the current HCBS quality measure set, which includes primarily survey-based information from consumers that are using home- and community-based services. In particular, our tool that we steward, the National Core Indicators for Aging and Disabilities, as well as our sister association, the National Core Indicators for Folks with IDD, are part of the quality measure set. And I think we already have at least four of our states that use the survey who are adding their PACE population to the survey mix. So we do have some initial quality data that allows the states to look across their full-service delivery system to see outcomes from PACE organizations.

So we have that data available, happy to make it available to the Commission staff if that would be useful, and await the Commission's final recommendations. Thanks.

CHAIR VERLON JOHNSON: Thank you, Camille.

Anyone else have a comment?

[No response.]

CHAIR VERLON JOHNSON: Okay. Seeing none, I do want to thank the two who did provide comments to us.

I also want to remind you all that you can go to our website, MACPAC website, and actually submit additional comments there.

We're going to go ahead and take a break now until 3:15 p.m. Eastern.

* [Recess.]

VICE CHAIR ROBERT DUNCAN: All right. I'd like to welcome everybody back. We're going to start the afternoon session with a pickup of where we left off in January around self-directed home- and community-based care. In that time, our team has done an environmental scan, and we've got Gabby and Katherine here to bring us up to date on what they have found and the key takeaways.

So with that, I'll turn it over to Katherine.

HEALTH AND WELFARE IN SELF-DIRECTED HOME- AND COMMUNITY-BASED SERVICES (HCBS): ENVIRONMENTAL SCAN

* KATHERINE ROGERS: Thank you, Bob. Good afternoon again, everybody.

Today, Gabby and I return to share with you the next stage of work related to the assurance of the quality of care and beneficiary health and welfare in self-directed home- and community-based services, or HCBS.

So today, I'll provide a bit of brief background. I'll recap the federal policy framework we presented back in January, and then Gabby will present the findings from our environmental scan and document review we've completed among three case study states. Our case study approach examines in depth the way the states promote quality and assure compliance with the federal health and welfare assurances in their self-directed programs and included both the document scans we'll talk about today and interviews with key state stakeholders.

Self-direction is a Medicaid HCBS delivery model that allows individuals to choose their HCBS providers and have control over the amount, duration, and scope of

services and supports in their person-centered service plan, or PCSP.

Self-direction programs operate generally within the existing framework of Medicaid HCBS. So self-direction does not fundamentally change the level of care determination process or the statutory, regulatory, or sub-regulatory guidance on HCBS more broadly.

These federal authorities require, among other things, the person-centered service planning process and a person-centered service plan, PCSP, which are hallmarks of HCBS programs more broadly than self-direction, as well as a framework for oversight of the quality of care, which is also something applied more widely in HCBS programs and not limited to self-direction.

Federal authorities require other supports that are specific to self-direction, like information and assistance, sometimes called I&A supports, that help HCBS participants navigate the unique roles, rights, and responsibilities of self-directing their own care, and financial management services, or FMS, which assists users with the business side of things, like payroll, taxes, and electronic visit verification, or EVV.

And lastly, for programs with budget authority, there are individualized budgets that allow self-directing beneficiaries to make choices about how to spend the funds they have for HCBS.

Per federal regulations, all HCBS, including self-directed HCBS, should deliver high-quality care that ensures beneficiary health and welfare and allows participants to remain safely in the community. The nature of self-direction allows and requires participants to operate with increased choice and autonomy in their service delivery. This includes an informed choice to take risks, which CMS has described as the dignity of risk in the person-centered service planning process.

HCBS users are diverse, with diverse service needs, and for all HCBS users, including self-directed participants, the PCSP must reflect individual choices, goals, and desired outcomes, as well as risk factors and measures that minimize them.

This person-centered planning process can and should include training for workers, quality monitoring and improvement activities with the beneficiaries, an engaged and active member of the service planning team according to

their preferences.

Through these person-centered service planning processes, the federal policy framework enables beneficiary choice and addresses risks, blending considerations for both beneficiary safety and choice.

As a refresher from our January presentation, the health and welfare assurances I mentioned are among several assurances states must make, and then document their approach to complying with, in securing the authority to implement an HCBS program.

The health and welfare assurances encompass a variety of provisions intended to promote high-quality, person-centered care that meets the needs of the population served. These safeguards are outlined in regulations governing Section 1915(c) authority, and other authorities generally mirror them with minor differences.

They include establishing standards for HCBS providers, such as licensing, certification, or screening requirements, ensuring services meet the specific needs of the populations they're designed to serve, ensuring services are provided in home- and community-based settings, and operating and maintaining an incident

management system that allows the state to assess, monitor, and improve the quality of the services delivered and address risks confronted by participants.

In addition to these safeguards, state programs must implement and monitor certain conflict of interest standards, which, among other things, can protect beneficiaries from potential abuse, neglect, or exploitation.

And finally, the 2024 ensuring access to Medicaid services final rule codified and expanded some existing guidance from CMS imposing minimum regulatory standards for incident management across authorities, which previously only existed in federal guidance for Section 1915(c) authority.

So, against that backdrop, it can be important to understand the recent evolution of self-direction. Self-direction has been around Medicaid HCBS for quite a while, but recent years have observed significant growth. Self-direction nationwide grew by 87 percent between 2013 and 2023.

Stakeholders have acknowledged that alongside that growth, there have been observable challenges,

including with the ability for states and other stakeholders to effectively manage or oversee the quality of self-directed programs.

In the last 15 years, both the Government Accountability Office, or GAO, and the Office of the Inspector General in the U.S. Department of Health and Human Services identified various concerns in state programs they audited, including provider screening gaps or misalignment between service planning and service delivery.

These issues persist in program audits published as recently as last year, and states have, as a result, implemented additional policies or issued policy guidance in response to these findings, including around increased monitoring, documentation, training and education, and requirements for key service planning elements like backup plans.

These programmatic challenges flagged by GAO and OIG can pose risks to the quality of care and ultimately to the health of the beneficiaries participating.

And so, with that, I'll turn it over to Gabby, who will walk us through our initial environmental scan findings from the case study work we've undertaken.

* GABBY BALLWEG: Thank you, Katherine.

As you said, I will now discuss findings from our environmental scan spanning three case study states.

Throughout this section, the states we discuss will only be included on the slides, and the findings are specific to self-direction, unless otherwise specified.

The first finding from our environmental scan that I'll be discussing is on reportable incidents. Across the states that we included in our study, reportable incidents consistently include abuse, neglect, and exploitation. State policies also list specific critical incidents that must be reported. These lists generally align with the new federal requirements under the access rule, including items like unexpected deaths, physical or psychological abuse, and serious injury. Specificity in defining the additional critical incidents and reportable events varies by state and delivery system.

One state established a list of additional incidents, including environmental and access risks, such as utility shutoffs, natural disasters, or an unreachable beneficiary at the time of a scheduled monitoring event.

Another state defines triggering events that only

exist in the state's managed care program and not in the fee-for-service program. These triggering events may signal potential risk to the beneficiary, such as the loss of housing or functional decline.

Although mandatory reporting of critical incidents is universal, reporting pathways differ. In all states, the FMS entity and MCO staff, when the state is using managed care, are mandatory reporters. In most states, the self-directing beneficiary and HCBS provider are also mandatory reporters, but in one state in our study, they are not classified as such in state policy documentation.

Instead, the beneficiary is responsible for taking corrective action in response to a critical incident investigation. States can have multiple reporting pathways for critical incidents, while others may be more streamlined. In one state, beneficiaries can issue reports to customer service or the supports broker, as well as via email, fax, web portal, or mobile application.

Supports brokers report directly to the state Medicaid agency and Adult Protective Services, or APS. The other two states require incident reporting through an APS

hotline or directly to the state Medicaid or operating agency.

The entity responsible for managing corrective action in response to a critical incident differs by delivery system. In fee-for-service, although another entity, such as the FMS entity, may have reported the critical incident, the beneficiary or the representative determines the corrective action and must report the corrective action to the state. The FMS entity can support the beneficiary or representative throughout this process by helping them to identify a new HCBS provider, or in some cases a new representative if necessary, and conducting enrollment processes while keeping the state informed of these changes.

The state Medicaid agency will intervene in a fee-for-service environment when the critical incident poses immediate risk to the beneficiary; the corrective action is in response to abuse, neglect, or exploitation; the representative must be removed, the corrective action is not implemented or reported; or issues persist.

In managed care, the managed care plans are responsible for tracking and trending incidents and risk.

The plan evaluates member risk, analyzes incident trends, and drives systemic corrective actions. Contracted HCBS providers must implement the changes identified through the health plan or the state's monitoring to reduce the recurrence of incidents.

States require in-person monitoring of beneficiary health and welfare that is specific to self-direction. Most authorities under federal law, except for Section 1915(j) authority, which is specific to self-direction, do not require in-person monitoring activities, but all states in our case study do for their self-directed programs.

Case managers in managed care, supports brokers, and FMS entity staff generally perform monitoring activities. The cadence of in-person contact varies by state, with some states requiring annual meetings, while others having quarterly visits.

In one state, higher acuity beneficiaries had more required in-person contacts than beneficiaries receiving low or moderate intensity care.

Virtual or phone monitoring activities that the states conduct are supplemental but cannot replace in-

person monitoring.

All states monitor service and budget utilization in self-direction, and they can include triggered monitoring activities or scheduled monitoring activities. Scheduled monitoring occurs at state-defined intervals, whereas triggered monitoring occurs based on the appearance of risk indicators in monitoring data or a medical record.

Among most HCBS authorities, monitoring service utilization is not a federal requirement, yet states are employing this strategy to ensure beneficiary health and welfare in self-direction.

The frequency of scheduled in-person monitoring ranges from quarterly to annually and may include reviews of the beneficiary's budget management plan, reassessments of the beneficiary's need or level of care reviews, and evaluations of health and safety as well as risk identification.

Triggered monitoring activities rely on data that may indicate risk. States leverage data systems to identify risk indicators, such as their claims adjudication, critical incident management, and electronic visit verification or EVV data systems.

Triggers could include over- or underutilization of service units or funds or anomalous utilization hours, critical incidents such as emergency department or hospital visits, functional decline, the inability to contact a beneficiary or missing their scheduled in-person visit, and EVV anomalies. States leverage EVV as a compliance and risk reduction tool. All states use EVV to identify discrepancies between the actual service use and a beneficiary's PCSP. States often integrate EVV data with other systems to bolster these monitoring activities.

States establish additional eligibility rules for requirements for representatives that generally go beyond the federal requirements. For example, states often implement availability and accessibility rules. One state requires that representatives live within 30 miles or one hour of the beneficiary. Another requires that representatives be available to attend visits or trainings, communicate with FMS and counseling entities, and respond to critical incidents.

States prohibit certain individuals from acting as a representative, including anyone with a history of abuse, neglect, or exploitation, subjects of maltreatment

investigations, those with disqualifying criminal or abuse registry history as well.

States can require the beneficiary to appoint a representative when the beneficiary cannot safely manage self-direction without additional supports.

Per state policy documentation, disenrollment from self-direction paired with the transition to agency-directed services is used as a final recourse when health, safety, or program compliance cannot be maintained in a self-directed program.

All the states clearly define conditions that may trigger beneficiary disenrollment from self-direction, and they could occur when self-direction no longer meets the beneficiary's health, safety, or welfare needs, the beneficiary can't effectively self-direct or manage their employer responsibilities and there is no appropriate representative available, the representative is under investigation, there's fraudulent use of a beneficiary's funds that is suspected or proven, or there's persistent EVV noncompliance. During care transitions, the state agency or managed care plan must ensure continuity of care.

Across all states in our study, HCBS provider

qualification standards are mandatory and multi-layered. All states have provider standards in pre-employment qualifications, training, and monitoring. Pre-employment checks all include a criminal background check, a review of state abuse and fraud registries, and a review of federal registries for excluded individuals. Beneficiaries may request additional background checks, and HCBS providers must receive training on reporting abuse, neglect, and exploitation, but ultimately, the beneficiary or their representative is responsible for selecting qualified caregivers, training them, establishing work agreements, and conducting performance evaluations. States may also impose requirements for training and qualifications of supports brokers and FMS entity staff.

Lastly, all states employ monitoring strategies to enforce these provider standards. In two states, EVV and monthly fiscal audits confirm HCBS provider credentialing, identify service misuse or performance issues, and ensure compliance with training requirements. One state mandates annual provider recredentialing as well.

Each state operates designated oversight and quality systems that track incidents, monitor provider

performance, and drive corrective actions. Generally, designated oversight and quality monitoring systems apply broadly across all service delivery types and are not specific to self-direction. These systems can include critical incident management systems that track, review, trend, and analyze incidents to detect patterns and risks.

In a managed care environment, health plans maintain quality assessment and performance improvement programs to analyze incident types, service locations, provider involvement, and investigation findings to detect systemic quality concerns.

Findings from these oversight and quality systems lead to performance improvement strategies, quality initiatives, and risk reduction efforts. In states that operate self-direction across agencies, these systems may span multiple operating agencies.

Another state has a specific division that monitors quality assurance standards and self-direction. The division procures and oversees all self-direction counseling and FMS entities to ensure compliance with program standards. They also employ a continuous reporting mechanism to monitor issues in real time.

Integrated program integrity controls are key programmatic oversight mechanisms to ensure beneficiary health and welfare. Some states integrate EVV data with background checks, credentialing reviews, and payroll systems to flag instances where the beneficiary is not receiving services in compliance with their PCSP.

For example, through integrated EVV and payroll systems, one state can prevent ghost visits, which occur when an HCBS worker claims payment for service hours that were not documented. These instances can also be an indicator of whether a beneficiary is receiving sufficient HCBS per their PCSP or whether corrective action needs to be taken to provide additional supports or education and ensure quality service delivery.

States also conduct regular audits of self-directed services to verify worker credentials, visit validity, and alignment of EVV data with service authorizations. Many different entities support program integrity and self-direction.

The beneficiary or their representative must certify all services rendered and is ultimately responsible for the oversight of each HCBS worker. HCBS workers must

attest to the truth, accuracy, and completeness of all submitted timesheets and documentation.

FMS entities conduct reviews of service hours and expenditures to ensure compliance with the PCSP. FMS entities or the MCOs also submit monthly reports of program integrity concerns, maintain written fraud, waste, and abuse compliance plans, and confirm provider qualifications.

The state Medicaid agency audits program materials to certify compliance with the state and federal policies, and the Medicaid Fraud Control Unit investigates allegations referred by the state Medicaid agencies.

This environmental scan provided a detailed understanding of state policy supporting beneficiary health and welfare and self-direction.

Next, we will complete the three state case studies by supplementing findings from the environmental scan with targeted stakeholder interviews. These interviews will probe features of program design or delivery in each state to identify state challenges and opportunities for federal policy change or guidance.

As a part of these next steps, we would

appreciate Commissioner feedback regarding which findings from the environmental scan are of particular interest to the Commission for further investigation. We plan to return next cycle to discuss findings from this ongoing work.

Thank you, and I will pass it back to you, Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Gabby. Thank you, Katherine.

I just found it interesting when reading the chapter from the environmental scan, seeing the commonalities on both how they approach but also commonalities in some of the issues, and so I think we'll probably have a rich discussion from our Commissioners on what particular interests they want to see fleshed out as we continue the case studies. So thank you.

So, with that, I'll open it up for questions or comments from our Commissioners. Dennis?

COMMISSIONER DENNIS HEAPHY: [Speaking off microphone.]

VICE CHAIR ROBERT DUNCAN: Okay.

Patti?

COMMISSIONER DENNIS HEAPHY: I'm sorry. Go, Patti.

COMMISSIONER PATTI KILLINGSWORTH: So, first of all, thank you. I think this is one of those topics that probably doesn't get a lot of attention, and it's a critically important option, especially for people who just desire more control and authority over the services that they're receiving.

I do think it's a particularly challenging one for states to monitor health, safety, and welfare, and to strike the right balance between the dignity of risk and that autonomy and authority that the model is supposed to give, while also maintaining the oversight responsibilities that they have.

My experience has been that sometimes incident management systems treat this population a little bit differently in terms of who does the investigations, and that it can be particularly challenging when, for example, a family member or someone close to that individual is the paid caregiver, and they are also the one who is the subject of an investigation around potential abuse, neglect, or exploitation.

So I would be interested in just understanding a bit more about some of those nuances, both on the program integrity side as it relates to the use of EVV systems. My experience has also been that states oftentimes use a different EVV system for their self-direction programs than they use for their other programs.

Part of what that means is that the data oftentimes doesn't find its way together to be aggregated, and so it's easier to miss an individual who may have allegations across multiple health plans or across multiple service delivery types, so maybe working for an HCBS provider and also employed directly by an individual through self-direction. So what are states doing to aggregate that data so that we can make sure that we're sort of checking all of the right boxes with respect to health, safety, and welfare, while also honoring the intention of the model to really give people responsibility and authority?

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

John, then Dennis.

COMMISSIONER JOHN McCARTHY: I think this is one of those topics that we're hitting at the exact right time.

I think we have to be a little careful looking at it on the data from the standpoint of between 2019 and now. So really during the COVID years, when there was a lot of changes in self-direction, we've seen a really big explosion in the utilization of self-directed services, which when I was Medicaid director, we were always trying to get more people to use self-direction, but under the program we had then, not kind of where things are now.

So I think one of the things that we need to look at is -- you know, there has been some big news stories on self-direction and fraud in the program. So how do we look at that, what's in there, but also identifying -- you know, you hear stories of this person made $300,000 off this. Well, if it's one person out of 5 million that are getting services, like we need to be able to couch that in the numbers that we get. So, obviously being data-driven and looking at, okay, if there is fraud, like what percentage of fraud is there going on in that? Because you don't want to throw the baby out in the bathwater, but also looking at what are those changes that have happened since 2020, those good changes, neutral changes, negative changes, being able to look at those different pieces.

My concern is that we're only looking at three states, and so may not hit all of those. I get it, that's who you're talking to, but I don't want this -- I mean, nobody wants it. But I want the chapter to be able to reflect really what's going on in a bunch of different places to be able for us to really evaluate it to see where it's at.

Maybe some of the changes that were made had good intentions behind them but, unfortunately, had some unintended consequences from it. So what do we need to change going forward from there? Thanks.

VICE CHAIR ROBERT DUNCAN: Thanks, John.

We have Dennis, then Carolyn, then Mike.

COMMISSIONER DENNIS HEAPHY: Thanks. I agree with what John and Patti said.

A lot of states have encouraged self-direction as a way of actually controlling costs, and so the self-directed model was very small years ago. It was primarily folks, adults with physical disabilities, and then since then, it's really expanded into other populations. That's because of families of folks with family members with ID/DD wanted to have self-direction for their family members or

other populations as well.

So I think, like, when I looked at the report, I was wondering, how do you distinguish between the different -- whether it's diagnoses or ages or service types, like, how many ADLs do folks get? There's a way of really better understanding the population as we're looking at, how the services are being used. So, for me, I really just need to see a breakout of the populations.

