



PUBLIC SESSION

VIRTUAL VIA ZOOM WEBINAR

Thursday, May 7, 2026  
3:00 p.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
<b>Session 1:</b> Automation in Medicaid Prior Authorization (PA)	
Katherine Rogers, Deputy Director.....	4
Patrick Jones, Analyst.....	8
<b>Session 2:</b> Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly (PACE)	
Brian O’Gara, Analyst.....	24
Michelle Conway, Senior Analyst.....	27
<b>Session 3:</b> Access to Appropriate Residential Treatment for Youth in Medicaid	
Sheila Shaheed, Analyst.....	37
Joanne Jee, Policy Director.....	n/a
<b>Session 4:</b> Implementing Community Engagement Requirements in Medicaid	
Melinda Becker Roach, Principal Analyst.....	56
Janice Llanos-Valezquez, Principal Data Analyst....	n/a
<b>Session 5:</b> Children and Youth with Special Care Needs (CYSHCN) Transitions to Adult Coverage	
Linn Jennings, Principal Analyst.....	65
Ava Williams, Analyst.....	n/a
<b>Public Comment.....</b>	<b>71</b>
<b>Session 6:</b> Vote on Recommendations for the June Report to Congress	
Katherine Massey, MPA, Executive Director.....	83
<b>Adjourn.....</b>	<b>129</b>

P R O C E E D I N G S

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

[3:00 p.m.]

CHAIR VERLON JOHNSON: Hi. Good afternoon, everyone. This marks our final MACPAC meeting of this cycle year, and I just want to begin by acknowledging the strong work of the Commissioners and the staff over the past cycle. I know that you all can agree with me that we have taken on some complex issues. We probably had some really thoughtful discussions, and today is just going to build upon that work, for sure.

Before we move forward through the agenda, I do want to extend congratulations to my fellow Commissioners who are reappointed for a three-year term effective May 2026 through April 2029, and that our Commissioner Hill, Commissioner Ingram, Commissioner Killingsworth, Commissioner McFadden, and Commissioner Snyder. We are so glad to continue benefitting from your expertise and your leadership.

With that, let's go ahead and kick it off with our very first session, Automation in Medicaid Prior Authorization.

We have had many conversations around this issue,

1 and we know that as technology continuously evolves across  
2 the health care system there are always questions around  
3 the use of automation, algorithms, artificial intelligence  
4 in coverage and everything else. So this discussion will  
5 focus on Medicaid programs and managed care plans are using  
6 these tools today, as well as implications for oversight,  
7 transparency, in access to care.

8           During this session we will review the draft  
9 chapter and recommendations, which the Commission will vote  
10 on later and consider. With that I am going to turn it  
11 over to Katherine and Patrick to get us started.

12 **###           AUTOMATION IN MEDICAID PRIOR AUTHORIZATION (PA)**

13 \*           KATHERINE ROGERS: Good afternoon and thank you,  
14 Verlon. This afternoon Patrick and I will present  
15 recommendations derived from our research on automation in  
16 the Medicaid prior authorization process as Verlon  
17 discussed. These recommendations will be subject to a vote  
18 at the end of today's Commission meeting.

19           Background will be very brief today, but I will  
20 recap a couple of key features of our work, review our  
21 findings, the challenges our work surfaced, and the policy  
22 principles we include in our draft report chapter. And

1 then Patrick will review our recommendation language and  
2 rationale.

3           We undertook this work as an outgrowth of some  
4 prior work on denials and appeals that culminated in a 2024  
5 report chapter. In this work, we sought to understand the  
6 extent to which Medicaid programs, either in managed care  
7 or fee-for-service, are using automation, including  
8 algorithms and artificial intelligence in the prior  
9 authorization, or PA, process. We zeroed in on the PA  
10 process, although we heard throughout our work about the  
11 ways in which Medicaid payers are applying automation  
12 throughout the program, including in other areas of  
13 utilization management. Our work involves a literature  
14 review, policy scans, and interviews with representatives  
15 from states, health plans, beneficiary advocates,  
16 providers, and technology vendors.