I agree with John. Three states is not enough, because some states, people have control over their budgets, and other states, they don't have control over their budgets. Really, it comes down to -- in Massachusetts, you get a time and task tool, and that's the number of hours you get, and that defines the services you receive, as opposed to another state where there really is a very intensive program in place where you have a broker. You've got someone who oversees your budget with you, and then you decide which money you'll be investing in what. So I think it's really important to distinguish between and how states do these things.

I think the other piece is ensuring that there's emphasis on choice and people being able to control who

they hire and who they fire and how training is conducted, because sometimes training -- someone who's a CNA may come into someone's home and say I've done the training, so I'm the expert. And they have no idea how to provide the appropriate services needed for someone to really facilitate their ability to live in the community. That's really when people come into someone's home and say, "I'm the caregiver. You're the patient." That's really not the role. The role is for the person to facilitate the ability of that person to live and thrive in the community independently.

I read the chapter a couple of times, but just delving more deeply into better understanding the populations, and where some of these issues are the greatest, where you find the most issues. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Carolyn, Mike, then Heidi.

COMMISSIONER ANGELO GIARDINO: Thanks. I had just a couple questions, but maybe there are items we have to follow up on.

I'm more focusing in on the EVV providers and some of the data issues, linking that information back,

whether it's to states or to managed care organizations, or whoever's collecting it. I'm wondering if you found any best practices in the states you've been talking about or talking with about maintaining that data, making sure the connections happen quickly, especially in rural communities.

I'll answer that first, and then I'll go on to the next one.

GABBY BALLWEG: Yeah. So, at this point, we've done the document review. We will be following up with interviews. So we're happy to ask more about the data piece on the EVV side and data integration.

COMMISSIONER CAROLYN INGRAM: That'd be great.

Then if you could add to that list of questions, if there are mechanisms or ways for those EVV entities or vendors found in states to integrate back with the health risk assessment. If a person's going in and they're logging in through the EVV services, but they found that maybe there's a concern about somebody's situation -- maybe it's a food security issue, or maybe it's safety -- what are they doing to input that information? Or is it a totally different system? They have to then go -- like a

case management system, they have to go in and report in. How do they capture that information? Because there's risk there.

Then I guess the other question would be the flexibility around the EVV provider to report that data up, whether it's to the state or to the MCO. What kind of reports do they generally create, and what are they producing?

The reason I'm asking all this is there's a lot of money spent, again, on these providers or these services, but we're also spending a lot of money on these types of data systems. I have a feeling, similar to when we start to look at work requirements or community engagement, there's newer technology, newer providers coming forward that can do things. Are states starting to look at some of that? Because some of these systems are pretty antiquated in terms of how they do reporting, how fast they can do it, how they capture information. We're here mandating it on states, but not in a cost-effective manner.

So I think my questions are really around that whole cost piece and how effective really are these EVV

providers or entities. Thank you. I'll pause.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn.

Mike, then Heidi.

COMMISSIONER MICHAEL NARDONE: I was going to say thank you for this work. This is incredibly complicated, and I agree with John, it's particularly timely.

The thing I always kind of come back to is -- the last presentation I think you did on self-direction, I was just struck by the variability in the programs across the states and just how different they were as you looked at Pennsylvania versus New York versus Kansas.

I guess one of the things I just wonder about, is there value in some guidance, particularly as this is growing so exponentially, to kind of look at what are the things that make for a high-performing self-direction model? I mean, I think the role of some of the key pieces I think there -- and this is not necessarily the whole list, but kind of following up on Carolyn's point around EVV, in addition to the value of EVV, I mean, I think EVV has some potential to actually help with ensuring quality around whether or not people are getting what they need in their service plans. So there's lots of potential there.

I'm not sure if anybody is tapping it.

I think also, you know, one of the things I was struck by in the presentation that we had where you had a Pennsylvania representative was that I realized -- and not to pick out my home state, but there is a variation in information and assistance or support brokers, sometimes not only across states but also within states. So I think some sort of, you know, kind of what are the models, what has been effective, what are the types of things that really help in terms of a high-performing program, and also the role of FMS in the different states. Some states use one FMS vendor; some states use multiple FMS vendors. Are there any things that can be teased out about that?

I think then you have that other piece, which is, well, MCO versus fee-for-service states. I think that you've raised and touched on a lot of issues here. But, God, this is, there's so much more that we could be delving into here, and I realize you probably have some limits on what you could do. But I wonder if maybe something that, like, basically brought together some of the really -- the best practice, kind of maybe what you said, Carolyn, some of the best practices, not only in EVV, but across some of

these key issues.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike.

Heidi.

COMMISSIONER HEIDI ALLEN: Thank you so much for this work, and this is exemplary of one of the things I've loved about being on MACPAC, which is watching how something evolves over time and how we take different bites of the apple and take different perspectives over time.

I'm reminded that we started this work with a number of recipients coming and talking to us and telling us about how they use their self-directed program, and that was just so impactful for me and my thinking and shaped my thinking throughout this whole process that I would just like to suggest that we continue to move into -- particularly if we're moving into recommendations, that we continue to engage with consumers, maybe have a panel again, and make sure that we get good feedback from people to make sure that we aren't inadvertently taking away people's rights or things about the program that are really important to them.

Then this is just a minor question that came to me when I was reading the materials, is that it frequently

talks about criminal background checks, and I'm curious about communities that have been heavily impacted by policing where many members have criminal histories. Is that just a rule-out? It said in one place qualifying criminal -- you know, but I'm thinking about, like, if you're trying to hire somebody in your community and say you have a cousin who is post-incarceration but would be a really good support to you. Are you allowed to hire them, or is that some kind of a rule-out?

GABBY BALLWEG: Yeah. So what we were seeing in our environmental scan thus far is that it is a rule around the criminal background check piece. I think it can vary a bit by state on this. We can get back to you and see, looking at the federal guidance and kind of compare it there and see what that looks like, include it maybe in the next memo for you.

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

Dennis, back to you.

COMMISSIONER DENNIS HEAPHY: Thanks.

To your point, Heidi, criminal background choices -- or criminal background checks could really be a choice,

that if someone's found someone they think is good and that folks over the years, that they should be able to hire them regardless of what their criminal background may be, unless, of course, they're a serial sex offender or something. But people, that's the problem. Emphasis is on choice.

But the concern this community has about EVV and more and more oversight is that we're going to create this panopticon nursing home with virtual walls, and that the EVV is going to turn into how much urine output did the person have today? How was their stools today? What was their blood pressure today? What was this or that today? Where did they go today? So that was not the intent of self-direction.

The intent was for people to be able to live full lives in the community, not to have micromanagement of their lives by the state, to ensure people are safe in their homes. As I say that, there are populations where if an older person is concerned and this level of oversight is necessary and their children or whoever the folks in their lives are want this, then definitely provide the level of support they need.

But for other folks who are managing their programs well, that do this fine, don't micromanage their lives, because they won't be able to actually live the lives that the program was intended to be able to do, like to live, work, and volunteer wherever in the community. So I think that's important to say.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: All right. Gabby, Katherine, do you think you got enough to dive a little deeper?

COMMISSIONER DENNIS HEAPHY: Definitely. Thank you. All right.

VICE CHAIR ROBERT DUNCAN: Thank you for the great work.

Now, as we switch over, I have jokingly said this during break that when I read this next piece on PBMs, I thought of our fellow Commissioner, Doug Brown, and this would be his time to shine with his expertise and knowledge. So I'm actually looking forward to this conversation.

I think Caroline and Chris did a nice job of laying it out of the PBM and impact in the Medicaid space. So welcome, Chris, Caroline. I'll turn it over to you, Chris.

PHARMACY BENEFIT MANAGERS (PBMS) AND MEDICAID

* CAROLINE O'NEIL: All right. Good afternoon, Commissioners. Today we'll be providing a high-level overview of pharmacy benefit managers and their interaction with Medicaid.

In recent years, some policymakers and stakeholders have raised concerns that PBM practices may contribute to rising drug costs. Most recently, the Consolidated Appropriations Act of 2026, passed into law in February of this year, regulates PBM compensation and increases transparency into PBM operations for the commercial insurance and Medicare Part D markets. While the act did not include Medicaid-specific provisions, all states have passed state-level laws and regulations governing PBM activities, and several states also have regulated PBMs within the Medicaid program.

We will begin with background on the Medicaid Drug Rebate Program and pharmacy benefit managers and then

highlight key concerns with PBM practices and how states and the federal government have responded to these concerns.

So we'll start with some background. The Medicaid Drug Rebate Program, or MDRP, governs Medicaid coverage of prescription drugs. The MDRP ensures Medicaid pays net prices comparable to the lowest prices offered to other payers. Manufacturers must enter into rebate agreements with the Secretary of the Department of Health and Human Services for their drugs to be covered under Medicaid. In exchange for these rebates, Medicaid generally covers all drugs from participating manufacturers when medically necessary. States can still manage utilization through tools like prior authorization and preferred drug lists, and additionally, federal regulations require Medicaid fee-for-service payments to pharmacies to reflect the actual acquisition cost of the drug, plus a professional dispensing fee.

PBMs play a central role in administering prescription drug benefits, providing both administrative and clinical services. Both fee-for-service Medicaid programs and Medicaid managed care plans contract with

PBMs.

PBMs manage core administrative functions, including claims processing and payment. After a prescription is filled, the PBM adjudicates the claim, determines patient cost sharing, applies formulary rules, and reimburses the pharmacy.

They also establish pharmacy networks, which vary by program. Fee-for-service Medicaid generally uses open networks that accept any willing licensed pharmacy, while managed care plans may use preferred networks, sometimes limiting access to a smaller network of preferred providers.

PBMs can also negotiate supplemental rebates with drug manufacturers on top of the required federal rebates under the MDRP, which are often tied to formulary placement and fewer utilization management restrictions.

PBMs support clinical management by developing coverage criteria and utilization controls to ensure appropriate and cost-effective prescribing. They help maintain formularies or preferred drug lists, which guide drug selection and encourage the use of specific drugs, and support processes like prior authorization, step therapy,

and quantity limits.

When a state uses a preferred drug list or a formulary, it must follow a formal process to publish and implement criteria, including using a committee, typically referred to as a pharmacy and therapeutics, or P&T committee, made up of physicians, pharmacists, and other appropriate individuals to make recommendations on various means of utilization management.

PBMs can provide research and data to state-run or plan-run P&T committees or develop coverage policies using their own internal P&T committee.

PBMs also assist in drug utilization review, or DUR programs, which are a required function for all state Medicaid programs. These programs monitor prescribing patterns and address potential misuse through prospective and retrospective review.

This slide shows a breakdown of services that PBM vendors provided to states as of July 1st, 2023. Note that the survey from which the data were obtained focused on services provided to states, but PBMs provide the same services to Medicaid managed care plans and other payers. And across states, the most common PBM functions included

utilization management, drug utilization review, and claims processing and/or payment.

As this diagram illustrates, the PBM sits at the center of the drug distribution chain and interacts with manufacturers to negotiate rebates, with pharmacies to process claims and set reimbursement, and with MCOs and state Medicaid agencies to manage benefits and billing. Effectively, the PBM is the hub of this system and is involved in the major transactions within the chain.

PBMs generate revenue from states and plans, manufacturer rebates, and pharmacy-related fees. On the payer side, PBMs typically operate under two pricing models, spread pricing and pass-through pricing. In spread pricing, the PBM charges the payer more than it reimburses the pharmacy and keeps the difference, and in pass-through pricing, the PBM charges the payer exactly what it paid the pharmacy and instead collects an administrative fee that's independent of drug costs. Spread pricing has drawn scrutiny over the years for potentially obscuring true drug costs.

On the manufacturer side, PBMs may retain a portion of the rebates or discounts they negotiate on

behalf of their clients, rather than passing the full amount through.

On the pharmacy side, PBMs may collect direct and indirect remuneration or DIR fees. These fees are payment adjustments that get applied after the point of sale and can include overpayments clawed back from pharmacies, fees for participation in preferred pharmacy networks, and performance-based fees.

DIR fees make it difficult for pharmacies to know what their net payment will actually be for a drug, making financial planning difficult, and DIR fees are more common in Medicare Part D.

While PBMs offer similar services to both state fee-for-service programs and managed care plans, the different regulations governing each delivery system lead to some differences in the scope of services provided.

For pharmacy payment, fee-for-service regulations require payment at actual acquisition costs plus a dispensing fee. These requirements do not apply to managed care. And as such, PBMs in a fee-for-service arrangement will generally pay at acquisition cost, which makes spread pricing less likely.

In managed care, PBMs can negotiate payment terms with individual pharmacies without being tied to actual acquisition costs. Spread pricing arrangements are more common in managed care.

For rebate administration, fee-for-service states may require PBMs to negotiate and pass supplemental rebates through to the state, while managed care PBMs have more flexibility to retain a portion of rebates.

And for pharmacy networks, fee-for-service generally requires contracting with any willing licensed pharmacy, while managed care can allow their PBMs to contract with a limited preferred network.

Finally, in fee-for-service, PBMs work with the state on the benefit management side of things, such as creating preferred drug lists and other utilization management criteria that apply broadly across the entire population. Under managed care, plans can design their own formularies and utilization management criteria, which can lead to different levels of coverage across plans and populations.

We'll now turn to commonly reported concerns about PBMs in Medicaid.

Spread pricing occurs when PBMs retain the difference between what health plans pay them and what they pass on to pharmacies. It is most common with generic drugs, where large manufacturer-to-wholesaler discounts create a significant gap between acquisition costs and benchmark prices like the average wholesale price. This arrangement lacks transparency into how much revenue the PBM receives. Additionally, some stakeholders are concerned that this creates incentives for PBMs to negotiate payment terms that do not fully cover the pharmacy's costs.

There has not been a comprehensive study of spread pricing in Medicaid, but a few states have conducted analyses that show the prices PBMs charged to managed care plans were often higher than fee-for-service prices.

And while spread pricing raises transparency concerns, switching to pass-through payments may not necessarily reduce overall drug spending. Most spread pricing occurs on generic drugs. So the spread gives PBMs an incentive to steer utilization toward lower-cost products.

Administrative fees may be similar to the amount

of revenue generated through the spread, and costs will ultimately be determined by how much the pharmacy is paid using pass-through pricing. One state's analysis of managed care spread pricing determined that paying at the state's fee-for-service payment amounts would have ultimately increased spending.

PBMs may prioritize drugs on the formulary that offer the highest rebates, even when those are not the lowest-cost option, potentially increasing beneficiary cost sharing. Rebate retention is less of a concern in Medicaid than in commercial insurance or Medicare, since most Medicaid rebates are statutorily defined and paid directly to the state.

Any additional supplemental rebates for which a PBM might retain a portion would be small relative to total Medicaid drug rebate dollars. While PBMs under managed care contracts could retain some rebate dollars, several states have implemented requirements that the plan-PBM contracts pass through all rebates to the plan.

In managed care, plans may each maintain their own formularies, which can create administrative complexity for states and pharmacies trying to align coverage across

multiple plans. Additionally, plans and their PBMs do not know the amount of the federal rebate. So their coverage decisions and associated rebates may not actually steer utilization towards drugs that are the lowest net cost to Medicaid after federal rebates, and in response, states can require plans to follow a single statewide preferred drug list or standardized criteria for certain drugs.

Limited pharmacy networks can lower costs for plans and reduce beneficiary cost sharing, but can also create access challenges, particularly in rural areas. A Federal Trade Commission report found that 10 percent of independent retail pharmacies closed between 2013 and 2022, worsening access in underserved communities.

There are also concerns that PBMs have strong incentives to steer high-margin specialty prescriptions towards PBM-affiliated pharmacies, and in fee-for-service, states generally must allow any willing qualified provider to participate in the network. And under managed care, states can also establish network requirements that allow any willing provider.

I'll pass it to Chris.

* CHRIS PARK: Thanks, Caroline.

In response to these concerns, both states and the federal government have implemented provisions regulating PBM operations.

As Caroline mentioned earlier, in February of this year, Congress passed the Consolidated Appropriations Act that included several PBM provisions applicable to commercial insurance and Medicare Part D plans. These provisions generally require pass-through of all rebates, tying PBM compensation to service fees at fair market value, requiring detailed reporting on rebates, pricing, and various fees that the PBMs charge, and also require the Government Accountability Office to study price-based PBM compensation in Medicare and Medicaid.

The CAA did not include any Medicaid-specific provisions for PBMs. However, essentially all states have implemented some form of legislation regulating PBMs within the state. Additionally, several states have used their authority to oversee PBM operations and Medicaid managed care contracts.

So this chart shows the number of states with PBM-specific requirements in their Medicaid managed care contracts. Twenty-five states have prohibited spread

pricing. Seventeen states require various forms of transparency reporting, and ten states require any willing pharmacy networks.

At a broader state level, many states govern various aspects of the PBM-pharmacy relationship. So 45 states prohibit gag clauses, and gag clauses are provisions where the pharmacist could not tell customers when a drug's cash price was cheaper than their insurance co-pay. This was eventually addressed in commercial and Medicare plans through federal legislation. Eighteen states have provisions prohibiting patient steering, and 29 states prohibit discrimination against 340B entities in terms of lower payment fees or network access.

Many states also have provisions related to the various fees that PBMs charge, the payments they make to pharmacies and beneficiary cost sharing. For example, 16 states have prohibited spread pricing broadly throughout the state, while 37 states have put in some form of limitation on beneficiary cost sharing.

Then, finally, a lot of states have also implemented oversight requirements, such as different reporting to the states or the health plans, and also

various licensure or registration requirements.

So, to wrap things up, overall PBMs play a central role in the drug distribution chain and provide a wide range of services to both Medicaid state programs and managed care plans. While the CAA in 2026 did not specifically address Medicaid, the changes required in PBM contracts in commercial and Medicare Part D plans could eventually result in broad reforms that are reflected in Medicaid PBM contracts.

Additionally, many states have already taken some action to regulate some of these issues through state level legislation and regulations.

Finally, states do have the ability to implement transparency and reporting requirements within their own PBM contracts and also within the managed care plan PBM contracts.

We plan to publish this issue brief shortly after this meeting. We welcome any questions you have in terms of the information presented here today, and with that, we'll pass it back to the Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Chris. Thank you, Caroline.

Comments and questions, I have Carolyn and then Patti.

COMMISSIONER CAROLYN INGRAM: Thank you.

Chris, can you help me understand the data and the different charts? You've got, I guess, one chart that shows that spread pricing is prohibited in 25 states, and it's on page 11. And then down lower on page 13, spread pricing prohibited 16?

CHRIS PARK: Yeah. So --

COMMISSIONER CAROLYN INGRAM: Is that like one is a law that was passed and one's reg or something?

CHRIS PARK: Yeah. So this was from a survey from the Health Management Associates, and this is specific to Medicaid. So this is based on their survey. Twenty-five states had a provision within their Medicaid managed care contracts prohibiting spread pricing.

COMMISSIONER CAROLYN INGRAM: Okay. And then the second chart?

CHRIS PARK: Yeah. This information came from the NASHP, National Academy for State Health Policy.

COMMISSIONER CAROLYN INGRAM: Right.

CHRIS PARK: And this is broad statewide

legislation. So 16 states broadly prohibits spread pricing across all of the payers in the state.

COMMISSIONERCAROLYN INGRAM: I'm just -- okay. Thank you for explaining that. I'm just curious as to the statements above where it is -- there's a chart. Actually, let me go back and find the chart. Oh, now I can't find it. It was in one of your slides, and it had like the difference between fee-for-service and managed care.

CHRIS PARK: Yes.

COMMISSIONER CAROLYN INGRAM: Yeah. So, on the right-hand side, it said spread pricing more likely. I think you just showed us data that actually a lot of states don't allow spread pricing. And I can tell you in the states we're in -- we're in 22 states -- none of them allow spread pricing. So I'm not really sure. I see the language of spread pricing more likely in managed care to be accurate. Our contracts all don't require -- don't allow it basically.

CHRIS PARK: Yeah. This was more --

COMMISSIONER CAROLYN INGRAM: I'm curious about the choice of the words "more likely" in that chart. Thank you.

CHRIS PARK: So we can address this a little bit in terms of through regulations, there's this requirement on the fee-for-service program to pay at actual acquisition cost. So that makes it more difficult to actually have any spread pricing, where on the managed care side, there are negotiated rates where spread pricing can be put into place.

But we can maybe tweak this a little bit in terms of noting that many states have kind of regulated on this area so that it's not allowed.

COMMISSIONER CAROLYN INGRAM: Yeah, because I'd wonder. I'd question a little bit; do we know of any states who have managed care that allow spread pricing still and that it's actually being done? Because after the -- I'll call it "issue" that happened in Ohio. I think it started there, and it spread across several states with litigation.

My understanding is most or all managed care companies that are at least large in participating in Medicaid quit allowing any spread pricing themselves, and many states then stopped it.

Maybe Doug knows, or maybe Jennifer knows. Are

there actually states that allow spread pricing anymore in managed care?

CHRIS PARK: I mean, based on the survey, I think two states didn't respond. So maybe it was like 38 states responded, and 25 states indicated that they did not allow spread pricing. So the remainder theoretically do or they didn't at least respond affirmatively about prohibiting it.

COMMISSIONER CAROLYN INGRAM: Yeah. I think we should adjust the language, frankly, in that section, since that's not really the majority of states, and we don't know for sure unless we were to investigate the contracts and look at them. Just my feedback. I mean, maybe others know.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn.

Patti, Heidi, Doug, then Anne.

COMMISSIONER PATTI KILLINGSWORTH: I wanted to be sure that I asked my questions before Doug.

So just a couple of questions. I'll ask them both, and you can answer them in whichever order is easiest for you.

Do you have any sense of why in the new requirements that were applied to commercial and Medicare,

they were not applied to Medicaid?

And then, second, in your review, did you identify -- because states are doing so much already, did you identify particular areas where there appear to be gaps in oversight that we might want to focus on?

CHRIS PARK: To answer the first question, based on what we've seen in press reports and early drafts of legislation, Medicaid provisions were included, and they were pulled before Congress actually passed it. The press reports are indicating that was due to cost, that it received a score that would have increased costs. So that's kind of what's been reported in, like, Politico and other places.

We did not necessarily evaluate the overlap of all of these provisions within the states and to see how, you know, if there are particular gaps within any specific state. Certainly, I think we've seen, not only at the state kind of legislative level, but within the Medicaid programs, a lot of states are doing things to address specific issues as they've come up. But we did not, like, really try to, like, do a gap analysis on that.

VICE CHAIR ROBERT DUNCAN: Thank you, Chris.

Thank you, Patti.

Heidi.

COMMISSIONER HEIDI ALLEN: I'm going to ask a question -- oh. I'm going to ask a question that may sound really ignorant, and if so, I apologize in advance. But it seems like the PBMs play this role, particularly in managed care, of negotiating prices and then also with fee-for-service and managed care of managing the drug rebate program. How does this fit with the Most Favored Nation? And does that -- I mean, I don't actually -- does anybody understand what the Most Favored Nation does to something like this, if the prices are set differently, and they're not negotiated, and there is not a rebate?

CHRIS PARK: So we don't have a lot of detail exactly how this will all work with Medicaid. There is a specific CMMI model called GENEROUS where they do have a RFI out in terms of expressing interest for both manufacturers and states, and what they've said there is it will essentially be calculated as a kind of guaranteed net price. That's the Most Favored Nation price. Then kind of based on that, after you take into account the federal rebates and everything, whatever is kind of remaining will

be kind of applied as a supplemental rebate.

So, essentially, at least within the GENEROUS model, it will replace what states may be doing on the state's supplemental rebate side.

COMMISSIONER HEIDI ALLEN: Okay. But there's been agreements signed with Pfizer, with some major companies, correct, that are specific to Medicaid? I mean, this is what I'm reading in the paper, that they're specific to Medicaid, and they're with these major pharma companies.

Am I interpreting what you're saying correctly, then, there would be less bureaucracy to be managed by PBMs if those become a more predominant model?

CHRIS PARK: So there's several different models kind of brewing at the same time. Most Favored Nation that you've referenced, we don't know the exact details of what specific drugs they've negotiated -- or, you know, have offered pricing for. It isn't a hundred percent clear exactly how those get applied to Medicaid. We haven't seen details on that.

Within the GENEROUS model, there is a little bit more information about exactly how they're going to

calculate the Most Favored Nation price off the second lowest price from these various countries that gets adjusted by GDP per capita. Then based on that, it basically turns into like a supplemental rebate agreement for states who want to participate.

The states that do participate and choose to try to access that Most Favored Nation price will be subject to standardized coverage criteria. So every state that chooses to access that particular rebate on that particular drug will have to follow the same coverage criteria. So that's kind of the way that particular program is working, but we don't know exactly like with the Most Favored Nation agreements that have already been negotiated exactly how that applies.

COMMISSIONER HEIDI ALLEN: So would this run in parallel to the existing program? So there would be some in some states -- so states could be participating in both the same time?

CHRIS PARK: We think so. We don't have all the details. The Most Favored Nation pricing, there'd be this GENEROUS model that is going to be up and running, I think, hopefully by the middle of the year. There's other models

that are called BALANCE, which is for the weight-loss drugs, the GLP-1s, that applies to both the Medicaid and Medicare. We don't know exactly how all these pricing models will work at this point in time.

COMMISSIONER HEIDI ALLEN: I'm glad I'm not the only one that's confused on this.

VICE CHAIR ROBERT DUNCAN: Thanks, Chris. Thanks, Heidi.

All right. We have Doug, Anne, Carolyn, and Dennis.

COMMISSIONER DOUG BROWN: Guys, thank you for this work. You did a very nice job recapping the relevant conditions around PBMs, how they fit into Medicaid relative to managed care and fee-for-service.

I think part of what could help to clarify the issue a little bit further is around nomenclature. When I think about PBMs in the Medicaid fee-for-service space, I think about them as a difference between a pharmacy benefit manager, a PBM, which is an at-risk model, and then a pharmacy benefit administrator, a PBA, which is a not-at-risk model, where they're managing the benefit on behalf of the state and the state is taking the risk.

The state is also directing the PBA to facilitate their program all the way through, from PA criteria to the drugs that are preferred to the contracts they want to execute, all the way down in all the different pieces. So they're managing it. The PBA is doing what the state asked them to do.

If there was spread pricing on that side, it would be because the state asked the PBA to do spread pricing, right?

In a PBA, the PBA is going to use the state's network. It's still a PBM. From the outside, it's still the same name on the outside of the company as you see in the commercial side. You don't know that it's a different company. It's the relationship that they have with the fee-for-service program dimension to manage the fee-for-service benefit. They're going to use the state's network, which is most often any willing provider network.

They're going to use the pharmacy reimbursement, which you guys appropriately talked about here, which is NADAC, and a professional dispensing fee. They're going to make the decisions that the state wants relative to drug coverage and criteria. They are going to negotiate rebates

with drug manufacturers on behalf of the states, and 100 percent of those rebate dollars flow directly to the state. They don't go to the PBA. They go directly to the state.

So the only way the PBA makes money in the model is from the fees that are negotiated through a competitive procurement process, and they're paid a certain fee every month for the remainder of the contract for the five years. The goal of that PBA is to win that contract again in five years, do a good job and win that contract again in five years.

I suspect that's why, with the legislation that passed, you see fee-for-service PBAs being kind of left out or Medicaid being kind of left out, because they're doing the directing on their pharmacy benefit administrator in that regard. And that's different from -- and this is a nice slide, with the exception of the spread pricing, that kind of separates the relationships you have between fee-for-service and managed care.

I do want to talk about some of the data that you've got in the slides. In the handout, it was Figure No. 1, but it was a chart that showed the number of P&T committees. And it was prior to this one. No, this is it.

So, in this slide, if you're looking at it, you're seeing PDL management in 20 states, P&T committee in 19 states. I get that it says 2023, but a lot earlier than that -- I mean, CMS has 47 states with PDLs or supplemental rebate contracting, and if they're doing supplemental rebate contracting, they've got a PDL. And the legislation requires that a state have a pharmacy and therapeutics committee if they're gonna have a PDL. So those numbers should be much further out, much larger than what we see here.

I get this was a survey and those other pieces, but from that perspective, most states have a P&T committee and supplemental rebating and doing contracting on that, based on what that report said from CMS.

If we go to Figure 2 -- yeah, in this model -- this pretty well represents, in my mind, the way things work. You'll see the capitated premiums are there between the state and the MCO and the right side of that slide is all at risk. And so that's where you see the different entities, pulling levers to continue to make sure that they're profitable against the capitated premium.

If you go to the next slide, which is what I call

the pharmacy benefit administrator --

CHRIS PARK: Yeah. We only included one of the figures in the slides, so we don't have that up.

COMMISSIONER DOUG BROWN: Oh, you don't have the other slide up here?

CHRIS PARK: Yeah. We just included one for simplicity sake.

COMMISSIONER DOUG BROWN: Okay. In that slide, there wasn't a supplemental rebate piece, and I would just modify it to say that the state is at risk and not the PBM. And that helps to, again, illustrate the difference between those.

Looking back at my note here to see if there's anything else. I think I'm going to stop there for a minute and reserve the right to come back. Thanks.

VICE CHAIR ROBERT DUNCAN: You have that right.

All right. We'll go to Anne, Carolyn, Dennis, Jami, then Mike.

COMMISSIONER ANNE KARL: I had a very simple comment, which is I really liked the table you had comparing fee-for-service and managed care, notwithstanding the edits to the spread pricing. So I didn't see that in

the issue brief, and I would recommend considering including it in the issue brief.

VICE CHAIR ROBERT DUNCAN: Thank you, Anne.

Carolyn?

COMMISSIONER CAROLYN INGRAM: Yeah. I don't want to just keep picking on it, but I feel like I need to call it out.

So, on slides -- or in the issue brief on page 7, you talk about some audits that occurred in 2018 in Ohio and something in Kentucky in 2018 that looked at costs and spread pricing. I just really want to caution us from using those citations.

A lot has changed since then. There was an investigation in Ohio that I don't think we go into deeply into this, that then caused across several states a settlement with one entity that changed pricing in Medicaid managed care. And so I know we've got a whole section in here about spread pricing, but I would just caution that this is really old data and that we probably should pull those out and then change the language in that section.

We're referring back to people raising concerns about spread pricing and transparency in 2022 and 2023

reports. Again, all the states we operate in -- and again, it's only, it's 22, so there's other states I realize that don't allow spread pricing. We just don't do -- we don't pay that way anymore. Nobody does. I don't think we ever did, to be honest, but I think we just need to use caution about that.

Again, if somebody else has other facts, I'm totally open to listening to them. I just think we should consider caution instead of using some of that old data in there. Thank you.

VICE CHAIR ROBERT DUNCAN: Dennis?

COMMISSIONER DENNIS HEAPHY: Thanks.

Could you say a little bit more, patient cost sharing? Am I right that only 37 states have protections?

CHRIS PARK: Sure. And that, again, is more broadly within the state in terms of state legislation across all payers. So it's not specific to Medicaid, and as you kind of alluded to, cost sharing in Medicaid is pretty nominal. So it's already limited.

COMMISSIONER DENNIS HEAPHY: I just wanted to make sure of that. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you.

Jami?

COMMISSIONER JAMI SNYDER: I was just going to tag on to some of Heidi's earlier questions, and I'm not sure exactly what next steps are in terms of publication of the issue brief. But if we plan to further pursue or renew our interest in the pharmacy space, I really think it might be valuable to bring in officials from HHS and CMS, CMMI to talk about some of the work that they're doing in this space around pricing; in particular, as you referenced, some of the new models that CMMI is pursuing.

VICE CHAIR ROBERT DUNCAN: Thank you, Jami.

All right. Mike, then John. Mike, your mic's off.

COMMISSIONER MICHAEL NARDONE: Thank you. A lot of AV problems today.

I was just going to say, I think in reading the issue brief, it might be helpful just based on some of the comments, to make sure that we're clearly marking where we're talking about Medicaid versus across all states. I think it just help to make it more clear. I think that was something I saw as I was reading it. Was this Medicaid-specific, or was it kind of more generally applicable?

I guess if we are pursuing this work further, one of the things that I think would be worth looking into is the impact of kind of what the results of the more limited networks might be having in terms of independent pharmacies. Particularly in rural areas, I think is an important area and would be interested in hearing more about that. Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Mike.

John, then April.

COMMISSIONER JOHN McCARTHY: As opposed to Mike who always disagrees with me, I'm agreeing with him on this one, like I often do.

Can we go a little bit more into that network part of it, the role that the PBM has in designing the network? Because one of the things that I had run into was talking to independent pharmacies, and I would say, well, just don't sign the Medicaid contract. They would come back and say that that type of a contract was not introduced to them. In other words, if you want to do -- you know, the contract that was presented to them wasn't a Medicaid-only contract. So if you wanted to have insurance company X, you had to sign the Medicaid, commercial, and

Medicare one, you couldn't pick and choose. So it really limited to what they could do if they were going to be underpriced in Medicaid.

Then the second part of that is a whole other thing probably Doug could explain to us in a whole other area. But on the pharmaceutical side, then on the network, there's also this issue that I understand that the independent pharmacies actually don't contract directly with the PBM for that network, that they're often in a part of a bigger group that is then like aggregating them. And that entity is signing the network contract with the PBM, and then that also impacts like who their wholesalers are or something like that. I don't totally understand that one, but just so we better understand that network side of it and where does the PBM play that role? And maybe that's changed, you know, since then, but obviously, that controlling the network is a big piece. Thanks.

VICE CHAIR ROBERT DUNCAN: Thanks, John.

April.

COMMISSIONER APRIL HARTMAN: I guess I just have a couple of questions.

As a provider, this is extremely complicated on

every level. When you have four different or five or six or I don't know however many formularies that are changing every quarter because of whatever reason, whatever rebates, it just makes it complicated. That's just a comment expressing some frustration.

But the question I have -- and I don't know where this is and everything is -- what impact does immunizations have on things? Is that considered a pharmacy benefit, or is that federal since most goes through VFC? Like, I'm just wondering where immunizations, especially in this current landscape of, you know, we're seeing a lot more people refusing vaccines. And I'm just wondering, because I know like a company like Pfizer, a huge amount of what they make comes from vaccines. And so if they're making -- you know, is it going to change the rebates and kind of change the cost of meds if people aren't getting vaccinated as much, which is definitely something that, you know, costs a lot.

CHRIS PARK: Yeah. Vaccines are kind of within Medicaid statute considered their own separate benefit, separate from prescription drugs, and they are not included in the drug rebate program.

As you mentioned, a lot of the vaccinations in Medicaid for children are covered under a separate program, Vaccines for Children program. So, you know, that is where CDC is negotiating the price with the manufacturers directly on that side.

For adults, vaccines are now mandatory for all adults within the Medicaid program, and there, the states do set up like a fee schedule as to how much they would pay the provider in terms of the vaccine costs plus the administration fee.

COMMISSIONER APRIL HARTMAN: I guess I just wanted some clarity on, do they use PBMs in those roles, like to negotiate with that, or is that it's outside of that?

CHRIS PARK: I am not quite sure if vaccines are covered within the PBM scope of services. For the most part, probably not, because they are kind of considered like a distinct benefit, and it's more on the medical side than the pharmacy side. But pharmacies can provide vaccines. It's not something I think that typically goes through the same kind of like utilization management and contracting.

COMMISSIONER APRIL HARTMAN: Okay, thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Chris. Thank you, April.

Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: When I was reading this issue brief, I thought, okay, we're going to get a lot of comments and a lot of questions on this, and I knew our resident expert would come in with some good advice and some things. So, Commissioner Brown, thank you for your input. But I'd like to thank everyone.

Chris, Caroline, do you feel like you got enough out of the discussion and questions?

CHRIS PARK: Yes. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you.

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

CHAIR VERLON JOHNSON: Thank you. Great conversations.

All right. So, before we end, we do want to go to public comments. So, at this point, I will again ask people in the audience to unmute their phones, raise their

hands if you would like to offer a comment. Please make sure you're introducing yourself and, of course, the organization that you represent, and we do ask that you keep your comments to three minutes or less.

PUBLIC COMMENT

* [No response.]

CHAIR VERLON JOHNSON: Okay. All right. Well, no problem. You all can definitely go to our website and submit any additional comments that you have later.

But, at this point, I'd like to adjourn our meeting and have -- I hope everyone has a great evening, and we'll see you in the morning at 9:45 a.m. Thank you.

* [Whereupon, at 4:35 p.m., the meeting was recessed, to reconvene Friday, April 10, 2026.]

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PUBLIC SESSION

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

Friday, April 10, 2026
9:46 a.m.

COMMISSIONERS PRESENT:

VERLON JOHNSON, MPA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
DOUG BROWN, RPH, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
APRIL HARTMAN, MD, FAAP
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
ANNE KARL, JD
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
MICHAEL NARDONE, MPA
JAMI SNYDER, MA

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:46 a.m.]

CHAIR VERLON JOHNSON: All right. Good morning, everyone, and welcome back to day two of our April MACPAC meeting. I just want to thank you all for a very thoughtful and productive discussion yesterday. I think we covered a lot of ground, and I really appreciate the engagement from both the Commissioners, the staff, and of course, our virtual audience too.

So today we're going to continue that work, including voting on the managed care recommendation that reflects yesterday's conversation, and we're also going to turn to some additional topics around program integrity, assisted technology, and home- and community-based services.

So, again, as we move through today's sessions, I'd really just encourage you all to stay focused on what's the most meaningful thing and the most actionable way that we can really make these discussions worthwhile.

VOTE ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS

* CHAIR VERLON JOHNSON: With that, let's go ahead

and get started with the vote.

All right. So, as I mentioned, yesterday the Commission discussed a draft recommendation related to state and federal tools for ensuring accountability of Medicaid managed care plans, and so we're going to turn to that vote.

But before we do, I want to note that MACPAC's conflict of interest rules apply. Our policies are posted on the MACPAC website, and so, as required by statute, Commissioners represent a wide range of backgrounds and bring diverse perspectives as well as reportable interest to their service. Our conflict of interest policy is designed to ensure that any financial or any interest that could rise to the level of a potential conflict are disclosed and appropriately reviewed in connection with the vote. Commissioners are required to report relevant interests at the time of candidacy and annually thereafter, and those disclosures which are publicly available form the basis for determining whether a potential conflict exists for a specific vote.