17           Current federal policy neither prescribes nor  
18 prohibits specific uses of automation in PA. There are no  
19 Medicaid requirements in either statute or regulation that  
20 specifically regulate, guide, or monitor the use of  
21 automation. We found in our research that some states have  
22 passed legislation regarding payers' use of automation in

1 care decisions, and states and managed care plans are  
2 already deploying AI in algorithms and Medicaid PA, and  
3 have found a variety of uses for these tools.

4           A subset of stakeholders reported using  
5 automation tools to issue PA decisions. These stakeholders  
6 reported that their automation tools only approve requests  
7 or refer them for further review. We found that states in  
8 the federal government have limited visibility into managed  
9 care plans' use of automation in Medicaid PA, and while  
10 states may leverage their existing oversight for managed  
11 care to identify uses of automation, not all states do so.

12           Automated PA processes present potential risks to  
13 Medicaid beneficiaries, providers, and payers, including  
14 potential incorrect determinations stemming from technical  
15 issues or data errors. Limited guidance on automation in  
16 PA may be impacting the adoption of automation. Some  
17 stakeholders acknowledge that they are reluctant to  
18 implement automation in the absence of federal regulations  
19 or guidance.

20           So all of this led us to zero in on a couple of  
21 key challenges.

22           First, there is limited transparency into how

1 automated PA systems work and their impact on costs and  
2 access to care. Stakeholders representing beneficiaries  
3 and providers stated that they have little visibility into  
4 how automation is being used, which can be clouded by the  
5 complex nature of AI and make it difficult for payers to  
6 assess unseen model bias, programming, or other coding  
7 issues.

8           And there is limited federal guidance regarding  
9 automation in PA, and state guidance varies. Automation  
10 has spread rapidly in recent years, but stakeholders  
11 expressed that the absence of guidance makes many states or  
12 plans reluctant to implement automation or worry that  
13 action they do take could be disruptive in the future.

14           Next, I will recap the principles we have  
15 presented in prior sessions.

16           Automation in Medicaid PA offers administrative  
17 efficiencies for payers and providers, which can improve  
18 timeliness of approvals, beneficiary experience, and access  
19 to care. So when contemplating the potential risks of  
20 automation use, we must also consider these benefits.

21           Transparency and disclosure are important tools  
22 in documenting and assessing the use of automation,

1 including the nature of emerging risks. With limited  
2 transparency, states and the federal government are less  
3 able to monitor for those potential risks posted by  
4 automation tools, including inaccurate coding, data bias,  
5 and more.

6           And lastly, due to the evolving nature of  
7 automation technologies and their increasing application,  
8 ongoing reevaluation of the oversight policy framework in  
9 Medicaid PA is warranted. Automation technology is  
10 improving in its functionality and expanding, which  
11 warrants ongoing data collection, evaluation, and  
12 assessment.

13           And with that I will turn it to Patrick to  
14 present our recommendations.

15 \*           PATRICK JONES: Thanks, Katherine. This next  
16 section of the presentation will present recommendations  
17 that address these findings and challenges.

18           Starting with Recommendation 1:

19           The Secretary of the U.S. Department of Health  
20 and Human Services should direct the Centers for Medicare &  
21 Medicaid Services to issue guidance to state Medicaid  
22 agencies and Medicaid managed care plans clarifying that

1 the language at 42 CFR 438.210(b)(3) requires an individual  
2 with appropriate expertise to review and authorize all  
3 decisions to deny service authorizations or to authorize a  
4 service in an amount, duration, or scope than is less than  
5 requested, including those proposed by automated systems.

6 This guidance should clarify further that (1)  
7 adverse determinations may not be made by automation tools  
8 alone; (2) adverse determinations must be made based on  
9 determinations of individual medical necessity; and (3) all  
10 existing regulatory requirements related to adverse  
11 determinations apply whether or not automation is used in  
12 the process of issuing an authorization decision.