In advance of this meeting, the Conflict of Interest Committee, which I appoint as Chair and which

reflects a mix of commissioners, review the reportable interest on file and any other relevant information. So, before we proceed, I'll briefly clarify what constitutes a conflict of interest on the Medicaid policy.

A reportable interest rises to the level of a potential conflict only if it would be particularly, directly, predictably, and significantly affected by the outcome of a vote on a specific recommendation. Generalized interests do not meet that standard.

So, on March 24th, 2026, the MACPAC Conflict of Interest Committee met by conference call and reviewed the Commissioners' reportable interest under that standard. The committee determined that no Commissioner has a potential or actual conflict of interest related to the recommendation under consideration today.

The members of the Conflict of Interest Committee were Bob Duncan who is the Vice Chair of the Commission and also the Chair of the committee, Sonja Bjork, Doug Brown, Jennifer Gerstorff, Angelo Giardino, Tim Hill, and Adrienne McFadden.

I will now turn it over to Holly and Chris to walk us through the recommendation. They will, in turn,

turn it over to Executive Director Kate Massey to facilitate the vote.

Thank you.

HOLLY SALTRELLI: Thanks, Verlon. Great.

I will now read Recommendation 3.1: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to planned noncompliance in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Holly.

So we will be voting on each of the two recommendations separately, so I'll call roll.

Heidi Allen?

COMMISSIONER HEIDI ALLEN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

COMMISSIONER SONJA BJORK: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

COMMISSIONER DOUG BROWN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

VICE CHAIR ROBERT DUNCAN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Jenny Gerstorff?

COMMISSIONER JENNIFER GERSTORFF: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

COMMISSIONER ANGELO GIARDINO: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

COMMISSIONER APRIL HARTMAN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

COMMISSIONER DENNIS HEAPHY: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?

COMMISSIONER TIMOTHY HILL: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?

COMMISSIONER CAROLYN INGRAM: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?

COMMISSIONER ANNE KARL: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Patti Killingsworth?

COMMISSIONER PATTI KILLINGSWORTH: Yes, with a caveat from the draft chapter that says the goal of this recommendation is not to document every communication between the state and managed care plan.

EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

COMMISSIONER JOHN McCARTHY: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Adrienne McFadden?

COMMISSIONER ADRIENNE McFADDEN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

COMMISSIONER MICHAEL NARDONE: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

COMMISSIONER JAMI SNYDER: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: And Verlon Johnson?

CHAIR VERLON JOHNSON: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Okay. So it's 17 in favor.

Holly, will you read the next recommendation?

HOLLY SALTRELLI: Yes.

So Recommendation 3.2 states: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue

guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans.

EXECUTIVE DIRECTOR KATE MASSEY: Okay. Heidi Allen?

COMMISSIONER HEIDI ALLEN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

COMMISSIONER SONJA BJORK: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

COMMISSIONER DOUG BROWN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

VICE CHAIR ROBERT DUNCAN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Jenny Gerstorff?

COMMISSIONER JENNIFER GERSTORFF: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

COMMISSIONER ANGELO GIARDINO: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

COMMISSIONER APRIL HARTMAN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

COMMISSIONER DENNIS HEAPHY: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?

COMMISSIONER TIMOTHY HILL: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?

COMMISSIONER CAROLYN INGRAM: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?

COMMISSIONER ANNE KARL: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Patti Killingsworth?

COMMISSIONER PATTI KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

COMMISSIONER JOHN McCARTHY: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Adrienne McFadden?

COMMISSIONER ADRIENNE McFADDEN: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

COMMISSIONER MICHAEL NARDONE: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

COMMISSIONER JAMI SNYDER: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: And Verlon Johnson?

CHAIR VERLON JOHNSON: Yes.

EXECUTIVE DIRECTOR KATE MASSEY: Seventeen in favor.

Thanks.

CHAIR VERLON JOHNSON: All right. Bob, turn it over to you.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chair.

We've got a wonderful topic to start out, very timely, as we look at program integrity in Medicaid. So the team has been working through doing some research, and as we finish, looking for feedback and questions that are really around what is the federal government's role in assisting or working with the states on program integrity.

So, with that, it's all yours, Holly. And here comes Patrick to join you.

INTRODUCTION TO MEDICAID PROGRAM INTEGRITY (PI)

* HOLLY SALTRELLI: Thank you, Verlon -- or Bob. And good morning, Commissioners.

Today, Patrick and I are going to present findings from the literature review and policy scan from MACPAC's new program integrity work.

We'll start with a background on program integrity, or PI, and fraud, waste, and abuse, or FWA. Then Patrick will walk us through Medicaid program

integrity roles and responsibilities held by the federal government, states, and health plans. We will finish up by discussing key issues in Medicaid program integrity.

First, we'll review the background on program integrity and FWA in Medicaid.

Program integrity refers to the activities undertaken to prevent fraud, waste, and abuse, and ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care.

The Medicaid program covers over 99 million Americans and accounts for 18 percent of total U.S. health care spending, making effective program integrity essential to protecting both program resources and beneficiary care.

PI activities include fraud prevention, detection, and investigation, overpayment recovery, and provider and beneficiary screening.

States and the federal government share program integrity responsibilities. Both have defined statutory roles, which Patrick will walk through later.

Fraud, waste, and abuse are related but distinct concepts in health care. Federal regulations define both fraud and abuse.

Fraud occurs when a party makes false or misleading statements to benefit themselves or someone else. A standard example is a provider knowingly billing Medicaid for services that were never delivered.

Abuse occurs when a party engages in practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Medicaid program. For example, billing for services that were delivered but not medically necessary would be abuse.

Waste is any act that directly or indirectly results in unnecessary costs, but unlike fraud and abuse, it is not intentional and does not involve deception. An example would be mistakenly ordering duplicative tests.

The total amount of FWA in Medicaid is unknown, but documented instances account for a small portion of program spending.

Measuring fraud and abuse is difficult because bad actors conceal their actions, and measuring waste is difficult because it often occurs due to unseen errors.

There are currently no data sources that capture the full extent of FWA in Medicaid, but Table 1 on the slide summarizes the data that are available from the

Centers for Medicare & Medicaid Services, or CMS, and the Medicaid Fraud Control Units, or MFCUs, which are state-run bodies that investigate and prosecute Medicaid fraud.

Between 2019 and 2024, CMS reported that its program integrity activities prevented or recovered $11 billion of FWA in the federal share of Medicaid spending, or approximately 0.4 percent of federal Medicaid spending. Halted or recovered federal matching funds for unallowable state Medicaid expenditures accounted for the majority of FWA prevented or recovered during this period.

Over the same period, MFCUs recovered $8.2 billion of state and federal funds from criminal and civil investigations of Medicaid fraud perpetrated by health care providers. This number accounts for 0.18 percent of state and federal spending between 2019 and 2024.

These data do not capture FWA that was undetected, unrecovered, or could not be prevented. It is possible that more FWA occurred during this period, but there are not enough data to determine its total amount.

The Payment Error Rate Measurement program, or PERM, is sometimes cited as a measure of FWA and Medicaid. However, PERM does not identify fraud and abuse, and its

ability to identify waste is limited.

PERM measures improper payments, which are any payments that should not have been made or were made in the wrong amount under statutory, contractual, administrative, or other legally applicable requirements.

In review year 2024, CMS estimated that $31 billion out of $610 billion in Medicaid payments, or approximately 5 percent, were improper. Of that improper amount, 74 percent were deemed improper due to missing documentation. Documentation may be missing because the underlying payment was problematic, but it also may just reflect an administrative error where the payment itself was appropriate.

PERM reviewers do not conduct fraud and abuse investigations and do not collect the information necessary to distinguish between the two.

It's also important to note that FWA can harm beneficiaries directly, not only program finances. For example, the Department of Health and Human Services, HHS, Office of the Inspector General, or OIG, found that Medicaid personal care service attendants who committed fraud also harmed the beneficiaries under their care.

MACPAC has examined program integrity throughout its duration. In 2012, the Commission made recommendations to improve the efficiency of program integrity and enhance state PI capabilities, including determining which federal PI activities are most effective and eliminating programs that are redundant, outdated, or not cost effective, and developing methods for better quantifying the effectiveness of PI activities.

In 2019, the Commission made recommendations targeted at improving the effectiveness of state PI activities specifically. Those recommendations called for conducting a rigorous examination to determine policy design and implementation features in state PI programs associated with success, establishing pilots to test novel strategies or improvements, and making use of the recovery audit program optional to provide flexibility for states.

Our current program integrity work builds on this prior MACPAC work by focusing on the activities the federal government conducts to assist state PI functions. Assistance in this context means providing information, resources, and direction that enhances states' ability to prevent, identify, pursue, and remediate FWA and their

Medicaid programs. Oversight and monitoring activities such as PERM are not in scope.

Our research objectives are threefold: identifying the activities the federal government conducts to assist state PI functions, identifying and describing barriers that limit that assistance and the ways they impact state PI functions, and identifying areas where states need additional assistance in areas where federal efforts overlap with state activities.

The work is structured into two phases. Phase one, which is the focus of today's session, consisted of a federal policy scan, literature review, and issue brief. Phase two will focus on federal assistance to state PI functions. MACPAC will gather data through interviews with state and federal stakeholders and PI subject-matter experts. Findings will be shared with the Commissioners during the '26-'27 meeting cycle and may inform an upcoming chapter with recommendations.

With that, I'll pass it to Patrick to go over the roles and responsibilities.

* PATRICK JONES: Thanks, Holly.

The next section of this presentation will detail

state, federal, and health plan PI responsibilities and issues in Medicaid PI.

The majority of federal Medicaid program integrity responsibilities fall under the Department of Health and Human Services and are given to CMS and HHS-OIG. Other HHS agencies also play a role in Medicaid program integrity, and the Department of Justice does investigate and prosecute some Medicaid fraud.

Many of the federal government's program integrity responsibilities are required by statute, such as those listed on this slide.

CMS carries out the majority of HHS's program integrity responsibilities. The agency provides training, technical assistance, guidance, and data to assist state program integrity functions. CMS provides training to states through the Medicaid Integrity Institute, and the agency also provides states with ad hoc technical assistance and hosts a PI technical advisory group.

CMS issues guidance on federal program integrity statutes and regulations. For example, the agency published and regularly updates the Medicaid Provider Enrollment Compendium, which provides states with guidance

on provider enrollment and credentialing.

Additionally, the agency shares Medicare and Social Security data and facilitates the exchange of Medicaid data between states to assist states with provider enrollment and screening.

CMS also contracts unified program integrity contractors, known as UPICs, to conduct investigations and audits of Medicaid fraud, waste, and abuse. When UPICs detect fraud, they collaborate with federal and state agencies to investigate and take administrative or legal actions against perpetrators.

CMS also conducts a number of program integrity oversight activities. The agency conducts financial oversight of state Medicaid spending, identifying state expenditures that are unallowable for federal financial participation. It also conducts reviews of state PI functions and service areas to identify vulnerabilities. The agency also oversees the PERM program. CMS will issue corrective action to states in response to findings identified by these focused reviews, PERM, and other activities such as state single audits.

The Department of Health and Human Services

Office of the Inspector General, also known as HHS-OIG, has multiple investigatory and oversight responsibility.

In the realm of oversight, OIG audits and evaluates states, providers, and federal agencies to identify vulnerabilities and methods to improve the economy, efficiency, and effectiveness of HHS programs, including Medicaid.

OIG also oversees states' Medicaid Fraud Control Units, also known as MFCUs, conducting annual reviews of their performance, administering their federal grant awards, and approving data-mining applications.

OIG also conducts civil, criminal, and administrative investigations into fraud and abuse in Medicaid and imposes sanctions on perpetrators, including provider exclusions. OIG must exclude providers from participating in federal health care programs if they have been convicted of health care fraud, patient abuse, and other crimes related to the Medicare or Medicaid programs. OIG manages the list of all excluded providers, which is known as the list of excluded individuals and entities.

Finally, OIG issues guidance and alerts on fraud, waste, and abuse, including advisory opinions on health

care industry practices, special fraud alerts, and fraud and abuse guidance and training documents for health care providers.

Outside of these agencies, other HHS agencies share data with state and federal agencies to assist their program integrity functions. For example, the Administration for Children and Families maintains the Public Assistance Reporting Information System, a data-matching service that states use to ensure applicants are not already receiving Medicaid benefits in another state.

Outside of HHS, the Department of Justice pursues major Medicaid fraud cases and coordinates federal, state, and local law enforcement efforts with HHS-OIG.

Moving on to states, states carry out the majority of day-to-day Medicaid program integrity functions. Responsibilities are split between two state bodies, state Medicaid agencies and Medicaid Fraud Control Units. State Medicaid agencies are responsible for preventing, detecting, and conducting preliminary investigations of fraud, waste, and abuse, and overseeing managed care plans. MFCUs focus primarily on investigations and prosecutions of suspected fraud and

patient abuse cases.

State Medicaid agencies have a number of responsibilities to prevent fraud, waste, and abuse. States must screen providers to ensure individuals and entities posing a high risk of fraud and abuse do not participate in their Medicaid program. States also must verify that program applicants are eligible for Medicaid. Some state agencies optionally educate providers and beneficiaries about how to prevent and report fraud and abuse.

State agencies must implement systems to identify fraud, waste, and abuse and recover overpayments. The majority of state agencies centralize these functions under a single program integrity unit, though some disperse program integrity responsibilities throughout the agency.

Regulations require states to implement a post-payment review system to detect potential fraud, waste, and abuse by using payment data to detect aberrant billing patterns. When state agencies discover evidence of provider fraud, they must conduct a preliminary investigation, suspend payments to the suspected provider, and refer the case to the state's MFCU.

State agencies must refer suspected beneficiary fraud to law enforcement and conduct their own investigations into beneficiaries suspected of abusing the program. The state agency also must recover defrauded payments identified by MFCUs or law enforcement and must refund the federal share of any recoveries to CMS.

Finally, state Medicaid agencies conduct oversight of managed care plans to ensure they comply with contractual program integrity requirements and report accurate financial and encounter data.

The MFCUs investigate cases of Medicaid provider fraud and patient abuse and neglect. The Social Security Act requires all states to operate MFCUs. Typical MFCU investigations begin with a referral from a state Medicaid agency managed care plan or another government agency. Some MFCUs also generate leads from data-mining operations. After receiving and assessing the referral, MFCUs conduct a formal investigation and may pursue a civil or criminal case against the suspected perpetrator. Successful MFCU investigations can result in the exclusion of the perpetrator from federal health care programs and the recovery of defrauded funds. MFCUs may recover funds

themselves or refer them to the state agency.

States receive enhanced matching funds to operate their MFCUs. However, MFCUs cannot use matching funds to investigate fraud committed by Medicaid beneficiaries. MFCUs also may not use matching funds for-data mining activities unless granted a waiver by HHS-OIG. Currently, 24 MFCUs have received waivers.

Additional state responsibilities include PERM and the Medicaid Eligibility Quality Control Program. States participate in PERM once every three years on a rolling basis. During a state's PERM year, the state must submit payment and claims data to a PERM contractor and grant them access to relevant state data systems. Between PERM years, states must conduct one 12-month Medicaid Eligibility Quality Control pilot to evaluate the accuracy of beneficiary eligibility determinations. States must take corrective action in response to findings from PERM and MEQC.

Finally, moving on to responsibilities from the health plans, federal regulations require all managed care contracts to contain certain program integrity provisions. The states have some flexibility in choosing how these

provisions are implemented.

Contracts must require managed care plans to identify and promptly report any suspected fraud to the state. Contracts must also require plans to report any provider terminations to the state and immediately cease payment to providers suspected of fraud.

Additionally, contracts must mandate plans have a method for verifying that beneficiaries receive services billed by providers.

State contracts vary in how they implement these requirements. For example, some state contracts require managed care plans to operate special investigation units dedicated to identifying fraud, waste, and abuse in their provider networks.

States can also define how promptly plans must report suspected fraud and what agency it is reported to. Contracts must also require managed care plans to have mechanisms for identifying, reporting, and returning overpayments to the state. States set their own overpayment retention policies. Some states allow managed care plans to retain all recovered overpayments, while others require plans to return overpayments to the state.

Beyond requirements to combat fraud, waste, and abuse in their provider networks, contracts must require managed care plans implement internal controls to prevent fraudulent and abusive behavior within their own organizations.

Finally, moving into some issues identified within Medicaid program integrity. Federal agencies have identified areas for improvement in Medicaid program integrity, including federal oversight, assistance -- and assistance and managed care.

Oversight bodies such as HHS-OIG and the Government Accountability Office have found opportunities for improvement in the federal government's assistance to state PI functions, oversight of states, and investigations of fraud, waste, and abuse.

For example, an HHS-OIG evaluation found that UPICs, which operate under the direction of CMS, engaged in limited Medicaid investigations. The evaluation found that UPICs conducted nearly four times more Medicare investigations than Medicaid investigations, and that only 11 percent of UPIC investigations involved Medicaid managed care.

Other issues involve assistance to state PI functions. A 2017 report from GAO found that CMS did not effectively collect and communicate promising practices from states. CMS has taken some steps to address these findings, such as distributing a promising practices template to states and sharing submissions via email.

GAO also found that the Medicaid Integrity Institute, while useful to states, was unable to meet all states' training needs due to limited staffing and classroom capacity.

Furthermore, a 2023 report by GAO found that the majority of state auditor findings were repeat findings and that CMS is not using auditor findings to inform PI strategy. Again, CMS has taken some steps to address this, such as tracking audit findings across states.

Multiple agencies, including GAO, HHS-OIG, and CMS, have identified shortcomings in both managed care plans' program integrity functions as well as state and federal oversight of managed care. For example, the managed care element of PERM only determines whether states properly paid capitation payments to managed care plans. It does not determine whether MCO payments to providers

were proper.

A GAO review of 27 states and federal audits found that PERM did not capture $68 million in unallowable plan costs and overpayments to network providers.

MACPAC staff identified trends in CMS reviews of managed care plans' PI functions. For example, in 19 states, plans referred an inadequate number of fraud cases to states or submitted low-quality referrals that lacked important investigative information. OIG evaluations from 2018 and 2025 shared similar findings.

A 2018 GAO performance audit identified incentives that may discourage plans from pursuing fraud, waste, and abuse, such as investigations' impact on provider retention and state overpayment retention policies.

CMS has taken steps to increase oversight of managed care recently, such as conducting audits of managed care plans' program integrity activities.

Key takeaways. Fraud, waste, and abuse occurs in Medicaid, but its scale and impact are not fully known. It's difficult to measure the total amount of fraud in the program, but known estimates account for a small portion of

program spending.

Furthermore, the PERM program identifies many improper payments that are the result of mistakes, not intentional fraud and abuse.

The federal government and states have a significant number of statutory and regulatory PI responsibilities, and agencies at both the state and federal level invest time and resources into preventing, identifying, and combating fraud, waste, and abuse in Medicaid.

Finally, there are opportunities to improve federal-state collaboration on program integrity and operations and oversight in managed care.

Our next steps. Staff will return next meeting cycle to present findings from our second phase of work, which will involve interviews with program integrity stakeholders. We welcome Commissioner feedback on today's presentation. We are particularly interested in hearing Commissioners' feedback on policy scan findings and areas for exploration during stakeholder interviews.

We ask that you consider the following questions during the Commissioner discussion. One, are there federal

activities that are of particular interest for the next phase of research; and two, are there state PI needs that are of particular interest for this next phase of research?

With that, I will pass it over to Verlon, who will moderate the Commission discussion. Thank you.

VICE CHAIR ROBERT DUNCAN: It's coming to me instead, Patrick, but thank you, Patrick, Holly, for a wonderful job.

I really appreciated reading this chapter because I thought you laid it out in a very simplistic yet complicated manner of what is the state's responsibility to the Feds and the managed care plans and how they interrelate. So thank you for that.

With that, for feedback and questions from our Commissioners, Tim.

COMMISSIONER TIMOTHY HILL: This is terrific. Nice work. It's a complicated issue and one, obviously, that's timely to help provide some context and understanding about what's going on in Medicaid.

I have kind of three general comments or thoughts for how you move forward.

I hear you when you say you're not going to focus

on the oversight parts of CMS, but getting to your questions, I would just note that there is a zero-sum aspect to what CMS has to do, right? There's only so many dollars in the system, and how they decide to spend those dollars and where the resources go matters a lot.

So I would encourage us to really think about PERM as a -- I want to be careful how I say this. I think they spend the vast amount of their money on PERM, right? I think it's an order of magnitude, at least it was at a period of time when I can remember. More federal administrative dollars are spent actually measuring what they're assessing than actually dollars being devoted to support states or to support activities going on to actually identifying and preventing waste, fraud, and abuse. So I think having an understanding about those choices, the fact that where we're putting our dollars is going to be important. So I would think about maybe thinking about the scope there and the sense of where CMS puts their dollars.

You got right to the issue on -- the second issue for me is managed care. Obviously, that's -- my observation has been, over time, that the fraud

infrastructure is still stuck a little bit in a fee-for-service mindset. While they're getting obviously better and understanding what the roles and responsibilities are with respect to managed care and what the issues might be that might be different than fee-for-service, I think pushing and helping to understand how that transition is going and how CMS in particular -- I think the states are probably a little more ahead of it because they've been transitioning to managed care for a long time.

But I think trying to get an understanding about how CMS is making that transition and also teasing out a little bit where managed care is a partner and where managed care is a target, right, I mean, just to use a loaded word. I mean, it is a provider in the system. They're paid a significant amount of dollars. There are risks associated with capitation payments, and so having an understanding about how CMS and states are teasing that out.

The last is -- I don't know if you can add any help to this, but my observation for Medicaid, in particular, because there are so many flexibilities in the statute about what a state can or can't do under state plan

or waiver authority, many times, rhetorically, what we see is people complaining about things that they don't like and calling it fraud, right?

California covers immigrants using state-only dollars. Well, it's approved, and it's allowed. You may not like it, but it's allowed.

I don't know. Maybe this is just too broad, but having something that can help frame the Medicaid program in a way that some of that rhetoric can kind of be stilted, because I think it -- the issues -- the fraud, waste, and abuse issues in Medicaid are real and important and need to be addressed. And I think sometimes it hurts the effort, if you will, if we start characterizing everything that we don't like as fraud, even though it's been approved and it's allowable under the statute.

So good luck, and I encourage you to keep working. Thank you.

PATRICK JONES: Thank you.

Just on the topic of PERM, I definitely hear you on that. Because it is such a large and complex topic, it's one that we want to kind of focus more of an entire project on. So it's on our list, but we kind of want to

give it its own focus.

VICE CHAIR ROBERT DUNCAN: Thank you, Patrick. And, Tim, thank you for the comments, questions, and the really encouraging there at the end for that.

So, next, we'll go to Anne, then John, Heidi, and Jami.

COMMISSIONER ANNE KARL: Thank you so much for this. It was really, really helpful.

I want to echo a lot of what Tim said in terms of I thought the way that you handled explaining specifically what fraud, waste, and abuse are and giving some examples in the materials, I think is important, because thinking something is bad policy doesn't necessarily mean it's abuse or waste. So I thought that was great.

The area that I would like to just see more about, just because I think it's so important and yet is less well understood and confusing, is around the managed care plan's role in the system.

And even just in the briefing materials, like the word "overpayment," which I assume is overpayments to providers for medical services, but it didn't say that specifically because you can overpay the plan if it's for

someone who, it turns out, is deceased or has left the state or things like that. So I think just sort of splitting out that to be really specific about that. And then just, you know, you indicate that some states do require or allow the plans to keep the overpayments and some don't. Just sort of going into that a little bit more and getting some color from states as to the rationale, because I could sort of see arguments on both sides. So that would be helpful.

VICE CHAIR ROBERT DUNCAN: Thank you, Anne.

John, Heidi, Jami, Carolyn, and Sonja.

COMMISSIONER JOHN McCARTHY: One of the things -- and you touched on it, but I would like you to dig into a little bit more, and the data's out there. It's on the MFCUs and, you know, some of the measurements from the MFCUs of how good they are by state.

They have an annual report. It's online. You can get it. I know you guys know this, but it's talking about in there. And there's two points I want to bring out on that one, if we could go into when you're interviewing states.

One is the delay that states face when it comes

to convictions. I know this has happened to me when I was Medicaid director both in D.C. and in Ohio, and then I know it's happened in other states where you find fraud, whether it's your state MFCU, attorney general, federal DOJ, where they say, don't do anything, don't tell the provider, and just let them keep billing as they're putting the case together. And so, at times, millions of dollars would go out the door.

Now, often that was, in the end, a good thing because they were tracking where the money was going. When we indicted the person, they were able to freeze those accounts so we can actually get the money back versus if you just indict right away, you don't know where the money is, and you can't get it back. But there is this delay in that. So if you could ask states, what is their frustration level? What is the average time on some of those things of seeing money go out the door?

And then the second part is, what are some KPIs on the MFCU units? Again, I downloaded the reports, sorted it, and Ohio is at the top of total investigations and towards the top of total indictments. I had a great MFCU when I was there, and we've really worked well with them,

got a lot of indictments of it.

You look at some other states, and the number of indictments are very low, and they're much larger Medicaid populations, and the number of MFCU staff are very low.

So, with all of our computer systems, AIs, and things like that, you can, quote/unquote, "catch fraud." But if the provider just moves to something else and just commits fraud someplace else under a new name, that doesn't help. It's getting those convictions. I'm not saying it's a deterrent, but at least getting some of those people totally on the system helps stop some of the fraud, waste, and abuse out there. Maybe it is a deterrent for some people. But, anyway, the point of it is, if you could get a little bit more into the role or the measurement of best practices for Medicaid agencies dealing with Medicaid fraud control units in the states and what comes out of that. Thanks.

VICE CHAIR ROBERT DUNCAN: Thanks, John.

Heidi?

COMMISSIONER HEIDI ALLEN: I have less to add because my former Commissioners are excellent.

I just want to encourage us to continue to really

be careful to distinguish what would be mistakes from what is fraud, because fraud should be intentional. Fraud should be systematic. Fraud isn't I moved from one state to another and enrolled in their Medicaid program and forgot to notify my other Medicaid program that I was leaving the state.

To continue, I hope to emphasize that it's interesting thinking of the public perception versus the evidence, because the public perception often focuses on fraud from the beneficiary perspective, and yet, when you look at the evidence, beneficiaries -- we can't even calculate it, it's so small.

So we make policy decisions to try to make it harder for beneficiaries to demonstrate eligibility to get into the program, and I think we keep a lot of eligible beneficiaries out in this effort to avoid this fraud that we have yet to be able to quantify and then less energy thinking about where there actually is fraud.

Also, that issue of mistakes versus fraud and thinking about overpayments, for example, if you see that -- especially when you're working with small providers, I think particularly having spoken to people in mental health

who've tried to work with the Medicaid program, it's very -- if they're Medicaid naive and they're just trying to engage in the program and they get their payments and they're like six months in and then all of a sudden they get a letter saying, you were overpaid, now you need to come back and pay this money, it's very disruptive to the clinic.

It's not fraud. It's something went wrong. Thinking about how we can make it easier for small health care providers to participate in Medicaid and not get caught up in a complicated program that then has them labeled as fraudulent or doing something wrong when really it's just a complicated program. A smaller agency is going to have less knowledge about how to navigate it. Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Heidi.

Jami, did your question get asked?

COMMISSIONER JAMI SNYDER: My fellow Commissioners covered my comments. Thank you.

VICE CHAIR ROBERT DUNCAN: Okay. Thank you. I want to make sure.

We have Carolyn, Sonja, then Patti.

COMMISSIONER CAROLYN INGRAM: Thank you.

Obviously, this is getting a lot of attention nationally, and so I have a lot of, I guess, areas I'd like us to start to look into.

The first one I'll just kind of -- they go all over the place. So I'll kind of list them off. One is best practices in stopping fraud up front. One of the whole reasons that states move to hiring managed care companies or -- I'll just say other large companies, like I'll name Accenture or something -- is because of their tools to be able to stop those claims through processing upfront.

We had a whole discussion yesterday about algorithms and things that are applied. One of the reasons I think you see different fraud numbers coming out in different states -- Texas just had a big hearing about this, I guess, recently -- is because of a lot of that management up front. So, really, if we could look at best practices in states around how they're preventing the fraud and abuse from occurring up front, that would be helpful.

Also, best practices of managed care companies meeting together with the MFCU entities, the Attorney

General's office, Office of Inspector General in states, I know at least, in the health plans that I've run or operated in, those meetings happen on a regular basis, and contact is made not just between those entities but across the managed care companies to share information, share facts and data back and forth. So, if there is something going on, there's a lot of collaboration around that issue quickly to try to figure out what the next steps are going to be in order for -- whether it's a prosecution to move forward or just a misunderstanding about claims payments and to stop those types of things.

The other thing that I think would be helpful and an area where we could do better work nationally, again, goes back to one of the conversations we talked about yesterday. We have very vulnerable populations in some cases who participate in programs and may have -- whether it's a mental health issue, a substance abuse issue, or maybe a developmental delay, they're not able to speak for themselves in some ways. Unfortunately, there are bad characters who take advantage of that.

There are payment practices that are set up that I think a lot of managed care companies help identify for

the states as poor payment practices that almost incentivize that poor behavior. I'm talking about things like, unfortunately, organized crime or sex trafficking, those types of things. There are some payments and things that are set up in regulation by the state that actually incentivize those behaviors.

So managed care companies and others can identify those to the state, point them out, but sometimes there's a lot of advocacy around them. And they're driven in a certain way that it's hard for the state to make changes to that. The self-directed care program that we talked about yesterday is an example of that. Some states pay a broker service to help people figure out how to get into self-directed care and how to direct their own care. Well, unfortunately, that's an incentive to those brokers to get more and more people in, and there are some bad actors who participate. So maybe there's a better way to pay for that instead of paying per person an incentive to help somebody, a different way to set up those payments. That's just one example.

I think there are some examples like that in personal care, where just the way it's set up in terms of

payment and the managed care companies just following the payment guidelines the states put in place and the requirements, we're actually incentivizing some of that bad behavior and harm to come to some of those more vulnerable populations who can't always speak for themselves or help themselves out. So I think there's a lot we can dive into here.

Also, I think as John pointed out, there are some things that states do unknowingly because they're trying to coordinate and put together a really strong prosecution on a case. During that time period, as a managed care company, one of the things that gets frustrating is money is just going out the door. We see a lot of that in DME equipment rentals and other things where our algorithms have identified there's clearly fraud going on in certain states.

It's brought to the attention of the MFCUs, the attorney general's Office, the OIG, those things, but while they're building that case, they really don't want the managed care company to step in and stop some of that, because they have to get their documents together, I guess, and it takes time. Well, millions of dollars go out the

door during that time period. So is there a better best practice that can be put in place to stop some of that around especially DME equipment, lab billing, some of those kind of one-off services? I think there's a lot of interest that's being asked about it. So there's got to be better practices that we can put in place to get those done. I'm happy to talk more about that.

VICE CHAIR ROBERT DUNCAN: Thanks, Carolyn.

Sonja, Patti, then Mike.

COMMISSIONER SONJA BJORK: The case doesn't get that much play in all of this, and so I would really like to see our chapters about waste very developed. What I'm looking for is identifying some of the factors that can create waste. There are some policies that just create waste in the system, and what's the mechanism for reporting that or having a policy reexamined to see if it can be tightened up or changed?

Another factor, an example is if a state or counties get way behind on eligibility processing, then we're going to have some retroactive eligibility issues. That causes so much waste in the system because you have to go back and then find out that the person was not eligible.

So then the managed care plan shouldn't have gotten that capitation payment. The patient probably received a lot of services during that time. Then there's the issue of how can you take back the payment to the provider who in good faith provided the service during that period where it was unknown that the person wasn't eligible. My goodness, what a big waste in terms of retrieving and dealing with all of that.

The final thing I wanted to mention is that there's a lot of tension right now about prior authorization. But UM, the utilization management, and the tools related to that is often the way to do prevention -- or that health plans are asked to do prevention, so kind of delving into that tension between the frustration that's being expressed right now with prior authorization and why do health plans do that and why all these steps are required, but then, on the other hand, the success that prior authorization can have in making sure that services aren't inappropriately rendered or that the provider is the right one or the service is the right one.

So those were my three. Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Sonja.

Patti.

COMMISSIONER PATTI KILLINGSWORTH: I really appreciate all of the data in this particular section.

Just sort of giving people a sense of the order of magnitude of how much fraud, waste, and abuse is there based on what we know I think is really helpful, and then also being able to look at the cost of recovering those amounts, I think is really powerful.

I agree with Tim that there ought to be some sort of an ROI analysis of sorts where we sort of look at is where we're investing the money really producing the greatest results in terms of identifying and correcting problematic behavior.

In terms of things that are of particular interest to me, I'm very interested in the high-risk services that have been identified and how those are identified and sort of the status of investigations and recoveries around those particular high-risk services.

I want to add a couple that I think I don't believe they're currently on the list, but they probably should be. And I would be curious if there's any investigations or findings that have been done around them.

The first is related to long-term services and supports (LTSS) and probably more particularly to home- and community-based services. It arises in states where a different capitation payment is made for people who are enrolled in managed LTSS programs than is paid for the general population. So it's not like we're adding a service and making it available to a broad population, but everybody in that group is getting a higher -- the plan is getting a higher capitation payment for them.

What we see happen a lot is that people are enrolled and then there are very lengthy delays before they actually begin to receive services. In the meantime, that big capitation payment is being paid, and no services are actually being delivered. Then there are also really significant gaps in services that people are supposed to receive and that are a part of that capitation payment. There's no adjustment that is made to really reflect the fact that the payment, the capitation payment, was made and the services weren't received.

While I get the fact that eventually the actuarial data will catch up -- and there are reports of all sorts of inappropriate practices with regard to

families being forced to receive 40 hours a week of service or get none. It's not about making sure that kids are getting the amount of service that they really need, but it's really being driven by a desire for providers to make more money delivering services. It seems to be fairly rampant across a lot of states and seems like an area that would be ripe for someone to really look at and figure out what is happening and how do we put appropriate policies in place to make sure that we're delivering the right amount of services and that we're not creating waste in the system or abuse.

Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, Patti.

Mike, then April.

COMMISSIONER MICHAEL NARDONE: Thanks, Patrick and Holly. I really appreciate your work. This is obviously very timely and top of mind for a lot of people.

I just want to say that I really appreciate in the issue brief kind of distinction you make between the PERM and fraud and abuse, and I think any time that you can do that and draw that distinction out for people, I just think it helps to kind of get people to understand what the

distinctions are. So I really appreciate that and hope that whatever we produce going forward, we kind of continue to make it clear, because there's so much out there, and I think it's really important to really understand what the differences are and what we're talking about here when we're talking about fraud and abuse. So I really appreciate the work that you put into this.

Now, with all things Medicaid, there's an awful lot of variability in the programs. I think what I'd be really interested in is kind of how states structure their program integrity roles. I don't know if that information is out there in terms of where they sit the -- or the work. Some do it outside the Medicaid agency. Some do it internal. I'm just curious to be interested in kind of if there's some sort of framework that describes that.

I know there's a lot of efforts going into fraud, waste, and abuse at the state level. I think we talked about the prevention. I think it's also important if there are best practices around recovery, and I don't know if this is something that might be helpful to have some sort of panel here at a future meeting where we discuss with states around what some of the efforts are, what's been

successful.

I know one of the things that I remember from my days at the state level was that frequently we could identify something, but the MFCU wouldn't necessarily take the case. So there was a lot of -- we had to do a lot of activity that didn't rise to the level of a court case, a civil proceeding. We were just looking at the stats. We do a lot of investigations in Pennsylvania. So maybe they have to really get to a certain level.

But I think it's interesting to -- I think there are things that maybe are barriers at the state level that would be interested in hearing about. The standard of proof, for instance, in making the fraud and abuse judgment, you could take the money back, but there are also appeal rights around that. And that can be very time consuming and a lot of effort that goes in from the state side.

So I think getting a feel for that would be helpful, and I just echo the comments around managed care and just understanding how states think about how they structure the different relationships around managed care recoveries versus paying back to the state would be of

interest to me.

So thank you. Thank you for this work.

VICE CHAIR ROBERT DUNCAN: Thanks, Mike.

April and then the Chair.

COMMISSIONER APRIL HARTMAN: Thank you for your work with this. I think it's extremely complicated.

I think most of my comments have been covered by my fellow Commissioners. I just have one thing I wanted to ask you to look into as you're asking questions.

When it comes to preventive activities that states are doing, one of the things that has really started to become more prevalent is prepayment audits on claims. This has become a big issue with a lot of providers, especially those who see a majority of Medicaid patients, that a plan will just downcode a claim prior to any audit or looking at any documentation or anything just based on the diagnosis.

If we feel this -- as a provider, if we feel that was not appropriate, we have to submit the documentation for review in order for it to then be accepted at the level that we coded it, and this is becoming more and more of a problem, and it does have a significant impact on practices

that see a majority of Medicaid.

So if you could just maybe find out if there are prepayment audit activities going on and what those look like and what impact they're having would be helpful. Thank you.

VICE CHAIR ROBERT DUNCAN: Thanks, April.

And we'll wrap up after the Chair's comments.

CHAIR VERLON JOHNSON: All right. Thank you.

So again, echoing all the comments, this was very well done, very educational for sure, and very strong, I feel, and very helpful for us as we try to really break down more of a complex area for us.

As I read it, the opportunity around making sure we're being even more clear, that we are providing a lot more clarity as we get into the next phase of work on this, but really appreciated how you define FWA, how you really broke down the roles and even the nuances between managed care and fee-for-service, for sure.

But, when Mike talked, he gave me -- some other things that kind of popped into my head around states, right? And when I think about the federal-state collaboration -- and those are one of the key takeaways

that you all had really honed in on there -- I do wonder as we get further in this work -- and I'm sure Tim will be very helpful to this as well, but where could CMS maybe be doing more to enable states and not just monitoring them but really being a strong partner in this? I think they're doing a great job now, but there's always probably some opportunities there.