13 This recommendation's guidance would clarify that  
14 a human reviewer with expertise must review all PA  
15 decisions, including those involving automated system.  
16 Human oversight safeguards against the potential risks of  
17 automation, such as bias in AI-based tools or programming  
18 errors in rules-based algorithms. There is consensus among  
19 stakeholders that this is a common and appropriate  
20 safeguard.

21 Furthermore, this recommendation creates  
22 consistency across states with varying laws regarding human

1 oversight of PA decisions.

2           Implications for Recommendation 1, CBO estimates  
3 that this recommendation will not have an impact on direct  
4 federal spending. This is true for all of the  
5 recommendations we present today, so I won't repeat that.

6           For states, states may benefit from clearer  
7 federal policy. States may also modify their oversight  
8 operations to ensure that managed care plans comply with  
9 this guidance.

10           This recommendation may provide enrollees with  
11 additional protection from incorrect adverse  
12 determinations. This recommendation may also impact some  
13 managed care plans that will need to implement new  
14 oversight procedures and policies.

15           Finally, providers may face fewer administrative  
16 burdens if this recommendation significantly reduces  
17 incorrect adverse determinations.

18           Moving on to Recommendation 2:

19           The Secretary of the U.S. Department of Health  
20 and Human Services should direct the Centers for Medicare &  
21 Medicaid Services to amend the regulations at 42 CFR  
22 440.230 to provide that, in fee-for-service Medicaid

1 programs, any decision to deny a service authorization  
2 request or to authorize a service in an amount, duration,  
3 or scope that is less than requested, be made by an  
4 individual who has appropriate expertise in addressing the  
5 enrollee's medical, behavioral health, or long-term  
6 services and supports needs.

7           This recommendation requires that an individual  
8 with appropriate expertise make all adverse determinations  
9 and that determinations must consider enrollees' specific  
10 needs. CMS could clarify that these requirements apply to  
11 automated PA systems.

12           Interviewees said that automation is limited in  
13 fee-for-service compared to managed care. We found no  
14 evidence that the standards for oversight should differ.

15           Implications for Recommendation 2, states may  
16 benefit from clear federal policy. States may also modify  
17 their existing PA operations to comply with this guidance.  
18 This recommendation may also provide enrollees with  
19 additional protection from incorrect adverse  
20 determinations, and may reduce administrative burdens for  
21 providers. This recommendation would not have an impact on  
22 managed care plans.

1                   And Recommendation 3:

2                   The Secretary of the U.S. Department of Health  
3 and Human Services should direct the Centers for Medicare &  
4 Medicaid Services to issue guidance to state Medicaid  
5 agencies and Medicaid managed care plans specifying ways in  
6 which existing regulatory oversight processes, including  
7 the external quality review process and mandated plan  
8 reporting required for Managed Care Program Annual Reports,  
9 can be used to create effective oversight of managed care  
10 plans' use of automation in utilization management (42 CFR  
11 438.66, 42 CFR 438.350 and 42 CFR 438.66(e)(1)).

12                   This guidance would describe how states can use  
13 existing oversight tools to oversee managed care plans' use  
14 of automation. It could also recommend states mandate  
15 reporting or other activities to gather information on  
16 automation.

17                   This recommendation addresses the finding that  
18 states have limited insight into managed care plans' use of  
19 automation in PA. Further, this recommendation complements  
20 and builds upon existing MACPAC recommendations for managed  
21 care oversight, including those voted on by the Commission  
22 in April.

1 States would be free to conduct these oversight  
2 activities in a manner that fits in their administrative  
3 capacity. States utilizing this guidance should benefit  
4 from the additional information these activities provide.

5 Some managed care plans may need to update their  
6 reporting and disclosure policies to comply with state-  
7 determined requirements, but this would vary by state.  
8 Providers and beneficiaries may experience some downstream  
9 impacts due to policy or procedure changes that result from  
10 increased oversight.