Then I also wonder, as I was hearing many of our former state Medicaid directors talk, are there areas that we're not really capturing how this really works in practice at the state level? So we have all the roles. We have the, quote, "processes," but are there some other things that we may be missing there? So what's ground truth versus theory? So maybe you can get into that as you get your conversations.

And the last thing is always going to be around data, really addressing the role of data in this, its limitations and opportunities, and how this can help us really get to a strong a program.

But, again, great work, and I learned so much from you all and my Commissioners on this topic. So I really appreciate it.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chair.

So Patrick, Holly, I think you got three to five years' worth of work here out of this, but I think you've touched on a point where there's definitely interest from the Commission as we look at this, and then again, how does the federal government support the states and how we make sure that the integrity of the Medicaid program is effective in taking care of our members as it should be. So thank you for getting us kicked off and started on this, but do you feel like you've got everything you need and more?

PATRICK JONES: I think so.

VICE CHAIR ROBERT DUNCAN: All right. Thank you very much.

Madam Chair, I'll turn the meeting back over to you.

CHAIR VERLON JOHNSON: All right. So we're on to our next topic, which is assisted technology, and so this is a new area for us, as you heard. It is an area that doesn't always get a lot of attention, but I think it does play a critical role of supporting independence, access,

and of course, quality of life for many of our Medicaid beneficiaries.

Also, I'm trying to -- I'm actually giving away a little bit of what you guys want to talk about, but I'm just going to say that as I was reading, I was so impressed with the breadth of this work, particularly the fact that you got insights from, I believe, all 50 states. Very impressive, right? That's not easy to do, and it really strengthens, I think, the foundation for this conversation.

So, Commissioners, as we think about this work, let's see this as an opportunity to better understand what's happening in this, how it's functioning today, where there may be gaps in what you're hearing, where you feel there may be opportunities, and really how Medicaid policy can better support.

So I will turn it over to Maddie and then Kirstin.

MEDICAID COVERAGE OF ASSISTIVE TECHNOLOGY (AT) FOR ADULTS: POLICY SCAN AND LITERATURE REVIEW

* MADDIE MUSTAINE: Great. Thank you.

Good morning. Today we will be discussing Medicaid coverage of assistive technology for adults.

Specifically, we will be reviewing findings from our policy scan and literature review.

We will start by reviewing our project objective and some background on assistive technology in Medicaid. Then we will present findings from our policy scan and literature review. We will end by discussing next steps for this work.

MACPAC's work on assistive technology, or AT, aims to identify the statutory and regulatory framework that governs how states cover AT and assess whether there are barriers to coverage of and access to AT.

MACPAC is focusing on adults to manage our scope and because they may experience less robust coverage of AT than children. Children may be able to receive some AT through the early and periodic screening, diagnostic, and treatment requirement. So far, we have completed a policy scan and literature review. We are also planning to interview key stakeholders and analyze claims data.

Now for some background. AT refers to a wide range of items that help individuals maintain or improve their functional capabilities. Research shows that AT can help individuals perform more activities of daily living

independently, and it may reduce some burden on the home- and community-based services, or HCBS, workforce.

In Medicaid, there is no statutory or regulatory definition of AT. For adults, states often provide AT through HCBS programs under Section 1915(c) of the Social Security Act. The Section 1915(c) Technical Guide, which is a tool states use to design their HCBS programs, defines AT as an item, piece of equipment, service animal, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants.

States have flexibility in how they cover AT. The Section 1915(c) Technical Guide serves as guidance to states, but does not prescribe how a state should cover AT. For example, some states may include items like personal emergency response systems as part of AT or as a standalone service.

States also cover items commonly considered AT under state plan benefits. For example, states often cover wheelchairs as durable medical equipment, or DME, which is a state plan benefit.

Because of this flexibility, it is important to

assess a wide range of services and benefits to gauge how states are covering AT.

MACPAC is considering multiple items covered in HCBS programs and state plan benefits as categories of AT.

This is a table of services and benefits that MACPAC is considering in its scope for AT. MACPAC reviewed the Section 1915(c) Technical Guide and the federal regulations for state plan benefits to identify services and benefits that may cover items that increase, maintain, or improve the functional capabilities of participants similar to AT.

On the left are services we identified in HCBS programs. Individual-directed goods and services are equipment or supplies for individuals who self-direct.

On the right are benefits we identified in state plans. Preventive services include services that promote physical and mental health, which may include items considered AT. For the purposes of our research and analysis, MACPAC is considering these services and benefits as categories of AT.

Now we will review findings from our policy scan.

MACPAC conducted a policy scan of all HCBS

programs operating under various authorities, including Section 1915(c) waivers, Section 1115 demonstrations, and Section 1915(i) and Section 1915(k) state plan amendments to identify coverage of AT.

Most HCBS programs cover some AT, primarily in Section 1915(c) waivers. Of the 263 HCBS programs we reviewed, 87 percent include at least one category of AT. Almost all Section 1915(c) waivers cover AT. Additionally, AT coverage differs by category of AT, state, population served by the HCBS program, how a state defines services, and any limits a state may place on these services.

This table shows the number of states covering different categories of AT. All states and the District of Columbia cover some AT for adults in their HCBS programs, and the type of AT covered varies. For example, all states and the District of Columbia cover home accessibility adaptations, and 28 states and the District of Columbia cover individual-directed goods and services.

This map shows the number of AT categories each state covers. All states and the District of Columbia cover at least two categories of AT for adults in their HCBS programs, while 17 states cover all seven categories.

For example, Arizona covers personal emergency response systems and home accessibility adaptations, while Alabama covers those services and a standalone AT benefit, specialized medical equipment and supplies, individual-directed goods and services, electronic and remote monitoring, and vehicle modifications.

This figure shows the number of HCBS programs through Section 1915(c) waivers that cover AT for specific populations. Section 1915(c) waivers can cover individuals in several different population groupings established by CMS. States may cover AT in their HCBS programs for some populations, but not others.

For example, almost all Section 1915(c) waivers cover some AT for adults with intellectual disabilities, a developmental disability, autism, or brain injury, while a portion of waivers serving adults who are age 65 or older, disabled physically or have a disability captured in the disabled other category do not cover AT.

States may include different items under the same service definitions. For example, specialized medical equipment and supplies may include automatic medication dispensers in one HCBS program, but not in another.

Additionally, some services include a list of items that are included or excluded from coverage. For example, home accessibility adaptations may include an exhaustive list of approved items.

States can also place limits on what a service covers. Many services in HCBS programs are limited to items that are not otherwise provided by the Medicaid state plan. For example, specialized medical equipment and supplies may only cover items that are not available as DME under the state plan.

Many AT services have expenditure caps. For example, in one HCBS program, individual directed goods and services has an annual expenditure cap of $1,000 per beneficiary.

Additionally, some services may only be permitted within a certain time frame. For example, in one HCBS program, home accessibility adaptations can only occur in a continuous 36-month period.

Now I'll pass it to Kirstin to review findings from our literature review.

* KIRSTIN BLOM: Thanks, Maddie.

So our literature review found limited federal

guidance on AT, aside from the Section 1915(c) Technical Guide that Maddie mentioned, which defines the benefit.

Existing guidance targets specific areas. For example, we found guidance on how environmental assessments are conducted for purposes of home accessibility adaptations and vehicle modifications, and we also found guidance on DME.

Environmental assessments are used to assess the beneficiary's need for services, such as vehicle modifications. According to the guidance, states can receive federal reimbursement for these assessments in several ways, including as an administrative expense and as an environmental modification cost under an HCBS waiver.

Medicaid DME covers AT in more settings than Medicare DME. According to the guidance, it can be used in settings outside the home, such as in the community or in a place of employment. In addition, Medicaid DME covers more items than Medicare. Medicare covers a national list of approved DME, but in Medicaid, states may develop an approved list, but the state must also have a procedure in place for beneficiaries to request items that don't appear on that list.

And coverage, of course, as you guys know, may overlap between the two programs. Medicaid payment for DME is tied to Medicare rates. Federal Medicaid reimbursement is prohibited for certain Medicaid DME expenditures that are in excess of what Medicare would have paid.

In our review of the literature, we found that states have flexibility in how they cover AT under Medicaid state plan benefits and HCBS programs. For example, some states cover augmentative and alternative communication devices, or AAC, under DME in the state plan, and some states cover it under specialized medical equipment and supplies in HCBS programs.

Because state plan benefits must be offered to all eligible Medicaid beneficiaries and HCBS programs are targeted to specific populations, the authority that a state chooses to use to cover an AT item can affect which beneficiaries have access to those items.

States also have flexibility in how they cover AT under service definitions in HCBS programs. They can cover the same item under different definitions. For example, some states cover AAC devices under a standalone AT service or as specialized medical equipment and supplies in their

HCBS programs. This flexibility allows states to design their programs in an intentional way to meet their needs, and it can make it challenging for policymakers, on the other hand, to understand the scope of AT across programs.

States can establish limits on AT to manage costs. Some states limit how much Medicaid can spend on AT or require that a device be the most cost-effective option in order to be covered. For example, one state has an AT benefit cap of $5,000 per year.

Finally, some MLTSS programs cover AT as a defined benefit. Many MLTSS states use in lieu of services, which allow managed care organizations to authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement.

Our literature review identified impacts on beneficiaries from AT. One study found that HCBS users have an unmet need for AT. Across five domains of unmet need, AT had the highest prevalence at 54 percent.

AT has been shown to improve quality of life and independence for users. For example, studies of state and federal AT programs indicate fewer hospital readmissions and physician visits among AT users. AT access is also

linked to increased labor force participation and community engagement among people with disabilities.

AT often requires repairs and maintenance to maintain its usefulness to Medicaid beneficiaries. Many types of AT are designed to withstand repeated and long-term use, but lack of timely and consistent access to repairs can impact beneficiary use.

One study found that 70 percent of Section 1915(c) waivers targeted to adults with physical disabilities covered repairs and maintenance.

Research has also shown that training beneficiaries on how to use AT is important for their successful adoption of those devices, and some states cover this training. Beneficiaries may discontinue or abandon an AT item due to a lack of training. The same study of Section 1915(c) waivers found that 55 percent covered training for AT users.

According to the literature, AT can help address pressures on caregivers. By enabling users to perform more tasks independently or with less hands-on assistance, certain technologies and modifications can reduce the total number of paid caregiving hours.

Finally, states and MCOs might need or might look for data on the effectiveness of AT to justify providing these services, but data on the impact of AT are limited.

Our literature review identified some population-specific findings. Medical necessity criteria vary by state, and the functional nature of AT might not align with those criteria. Federal policy requires beneficiaries to meet medical necessity criteria to receive Medicaid coverage, and states define those criteria.

The Assistant Secretary for Planning and Evaluation at HHS reports that HCBS programs using functional language to determine necessity of AT rather than medical language or medical necessity criteria might be more closely aligned with the intent of HCBS programs, which is to maintain independence in the community.

For people who are dually eligible, misalignment between Medicare and Medicaid DME can create confusion. As we noted earlier, Medicaid DME covers more items and can be used in more settings than Medicare DME. As a result, it can be unclear which program will cover which DME for duals. This misalignment can also result in reluctance from DME suppliers to provide equipment, given the

uncertainty about who's going to cover it, as well as cost shifting and administrative inefficiency.

AT coverage is more expansive for individuals with intellectual and developmental disabilities than for people who are aged or physically disabled. HCBS waivers targeting people with physical disabilities are less likely to include AT services than those targeting people with IDD.

The process of becoming an AT provider varies by the type of AT. For example, federal regulations define qualified providers for DME and HCBS programs but leave specific standards up to the state. DME professionals in most states have specific licensing and enrollment requirements that can differ from other AT providers.

Training for providers on how to use AT is not widely covered by Medicaid. Providers may be required to train beneficiaries on how to use AT, as well as the people who are supporting them in using those devices. Some states limit AT training to the covered individual, family member, or direct care worker.

Prior authorization for AT can be burdensome and can cause delays. It can include elements such as complex

documentation, frequent reassessments, and slow approvals for repairs.

AT billing and payment differs across states and types of AT. A number of states use a fee schedule based on the Medicare payment rates or a percentage of those rates for Medicaid DME.

MLTSS programs often rely on an MCO contract for billing and payment of AT, with every Medicaid MCO potentially having its own independent fee schedule and provider contracts.

For AT covered under fee-for-service, HCBS states usually have a list of rates and units for all services. However, some types of AT do not have specific standardized billing codes, which can make billing difficult.

Medicaid is the payer of last resort, and statute requires that states take all reasonable measures to exhaust alternative sources of funding before providing Medicaid coverage. For example, one California HCBS program requires proof of request and denial from other sources that provide AT, such as Medi-Cal, state plan, Medicare, and private insurance. This can pose barriers for people who are seeking AT that is covered under other

sources but that is also not readily available, such as services under the Rehabilitation Act, which have long waiting lists. This might be especially burdensome for people who are duly eligible.

And Medicaid coverage of new technologies typically lags behind technological advancements and other payers. Medicaid payments have to be consistent with efficiency, economy, and quality of care. Medicaid programs often either defer to or use Medicare coverage policies to establish their policies. Medicare coverage policies are established through national coverage determinations, where items go through an evidence-based process to determine whether they are reasonable and necessary for diagnosis or treatment and within the scope of Medicare benefits.

CMS national coverage determinations for medical devices often follow FDA approval, which is based on safety and efficacy, and some items may be adopted by state Medicaid programs over many years.

So, finally, next steps. We are in the process of gathering information through interviews and we have an upcoming analysis of claims data. So we will be back in

the next analytic cycle to talk with you guys about our findings from those two things.

For today, we would be very interested in your thoughts on these two questions. Did any of the barriers raised in our literature review today stand out to you, and what areas would you flag for further investigation in our interviews and analysis of AT claims data?

Thank you. I'll pass it back to the Chair.

CHAIR VERLON JOHNSON: Thank you. That was very, very helpful, for sure. I guess I continue to be struck, too, by the variation with states and how they're using AT, how it's delivered and assessed, for sure.

So your question about any barriers that stood out, the training, this is a great technology that could really help to improve folks' lives, and we see that there are barriers in how it's delivered. It sounded like there are some that are coming, maybe from the providers, because that's what the states are requiring. There may be some family members or other things like that. But when I think about anything that could be new and additive to improve life, I go back to -- I don't even know what year it was, but there was a whole campaign about from here to coverage.

We made sure that everyone got their coverage, but then we realized they weren't using it. And so we really wanted this campaign to help educate people.

So I think whenever we're trying to really think about how we can really do something more positive, we should really think about that training aspect of it. So that's the one that stood out for me.

But there are others I'm thinking about. But let me pause there and open it up to my fellow Commissioners.

So we have Patti and John first.

COMMISSIONER PATTI KILLINGSWORTH: You have done an excellent job of introducing this topic and covered a lot of ground, which I really appreciate. I'm going to push us to cover a little more.

I think access to assistive technology is a bigger issue than is the benefit covered. It's a much bigger issue than that, and fundamentally, when we think about policy barriers, it really starts with the Medicaid statute itself.

If you read it -- and I have multiple times -- it barely mentions any expectation that we support people in ways that maximize their opportunities for independence.

It is not identified as an expectation, and it's not implemented as an expectation in most situations.

If you think about the way that we deliver home- and community-based services, we identify the things that a person needs help with, and then we authorize someone to come in and do all of those things. Very rarely do we stop to say, where would you like to be more independent? What are the ways that we could help you to be more independent? Would a course of therapy help you? Would some simple, typically very low-cost items help you be able to do more of these things for yourself? Which would give people a better quality of life in the community and enable them to do more things and, oh, by the way, cost the Medicaid program less if we hearken back to our previous discussion on waste. It's just not the way that we do assessments. It's not the way that we do person-centered planning.

You can have all of the covered benefits in the world, but if the person conducting the planning isn't attuned to the real options that are out there and isn't asking the question first, is there a way to empower independence before I go to authorizing personal care hours, we are not going to create access to these services.

And I could continue on.

In the way that we pay providers, we pay providers to deliver more services. So, as long as we continue to do that, providers will deliver more services, and they're not terribly incentivized to look for opportunities to help people be more independent. So there's a lot about the system that really has to be turned on its head a bit.

We are still operating from expectations that were created in 1965 or maybe in 1980 when 1915(c) waivers began, and many of these things weren't available, but we know so much more now.

I would also say with regard to different populations, if we want to get, I think, a really good perspective, the system that serves people with intellectual and developmental disabilities is light years ahead in terms of this particular issue. I think 40 of the states have declared themselves technology-first states.

Typically, again, in those IDD systems, they've done that through law or Executive Order or policy, but they have structures in place to really help them transform their service delivery systems to be more progressive and

to focus on independence.

I would call out my home state of Tennessee, which I think does an excellent job. I would call out my other home state of Missouri, which I think also does an excellent job. There are others, by the way, and doing maybe a panel discussion and bringing some of those folks to talk about the barriers and how they've overcome them and how that needs to be threaded throughout the service delivery system could move access forward substantially.

Thank you.

CHAIR VERLON JOHNSON: All right. John? I was just so into what Patti was saying. Sorry.

COMMISSIONER JOHN McCARTHY: I totally agree with what Patti's saying, and I think this is an area for MACPAC to really get into, to really do some recommendations of true reforms of the Medicaid program.

I think this is an area that states really struggle with, and I'll get into a few of those examples in a minute. But I'm a little concerned because the title of this was assistive technologies, but we're really dealing with any type of assistance that somebody uses outside of just an aide or something.

So, for instance, you talked about home modifications. I don't think of home modifications as a technology. You're just modifying the home.

So a part of it is do we split -- as I said earlier, do we split this chapter into truly assistive technologies versus other things or change the title of it? Because you're going to get into some very, very different issues and how they can be modified.

So, on one side of the table, it's things like home modifications and things like that, and these are really, really difficult decisions, after we just had the fraud, waste, and abuse conversation, because I'll give you a real-world example -- is if you're doing home modifications, you're running these issues where a person is in a program. They can get it, but let's say it is a child that got eligibility through Katie Beckett. So you're ignoring the parent's income. Well, the parent's income might be exceptionally high, a million dollars more, and they're asking for a home modification because the child is eligible for that. When that gets reported in the news, it looks like waste in the program because you're modifying the home of a millionaire or even more. So it's

like, how does the state deal with those issues? Do we need to rethink some of those benefits and who can get them and how they're delivered?

On the flip side of that, like, when I was here in D.C. and I was Medicaid director, you might have somebody that lives on a third floor walk-up. So you really need to put in an elevator, but the benefit is only $5,000 a year, and you can't get an elevator for that. So there's real-world issues around home modifications.

The last one on that one is, how do you enroll the provider? Because the provider needs to be a Medicaid-approved provider, and these are contractors. They don't know how to be a Medicaid -- it leads to a whole bunch of other issues. So, on one path, it's like, what reforms do we need to do on that side of the house and do those things? On the other side, again, looking at what are states running into -- and I can't believe I'm saying this, but it's one of those areas like, do we need some type of federal panel to look at technologies and what works? Because I'll never forget one of the times, I had to make a decision where a child wanted -- there was a request to buy an iPad for a child. An iPad at the time was like $800,

and we couldn't do it, because an iPad wasn't an assistive device, but yet I had to pay for -- the option that I could pay for was one of the language boards, which cost, like, $2,000 or $1,400, whatever it was, where the iPad would have been actually less expensive, but then could be used for other things. S these are really hard decisions states are made.

So it's almost like is there some way, in talking to states, how would they feel about some type of national decisions around some of these things to say, yes, this could be beneficial or something in those areas? Technology is moving so, so quickly. It's just hard to stay up to date on these.

Even with AI now coming out, how is that going to help people communicate and do some of the things? So you've got a lot of work to do. So that's why I was thinking, do we need to split this up a little bit? Otherwise, it's going to be a really, really long chapter.

Thanks.

CHAIR VERLON JOHNSON: Really good points there.

Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks.

I am grateful for assistive technology. I open and close my windows, adjust my thermostat, fans, humidifier, all these things that I would need a person to do for me if I didn't have the assistive technology. I could open my door, things like that. And so it's really just these are daily functions that I would need someone there to take care of, really on almost an hourly basis, because of just things with my disability. So assistive technology is so key to people's independence. I do think that in terms of reducing dependency on people, I think there's an opportunity there.

Something that -- John, you stole my thunder with the dual use stuff, that states will deny access to an iPad or a tablet because the person can use it for other things other than the designated task it's supposed to carry out for the person, even if it's the most effective, most efficient, and less costly alternative or option for the person. So I think that's really key.

The other is proficiency requirements for access to like AAC and other pieces of equipment, that the only way to get proficiency is by using the piece of equipment. It seems like a civil rights issue, especially for AAC,

where you've got youth who can't prove that they've got proficiency in communication. So, therefore, they can't communicate until they're able to use a device, if that makes sense.

So I think it would be really helpful to look at different states and how they determine proficiency and what the requirements are, and then the dual use piece.

The other thing I've heard from providers is that the reimbursement rates are so low that they really can't afford to provide the equipment, and the equipment itself is so low cost. I mean, Alexa or Google or whatever can carry out most of the activities.

But thank you. It was really interesting.

CHAIR VERLON JOHNSON: Oh, thank you. Thank you for that perspective. That was really helpful.

Any other thoughts or comments? This is our first look at it. So I'm sure you'll noodle on a little bit more, for sure.

But I think you guys -- oh, Mike. Okay, Mike.

COMMISSIONER MICHAEL NARDONE: Sorry. I just wanted to thank you for this work.

The issue that I'm really interested in is the

dual-eligible angle and kind of what that means in terms of access to services. Particularly, as D-SNPs are providing supplemental benefits, I'm wondering what the interplay there is. So that was something.

I just want to echo Patti's point earlier about the importance of the assessments and managing some of the HCBS waivers. I know that as new technologies rolled out, that was one of the barriers that we found with the people who were actually doing the assessments didn't necessarily -- and doing the planning didn't necessarily incorporate the assistive technologies that could have benefitted someone to be living in the community. So I think kind of looking at that, I just want to echo that point.

And then the last thing I had was just a question that as I was looking through the briefing materials -- and I just want to understand this, and maybe I'm misreading some of this -- is that it makes sense that -- I understand that for IDD, the waivers were -- the assisted technology was most expansive use of assisted technology. And then an earlier analysis that was cited said less than 4 percent of individuals in IDD waivers were projected to receive AT.

I was trying to square that circle. Is 4 percent

then a lot compared to the other? I was just trying to understand those two data points and square the circle, to kind of square the circle for me.

KIRSTIN BLOM: That's a good question, Mike. I think we might want to go back and double-check that.

Go ahead.

COMMISSIONER PATTI KILLINGSWORTH: Go ahead.

MADDIE MUSTAINE: So the fact about the 4 percent, so that's when looking within a waiver, that's the number of people that would be projected to receive those services. The number of waivers that in their service breadth have assistive technology is a large amount. That means that they could only be providing that service to a couple people in their waiver. So that's where the difference lies. It's a lot of waivers cover it, but the amount of people that may be receiving it within that waiver is low.

COMMISSIONER PATTI KILLINGSWORTH: That's a great explanation. And I would just say and therein lies the problem, right, is that you can cover the benefit, but until you change how assessment and planning occurs and really prioritize opportunities for independence and

employment and integration and all of the things that we value in our own lives and that people with disabilities value, too, all of the benefit coverage in the world isn't going to matter, because utilization is going to stay low.

MACPAC did a study -- I'm trying to remember -- on how -- it's been a while -- on how Medicaid home- and community-based services were utilized. I'm pretty sure it was MACPAC, and it was, like, less than 1 percent of all of the expenditures in Medicaid home- and community-based services went to assistive technology or like services, things that would enable independence. And the vast majority of it went to in-person supports, whether that was personal care-type services or respite services or a lot of residential services.

But you just see it in the utilization, even in the system, which I think is the most progressive in terms of really trying to transform, and you will see some waivers with higher utilization. But it's hard to change how things have been done for 20, 30, 40 years, and that's really where we are, is waking people up to there's a better way, and people should have a choice of being able to be more independent in their lives. As a Medicaid

program, we should prioritize that.

The Medicaid statute should align with the ADA, right? Those two things should be congruent, and the way that we deliver Medicaid services should align with the goals of the ADA, which says that people should receive services in the most integrated setting appropriate, which means that they have rights to all of the full benefits of community living, employment, integration, independence, all of the things that we value, and yet the Medicaid program makes it extraordinarily hard for people to get the things that they need.

Try to get some of these things approved through CMS or alternative payment methodologies that would actually incentivize providers to help people become more independent. I'd rather go get a root canal. It's really hard. Those are the things we have to change.

Sorry. Off my soapbox.

CHAIR VERLON JOHNSON: You're okay. We like your soapbox.

All right. I think -- was it April? Did you have a comment? She covered you. Okay, okay. Gotcha.

Heidi and then Dennis again.

COMMISSIONER HEIDI ALLEN: Yeah. I just wanted to second what several other Commissioners had mentioned about thinking about home modifications and how important they can be in keeping people not only home, but well. It reminded of something that Patti told me when I was asking her about helping to keep my grandmother in her home, and she had listed a number of technologies that she thought could be helpful. One of the things she said is you want to avoid moving her at all costs, because once you do, people tend to deteriorate really quickly. And that turned out to be true. The minute that we had to move her into a new environment, her health and mental health declined precipitously, and she died not very long after.

I think that the idea that somebody who's going to come in and help modify your home has to be a Medicaid provider, that just seems so ludicrous.

If we can continue to look at that and particularly in a context right now where many people are locked in place in their home, especially in urban environments where it's really hard to find affordable rentals, where houses aren't for sale, where moving is just difficult, that we want to be able to serve people in their

homes as long as possible.

Thank you.

CHAIR VERLON JOHNSON: Dennis?

COMMISSIONER DENNIS HEAPHY: Thanks.

A few things I left out, and that's to pay for repairs of AT. It really is really important.

And training, there's so many folks who use AAC and other devices throughout school, and then they turn 22, they go to a day-hab, and no one at the day-hab knows how to use the equipment or set it up for the person. So, literally, thousands and thousands of dollars are used to facilitate someone's ability to communicate. Then they go to a setting, and no one there knows how to use the equipment, and so the person doesn't know how to communicate. So it's devastating.

Then with the Medicare pieces, is it possible for states to create MLTSS requirements for MCOs and for D-SNPs to streamline the process and make it easier for folks to access AT?

And, finally, it would be really helpful to have a quality measure that measures the number of folks who have identified a need for AT but haven't received it, like

maybe NCI-AD or something, or NCI itself.

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

Any others?

[No response.]

CHAIR VERLON JOHNSON: All right. So I think there is a little interest in this for you all to take back. I think we had some really good comments that should help. But if you have additional thoughts for us before you leave, I don't know if there's other questions you all have for us.

Good? Okay. Well, thank you so much. Again, very helpful.

I'll turn it over to Bob.

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chair.

We're going to pick up where we left off last fall as we look at the second phase of our work in Medicaid's role in providing mental and behavioral health services. The team has been working to do an environmental scan of intensive community-based behavioral health services, and what they have found, they're going to share

with us. Afterwards, we're supposed to provide feedback and consider what direction we want them to go next.

So, with that, welcome back Holly. Linn, good to see you today. So it's all yours.

INTENSIVE COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES: FINDINGS FROM FEDERAL AND STATE POLICY REVIEW

* HOLLY SALTRELLI: Great. Thanks, Bob, and good morning again, Commissioners.

Today Linn and I are going to present findings from our federal and state policy review on access to intensive community-based behavioral health services for Medicaid-covered children and youth.

First, I'll start with a background on children and youth's behavioral health needs and how this project fits into MACPAC's broader work on the topic. We'll then review the federal authorities available to states to provide intensive community-based behavioral health services, including Medicaid's mandatory and optional benefits, state plan amendments, or SPAs, and waivers, and non-Medicaid funding sources. And finally, Linn will take us through what we found from our state scan about how

states are actually using these authorities to deliver these services to children and youth.

Research indicates that rates of behavioral and mental health conditions are on the rise. Between 2009 and 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by over 40 percent.

As described in our June 2021 report to Congress chapter, Medicaid-covered children and youth with significant mental health conditions often experience challenges with accessing behavioral health services, including the intensive community-based services that can help them remain in the community, and they also report higher rates of residential treatment than those who are privately insured.

Some of the factors that can affect access to intensive community-based behavioral health services include Medicaid coverage policies, Medicaid authorities used to design behavioral health benefits, understaffing and workforce constraints, and coordination among the multiple agencies involved in covering these services.

In 2024, MACPAC initiated a multi-phase work plan

to continue its work examining access to behavioral health services for children and youth with behavioral and other co-occurring needs.

The first phase of this work examined appropriate access to residential treatment services for Medicaid-covered children and youth who require this level of treatment and resulted in a chapter in MACPAC's June 2025 report to Congress and a forthcoming chapter and recommendations in June 2026 report to Congress.

The second phase, which is the subject of today's session, focuses on intensive community-based behavioral health services. Through this work, we aim to examine existing federal policy levers and state approaches for supporting children and youth with complex behavioral health needs to remain in the community and to identify whether there are policy barriers to states covering these services or to children and youth accessing them that could be addressed through federal policy.

The third phase of work, which is under development, will focus on the quality and safety of residential treatment.

For Medicaid beneficiaries, federal laws are in

place to ensure access to appropriate behavioral health services in the least restrictive settings. These include the Americans with Disabilities Act of 1990 and the Supreme Court's ruling in Olmstead, which together require that services, including necessary mental health treatment, be provided in the most integrated setting appropriate.

Additionally, all children up to age 21 who are enrolled in Medicaid through the categorically needy pathway are entitled to services under the Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, requirement.

Under this requirement, states must provide access to any Medicaid coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan. For example, home- and community-based services might not be included in a Medicaid state plan, but a child is entitled to those services when medically necessary.

Research shows that access to services along the continuum of behavioral health care for children and youth affects their need for residential behavioral treatment. In particular, intensive community-based behavioral health

services can help children and adolescents with significant mental health conditions remain in their communities and avoid unnecessary residential treatment. It improves clinical and functional outcomes, prevents out-of-home placements, and reduces involvement with the child welfare and juvenile justice system.

In 2013, the Centers for Medicare & Medicaid Services, or CMS, and the Substance Abuse and Mental Health Services Administration, or SAMHSA, released joint guidance that describes key behavioral health-related home- and community-based services that have been shown to improve health outcomes for children and prevent out-of-home placement. Those services included intensive care coordination, family and youth peer support services, intensive in-home services, respite care, and mobile crisis response and stabilization.

Given the breadth of community-based behavioral health services, we conducted a literature review and background interviews with experts. Based on those findings and the 2013 guidance, we focused this work on five services.

So the five services are intensive care

coordination and targeted case management, high-fidelity wraparound, mobile crisis response, crisis stabilization, and respite care. I'll briefly go through the definitions of each service here, which draw from CMS and SAMHSA guidance and our literature review. Because federal Medicaid statute does not define these services, states maintain flexibility in defining them and may use different terms for the same type of service.

Intensive care coordination, or ICC, is a care management approach for youth with serious emotional or behavioral challenges that coordinates services across systems like mental health, education, child welfare, and juvenile justice to support the whole family. The primary goal of ICC is to support children and youth with remaining in the community. Targeted case management, or TCM, is similar and provides individualized support to help youth and their families access, coordinate, and manage behavioral health and related services.

High-fidelity wraparound is an evidence-based approach to ICC that is youth- and family-driven, a planning process that brings together professionals and family supports to create a highly individualized care plan

for youth with complex behavioral health needs.

Mobile crisis response involves rapid response services provided by a mobile team that travels to the beneficiary's location in the home, school, or community to de-escalate behavioral health crises and connect families to ongoing care.

Crisis stabilization provides immediate, short-term, intensive support for beneficiaries experiencing behavioral health crisis delivered in a structured setting to avoid hospitalization or institutionalization.

And, finally, respite care provides short-term, temporary relief to families and caregivers to reduce stress and prevent crises or out-of-home placements.

Next, I'll highlight the different federal authorities that states can use to cover and finance these services.

Although the Social Security Act broadly authorizes Medicaid behavioral health services for children and youth, federal Medicaid statute does not explicitly define benefits for the intensive community-based behavioral health services in our study. Instead, states make policy decisions regarding their program's behavioral

health benefits within the federal requirements to meet their state-specific needs.

All state Medicaid programs are required to cover certain behavioral health services, including medically necessary inpatient hospital services and physician services. Some of these mandatory benefits can be relevant to delivering the services of our study, such as home health services.

States may also elect to cover optional behavioral health services, which include targeted case management (TCM), rehabilitation services, rehabilitative therapies, clinical services, and peer supports. Statute does not explicitly mention any of the five services in our review by name, but states can cover intensive community-based behavioral health services under the optional benefit categories.

For example, case management is an optional benefit that states can use to authorize ICC, and they can also use optional rehabilitative services benefit to cover a wide range of crisis services.

States use different optional state plan and waiver authorities to cover the intensive community-based

behavioral health services included in our study, depending on their policy goals, population needs, and program structures. Each authority has different requirements for geography, such as whether the service must be offered statewide or not, diagnostic eligibility criteria, and whether enrollment caps can be used. States can also use the state plan and waiver authorities to deliver these services within non-restrictive settings.

States also have access to non-Medicaid federal funding to supplement Medicaid financing for these services. The American Rescue Plan Act of 2021, or ARPA, added Section 1947 to the Social Security Act, which provides an optional state plan authority for state Medicaid agencies to cover qualifying community-based mobile crisis intervention services for people outside of a hospital or other facility for a period of five years, ending in March 2027. ARPA also provided an enhanced 85 percent FMAP for qualifying mobile crisis services through March 2027.

The Certified Community Behavioral Health Clinic model, or CCBHC, includes 24/7 crisis services, TCM, and care coordination. That demonstration was codified as an

optional Medicaid state plan benefit in 2024.

Other federal funding streams, including SAMHSA mental health block grants and Title IV-E of the Social Security Act, can support a mental health system of care that may not fund Medicaid enrollees directly, but from which Medicaid enrollees benefit. Block grant funds are generally time-limited within the award year and, importantly, should only be used to cover services not already covered by Medicaid or other insurers.

And now I'll pass it to Linn to review findings from our state scan.

* LINN JENNINGS: Thanks, Holly.

So we conducted a state policy scan of a subset of 14 states that cover one or more of these five project services through one or more SPAs and waivers, and the purpose of this review was to understand how the subset of states cover these services using a variety of Medicaid authorities and to inform our state interview selection and our interview protocols, which will focus on understanding the state experiences in covering these services. And we'll present these interview findings next fall.

So, in the next few slides, I'll summarize

findings from how each state covers these intensive community-based BH services that we're focusing on in our work.

In our review, we identified several states that cover ICC and their TCM through SPAs and waivers. As Holly described, ICC and TCM are similar in many ways because they are both teams-based approaches to supporting children and youth with care planning and coordination of services across systems.

However, there are some key differences. As ICC is an approach to TCM, it is more intensive and specifically focuses on children and youth with complex BH needs who are often involved with multiple agencies, and as Holly said, one of the primary goals is to support children and remaining in their home and community.

Further, these services are often separate from case management services received from a managed care plan that are used to coordinate health care and service utilization under the plan.

So, in our review, we identified some states that provide ICC for children and youth with more complex BH needs who need a more fully integrated care team who can

provide a wide range of treatment and support services, and these services can include linking beneficiaries to crisis stabilization and other advocacy and specialized services.

For example, one of the reviewed states covers ICC through an 1115 demonstration, and those who are eligible for this demonstration must enroll in one of three types of managed care programs, which includes one that has a behavioral health and IDD-tailored plan that provides integrated care management and intensive outpatient services to address behavioral health needs in the community.

Some states also use SPAs to cover TCM for children and youth who need individualized care plans and additional access to medical, social, and educational services that are not otherwise covered. These services could be provided to children and youth with a wide range of health needs, and this can include those with complex BH needs.

Our findings indicate that of the reviewed states that cover wraparound services, most cover high-fidelity wraparound or other wraparound approaches through an 1115 demonstration or 1915(c) HCBS waiver. A couple of states

explicitly cover high-fidelity wraparound through a Section 1115 demonstration or concurrent 1915(b) and 1915(c) waivers. And high-fidelity wraparound requires specialized professional training for providers on how to conduct this approach to ICC. Both of these states cover these services explicitly for children and youth with specific BH diagnoses who are also at risk for hospitalization or being placed in residential treatment.

Additionally, some states cover wraparound facilitation for children and youth with moderate to high BH needs, and these states cover wraparound facilitation specify in their waivers that the facilitation is conducted by a certified wraparound provider who brings together the MCO, beneficiary, and family to develop an individualized person-centered service plan for the beneficiary.

Our findings indicate that states cover a variety of different mobile crisis services through SPAs and waivers as either a standalone service or as a broader approach to crisis state crisis intervention, and these services are designed to be short-term, immediate response services for individuals experiencing a health crisis that could lead to an individual needing to be hospitalized or

placed in residential treatment.

States have used different approaches to covering these services that target specific populations based on diagnosis, age, and regions of the state. One state covers 24-hour mobile response services through a 1915(c) HCBS waiver, and to be eligible for this waiver, the child or youth must be between ages 3 and 21, meet the state's hospital level of care, and have had a mental or behavioral health diagnosis in the past year.

Two of the reviewed states provide statewide mobile crisis services to a broader population of Medicaid-covered individuals under Section 1947(b) of the Social Security Act, which was added under authorized states to cover mobile crisis services.

Several of the reviewed states provide crisis stabilization as part of their crisis intervention services, and in general, states provide these services to divert acute and patient hospitalizations, stabilize individuals following discharge, and support with de-escalation in an effort to support youth with remaining in school and in their community.

There's variation in how states define crisis

stabilization, what these intervention services may entail, and in the populations that are eligible for these services. A few of the reviewed states use Section 1115 demonstrations and Section 1947 SPAs to provide crisis interventions to a wide range of children and youth under age 21.

For example, one state uses Section 1947 SPA to cover community-based crisis intervention services, including crisis stabilization to those who experience acute behavioral health challenges, and the goal of these services is to de-escalate and minimize the risk of acute crisis, incarceration, and hospitalization.

All of the reviewed states that cover respite care to families and guardians provide these services through either a 1915(c) HCBS waiver or 1915(i) SPA, and in these SPAs and waivers, states specify whether these services can be planned or unplanned and if they're provided for short-term relief in crisis situations or if they can be provided on a more regularly scheduled basis.

For example, one state covers short-term respite care through a 1915(c) HCBS waiver that enrolls children and youth with an SED diagnosis who meet a hospital level

of care, and the waiver covers temporary respite services for parents and caregivers so they can receive relief from their caregiving duties and meet their own needs.

Further, many states specify whether these services can be provided in the home or in the community, and some waivers cover crisis respite care specifically for families and caregivers who are unable to manage a crisis situation without that assistance.

The findings from our federal and state scan demonstrates that states have extensive flexibility in determining which intensive community-based behavioral health services to cover, how they define these services, and who can provide them and in defining eligibility criteria, and that there are many state approaches to covering these services for children and youth with behavioral health needs.

So, for example, some states cover a wide range of these intensive community-based BH services, including all five of our project-defined services through 1115 demonstrations, a combination of SPAs and waivers, or concurrent 1915(b) and (c) waivers, and others cover a more narrow scope of services through only one SPA or waiver.

Some states are also very prescriptive in how they define these services and who can provide them, and some states vary in how they define the populations who are eligible for these services, with some covering one or more services to a broad population, or others covering these services for a more targeted population.

This spring, we'll conduct stakeholder interviews and aim to understand how states have developed their programs to cover these five project-specific intensive community-based BH services, state experiences with and barriers to implementation, the beneficiary experience with accessing these services, and how states can address these barriers.

So, at this meeting, we'd appreciate feedback on the direction of this work, considerations, as well for our stakeholder interviews, and we've included two specific questions to guide your discussion today. What implications may arise from states having flexibility in determining which of these intensive community-based BH services to cover, and are there considerations around these flexibilities that you would flag for additional exploration?

With that, I'll turn it back.

VICE CHAIR ROBERT DUNCAN: Thank you, Linn. Thank you, Holly.

Again, wonderful work in doing this and our continued focus on mental and behavioral health.

Ironically, on Tuesday, I was working with the state of Connecticut, who has an extreme desire to provide better services so that children and adolescents aren't trapped in hospitals or settings that are not appropriate. So this chapter was very helpful in having that conversation.

But, as we think through these mechanisms, one of the big issues that we continue to face is the workforce to provide these services and then the adequate payment to encourage the workforce to provide these services. So I encourage you, when we create the stakeholder interviews, to ask the states, what could be helpful in attracting and getting more people to provide these intensive outpatient services? Because it's a huge need. But extremely wonderful work.

All right. I'll go to my Commissioners now. I've got John, Jami, and Heidi.

COMMISSIONER JOHN McCARTHY: I want to focus on the payment portion of MACPAC. So, in this one, I think it'd be hugely beneficial to us if you could do a table of all the 51 programs for these services and list out what are their payment rates for those services, especially TCM and some of the other ones. It is extremely hard to set rates for these services, and I think we'll see a huge variation around that.

Also, when you're interviewing states or an AMD, what are those barriers to setting the rates for the services? I know Bob focused on what you pay people, but literally setting the rates for these is really, really hard to do, what you include. Sometimes they're cost-based rates, which a sister agency is doing, like, what's in there.

I'm bringing this up again because we earlier talked about FWA. This is an area where audits had happened in the past, and states were -- when I say in the past, I mean pretty long ago, like the 2010s, you know, 2000s. But there were huge paybacks on TCM. So many states moved away from it, maybe looking at it.

I know then when managed care gets involved, it

makes it harder to get rates, but at least if there's a fee schedule that we can have some ideas on there -- and again, it's back to like, what can we do, make recommendations around this, to help states think through how to add some of these super beneficial services that have a huge ROI on them? That, you know, crisis stabilization and crisis response saves the state millions of dollars. But, again, how do you set that rate for a service, you know, crisis stabilization response? How do you fund just the Medicaid portion of it when commercial doesn't pay for it at all? Those are the issues, like, are states still feeling those?

Thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, John. You actually expressed what I was trying to say much better than I did. So thank you for that.

All right. We have Jami, Heidi, April, and then Patti.

COMMISSIONER JAMI SNYDER: Thanks for your continued work on this topic. I think it's so important.

When I heard from parents in both Arizona and Texas about this sort of service array that we're focusing on, mobile crisis and crisis stabilization capacity was

always top of mind. It was the biggest challenge that families faced, so thrilled to see this on the list among the services that you're covering.

Kind of tying into John's comment, I think it will be important for us to look at funding models when it comes to those two services, because often the services, of course, are extended beyond Medicaid-eligible enrollees. So what do those funding models look like? What do the reimbursement models look like?

Mobile crisis, you know, we always talked about this kind of firehouse model for reimbursement when it came to mobile crisis in Arizona, something to consider, and then staffing models. So just really some of the kind of logistics and operational components, I think are going to be really important.

But, again, just really happy to see that we are looking at mobile crisis and crisis stabilization, and in particular, models that are tailored to children and youth, because I think that's really important as well. So I'd love to hear about best practices from states that have youth-focused models.

VICE CHAIR ROBERT DUNCAN: Thanks, Jami.

Heidi, April, Patti, then Dennis.

COMMISSIONER HEIDI ALLEN: Thank you for this work.

I'm a parent of a kid who's had a lot of interaction with the mental health system, and so this is really top of mind for me often.

I'm struck -- you know, we're focusing on intensive services here. But, in my experience, the best way to not have to call mobile crisis unit is to be able to call the child's therapist, and I think while commercial insurance has had difficulty accessing these more intensive services, I think that Medicaid kids have had a harder time connecting with therapists who see Medicaid. So it's like that foundational relationship with somebody that you can tap into when a child is starting to escalate. I think if that part is missing, then you end up pushing more kids into this respite crisis care system. It goes quicker to hospitalization because you don't have that person that they've been working with for months or years, like I'm able to access with my commercial insurance.

I've always thought it's interesting that, you know, when you have commercial insurance, you're like, wow,

wouldn't it be great to have access to these more intensive services that Medicaid has? But when you have Medicaid, you can't get that prior stuff.

And then that leads me to my second question, which is the interaction with the schools. To me, this is so critical because school is actually a place where a lot of crisis happens for kids and where crises are created. There's like this like siloed systems of service delivery, and I would really be interested in like how they're intersecting.

So, you know, especially when it comes to like special ed, IEP services that kids are receiving for mental health, just elucidating a little bit how, you know, if a kid is in crisis, it's involving the school, the school is providing services. Is there anything -- is Medicaid coordinating at all is trying to think of like new school placements that might actually de-escalate the mental health crisis, or is that entirely being dealt with through an IEP and the Department of Education? So that would be helpful for me.

Those are my two thoughts. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you.

April, Patti, Dennis.

COMMISSIONER APRIL HARTMAN: Thank you for your work on this. I have a whole list of comments, but I will limit.

One thing -- a couple of things I really wanted to point out. When we are looking at kids with these kind of problems, the question becomes -- you know, a lot of it is funding related, right?

So, at least in my state, I know one of the things that happens is mental health is carved out, And it's a different funding stream from physical health. A lot of times these kids will receive crisis intervention, and then they're told to follow up with their primary care provider who has no idea of what's going on because that lack of communication. When you look at behavioral health issues, you have to kind of figure out who's providing the care, because if it's being done by psychiatrists and psychologists, there is going to be much more focus on crisis and crisis intervention.

But a lot of this, because of the lack of workforce, has fallen on primary care providers, and a lot of this care and treatment of depression, anxiety, a lot of

these things are being taken care of by primary care providers, so just want you to keep that in mind.

Then another thing I wanted to have you ask about is the availability of these services for kids in rural areas. This is a big issue. I know in Georgia, there's a lot of resources around the Atlanta area, and we always say, what about the rest of the state? So I think this is common for a lot of states that have large rural areas, is what is the access? And a lot of times, that has fallen to telehealth, which may be okay for like high school-age kids, but may not be great for elementary school age or younger, and so just kind of how are these services provided to kids in rural areas? What access do they have to mobile crisis?

Then another question I had is, who's on these mobile crisis units, and who can access them? Because I know we had an incident where we had a kid that was determined to run out into the street to be hit by a car, like she was determined. It was all we could do to contain her. We called a mobile crisis unit. This is while I was at a child advocacy center. We called the mobile crisis unit, and they said, don't you have a licensed clinical

counselor there at the child advocacy center? And we're, like, yeah, and they're like, well, you're more qualified than we are. You figure out what to do.

So it just kind of made us say, well, like who's on these mobile crisis units, and who can access them and for what purpose? I guess just a better definition of what they're supposed to be used for.

Then one last point is with the CCBHCs, these community-based centers. A lot of times there's maps that say, oh, these are all the places that we have these centers, but they don't all offer the same services, and they don't all serve kids. And if they do serve kids, sometimes it's 12 and up or, you know, like, they don't serve everybody fully. So just more specifically, what services are available, and is there a standard, or are they just pick and choose? When you say do you have these centers, yes, we have all these centers, but they're not always for kids.

And then we've also, you know, had complaints. We send kids to some of these centers, and there's adults that are off their meds and very threatening, and their families are afraid to go to them, even though they do

serve kids. It's just -- it's not accessible, because it's scary for them to go to these places.

So just wanted to mention those things. Thank you.

HOLLY SALTRELLI: I will mention -- a lot of great points there, but for the carve-out, we will be talking to states that do both, but if people do have other kind of aspects in the carve-out realm, we're still trying to kind of suss out the differences there.

VICE CHAIR ROBERT DUNCAN: Thank you, April. Thank you, Holly.

All right. Patti, Dennis, then Heidi.

COMMISSIONER PATTI KILLINGSWORTH: For almost 30 years that I've been in Medicaid, I feel like I've had the same conversations around children especially, but also adults, but especially kids with complex behavioral health needs that cross multiple systems and how to support them well. We've made some progress, but not nearly enough progress for the amount of time that's gone by, because we still have a lot of the same conversations.

I think what troubles me the most about your report, which was excellent, is that since 2013, we have

jointly recognized among two federal agencies, five evidence-based services that we know improve outcomes for these kids. And 13 years later, they're still not consistently available across states to children in the Medicaid program. That's an access issue.

That's a big access issue, because if we're covering them through this hodgepodge of -- state plan amendments is one thing. Waivers is another, because waivers limit target populations, and they can limit enrollment. And the services may not be available to everyone who needs them. So maybe we could put a stake in the ground and say it's time to really address -- to do our best to address this access issue and be sure that kids have consistent access to these services.

I'm particularly interested in the intersection of the availability and utilization of these services compared to things like inpatient psychiatric care or out-of-state residential treatment. Are we driving kids out of their homes? Placement in state custody, because we don't have the right services available to support them in their homes with their families. And so I think that would be another area of interest for me.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti.

Dennis, then Heidi.

COMMISSIONER DENNIS HEAPHY: Thank you.

As I was reading the information, I was thinking school-to-prison pipeline. I'm wondering how many of these folks end up in prison because they're not getting the appropriate services they need in school.

But in reading -- and Patti was just saying this -- are there best practices that we know that are really effective that states should be implementing countrywide? Not to stifle innovation, but are there some baseline best practices and services that we think all states should be offering to kids and their families? So for me, that's what I'd like to find out. How are you measuring quality of services and the outcomes? And where is the evidence base of the program? Is it really being effective? Like, how can we support more states implementing those best practices?

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Heidi.

COMMISSIONER HEIDI ALLEN: Sorry for speaking again, but I was just curious if any states have taken

advantage of the increased access that young people have to technology to implement any crisis lines for them to reach out to, like text and phone crisis services?

HOLLY SALTRELLI: 988 crisis service has come up a fair amount, but that's a great flag to --

COMMISSIONER HEIDI ALLEN: I'm not sure if 988 is really advertised to young people in the way that -- yeah. So just thinking of like --

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi.

Dennis, did you have another?

COMMISSIONER DENNIS HEAPHY: So it's really important to collect data on race, ethnicity, SOGI data, rural, rural versus urban, that really a better understanding who's getting the services, who's not getting the services, if that data is available, where that data is available, and to see where the disparities are.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Anyone else?

[No response.]

VICE CHAIR ROBERT DUNCAN: Holly, Linn, I think you've touched a nerve with the group in the continued work on the mental behavior health services. We look forward to

the interviews and what you come back to with us in the fall. But I do think as we look at Medicaid and making sure that we're getting people set up for success and thriving, both Patty and Dennis touched on a couple of things. One, the millions of dollars we're spending in services that are necessary because we don't have these outpatient services, as well as Dennis calling out the school to the prison pipeline and giving kids the adequate services needed. So this is critical, important work, and thank you for doing it, and we look forward to the follow-up.

With that, I'll turn it over to Madam Chair for a public comment.

CHAIR VERLON JOHNSON: All right. Thank you. That was a very great conversation.

So, as my Vice Chair said, we will now open the floor for our final public comments. We invite you in the audience to raise your hands if you would like to offer a comment. We do ask that you keep your -- introduce yourself and the organization represent and also keep your comments to three minutes or less.

And we have a former Commissioner, Brian Burwell,

as our first commenter. So, Brian, the floor is yours.

PUBLIC COMMENT

* BRIAN BURWELL: Can you hear me?

CHAIR VERLON JOHNSON: We can hear you.

BRIAN BURWELL: Great. I'm going to time myself as I tend to run over.

CHAIR VERLON JOHNSON: Don't worry. I'll let you know when you're over time.

BRIAN BURWELL: I'm sure you will, Verlon.

I want to give a shout-out to two Commissioners. I want to make comment on the assistive technology session that we had this morning, and the first Commissioner is John who is the only person in that session that used the term "AI." And I'll talk more about that later.

The second is Patti, who is very emphatic and passionate about the use of technology and HCBS, and I just want to build on that. In another venue which Patty and I work together on the future of HCBS, she was very articulate in saying we have an LTSS crisis, we don't have enough caregivers to provide personal care to all the Medicaid population that needs them. You just look at demographics. You're not going to solve it by increasing

the number of personal care workers, and we have to maximize the use of technologies to support people to live independently. I totally agree with that.

I recommend that we look to some other countries that have dealt with the same issue, particularly Japan. Japan is now at the point where we will be in -- I don't know -- 20 years or so in which the percent of the population that is aged compared to the percentage that is in a caregiving age cohort is far worse than ours, and the country in response has developed a national policy around using technology to support aged persons to live in their own homes independently for as long as possible.

There's been some -- I've read some articles about that, and I encourage the researchers, the staff to bring those articles or what's been done in other countries into this chapter.

Going back to AI, this is a personal interest of mine, the potential use of AI in HCBS, and I can tell you that there are hundreds of firms out there. As you know, everyone's trying to develop AI-driven products that will be successful in the marketplace, and there are many firms out there who have looked at the elderly population and

seeing that as a potential market for AI-driven products, including robotics. And I would highly recommend looking how that market is evolving, although it's very current and difficult to follow. It changes week to week. But there is a lot of potential there. I don't know how we would evaluate it since most states don't know about what's potentially available and therefore isn't covering them under waiver programs. But I think it's a topic that is worth some looking at and mention in the chapter.

I'm over.

CHAIR VERLON JOHNSON: You are over.

BRIAN BURWELL: I'm over by 29 seconds.

CHAIR VERLON JOHNSON: By 13 seconds, only 13 seconds, but we appreciate your comments, Brian. Thank you very much.

So next up for comments, we have Hugo. I think it's Dwyer.

HUGO DWYER: Hi. It's Hugo Dwyer. I'm Executive Director of VOR, Voice of Reason.

I'd like to thank you for the presentation. I'm also concerned, though, about those not mentioned in this program, the people who do fall between the cracks. This

program covered children and youth. We need coverage for people after they turn 21. These problems don't go away, as we all know.

Second, what happens to the people with aggressive behaviors? Their behaviors really exceed the ability to meet the needs in these community settings or living at home with mobile units available. There are people in psychiatric hospitals, psychiatric wards, and non-psych hospitals, ICFs which serve a different cohort of individuals and aren't really the appropriate solution for these people -- or in jails. We need to develop, I think, some kind of specialized facilities with properly trained doctors, psychiatrists, and DSPs and psych techs. That's somewhere between larger long-term care facilities and three-person group homes and at-home care. I'm just wondering if anything is being done on those fronts.

I'd also like to just thank John McCarthy, Heidi Allen, April Hartman, and so many of the others who have spoken, and this committee, so thank you.

CHAIR VERLON JOHNSON: Thank you so much. We appreciate it, Hugo.

Next up is Henry Claypool. Good to see you. The

floor is yours.

HENRY CLAYPOOL: Thank you.

Just wanted to touch on your work on assistive technology and thank the Commission, of course, for going down this path and reinforce a couple of points that were made by a commissioner on breaking the category out.

I would definitely think about home modifications as different than the type of assistive technology that people are using to communicate. Again, looking at environmental controls, they may be a separate category, but again, starting to think about assistive technology as something that may be a broader couple of categories and instead of just leaving it under this label of assistive technology. I'm not sure that it serves Medicaid and the people that rely on it that well.

And then also, I would kind of echo Brian's point around what have been referred to as emerging technologies, but AI, the data-driven nature of our society, and how those tools can be put to use in this space is something that should be examined.

There was also one other comment about accessing these benefits. I think there are just equity issues

across the program when certain eligibility pathways allow you to access a broad array of benefits and then another eligibility pathway has a more restrictive access to this, to very similar or different set of benefits. And it may serve us well to think more broadly about how to access those benefits and ways that people with resources or family with resources can contribute to the program as well as continue to receive the benefits that they've been entitled -- or that they're eligible for.

I don't know if you want to go down that path, but I think just looking at the HCBS authorities would be an interesting thing to examine.

Thank you.

CHAIR VERLON JOHNSON: Thank You, Henry.

Any other comments?

[No response.]

CHAIR VERLON JOHNSON: Okay. Seeing none. I do want to thank everyone who did make a comment today, and for those of you who may have comments later, please feel free to go to our website, the MACPAC website, and submit your comments there, for sure.

All right. So, before we adjourn, I just want to

thank everyone for having a very thoughtful and productive two days. We covered a wide range of topics, as you know, program integrity, managed care accountability, prior authorization, HCBS, all those things, all with the goal that I think that our fellow Commissioners stressed out is to really make the program work better and more effectively for the people who need it the most. So always appreciate the engagement from my fellow Commissioners, for sure, from the strong work of all the teams here on the staff, and then for the audience to really be engaged as well.

So, with that, we will adjourn, and we hope that everyone here has a great weekend. We'll will see you in May. Thank you.

* [Whereupon, at 12:10 p.m., the meeting was adjourned.]