11 And finally, Recommendation 4:

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

1 burden.

2           In interviews, states reported little newly  
3 imposed oversight specific to automation in managed care,  
4 which limits their visibility into plans' use of  
5 automation. This recommendation increases transparency by  
6 using existing state mechanisms to conduct oversight of  
7 managed care plans' use of automation in PA.

8           States would be free to adopt this recommendation  
9 in a way that matches their current administrative  
10 capacity, and states should benefit from the additional  
11 information obtained through these activities. In states  
12 that adopt this recommendation, managed care plans may need  
13 to update reporting and disclosure policies to comply with  
14 state requirements.

15           And finally, beneficiaries and providers may  
16 experience some downstream impacts from this  
17 recommendation, due to policy or procedure changes that  
18 result from increased oversight.

19           This concludes our presentation of the  
20 recommendations for automation in Medicaid PA. These  
21 recommendations will be subject to a vote this afternoon.  
22 We ask that Commissioners share their feedback on the draft

1 chapter during their discussion.

2 Thank you, and I will pass it back to you,  
3 Verlon, to moderate the discussion.

4 CHAIR VERLON JOHNSON: All right. Thank you so  
5 much, Patrick. Thank you, Katherine. Very timely  
6 presentation and significant in all that you all said. So  
7 let me see now. I'll open it up to the Commissioners for  
8 any comments, questions, or feedback on the draft chapter  
9 or recommendations.

10 VICE CHAIR ROBERT DUNCAN: You have Patti and  
11 Adrienne.

12 CHAIR VERLON JOHNSON: Okay. Patti first, then  
13 Adrienne. Thank you, Bob.

14 COMMISSIONER PATTI KILLINGSWORTH: I just have a  
15 couple of requested minor clarifications in the  
16 recommendations, really intended to make sure that the  
17 recommendations are consistent with the scope of  
18 circumstances under which the recommendations would apply.  
19 And it is really for decisions that are based on medical  
20 necessity and not adverse determinations that might be  
21 based on other reasons, such as, for example, eligibility  
22 for a benefit, benefit limits, things like that.

1           In Recommendation 2, I would suggest that we add  
2 into the language, following the reference to the CFR, to  
3 provide that in fee-for-service Medicaid programs, any  
4 decisions to deny a service authorization request or to  
5 authorize a service in the amount, duration, or scope that  
6 is less than requested, based on medical necessity, be made  
7 by -- and then no other changes. So just clarifying that  
8 the recommendation really applies to medical necessity  
9 determinations.

10           In Recommendation 3, I would ask that we consider  
11 adding the same language in the exact same place. So  
12 decisions to authorize a service in an amount, duration, or  
13 scope that is less than requested, again, based on medical  
14 necessity.

15           And then in the sub-romanette 2/ii, adverse  
16 determinations based on medical necessity must be made  
17 based on an individual determination of medical necessity.

18           That's all for me. Thank you.

19           CHAIR VERLON JOHNSON: All right. Thank you,  
20 Patti.

21           KATHERINE ROGERS: I'm sorry, Patti. I'm just  
22 going to go back to the -- thank you, Verlon, for nudging

1 me on this. We can go back to the recommendation slide  
2 itself.

3 So for the fee-for-service Recommendation 2, so  
4 you mentioned right after the CFR --

5 COMMISSIONER PATTI KILLINGSWORTH: Right after  
6 the word "requested," if we can just add "based on medical  
7 necessity." Which would make clear that we are not asking  
8 them to require a person with medical or behavioral health  
9 expertise or long-term services and supports expertise to  
10 review a decision that isn't based on medical necessity,  
11 that's based on potentially some sort of administrative  
12 issue or error. Those are not the reasons that we would  
13 need that medical expertise.

14 KATHERINE ROGERS: Okay. And if I can go to  
15 number 3.

16 COMMISSIONER PATTI KILLINGSWORTH: And then in  
17 number 3, in the exact same place, requested based on  
18 medical necessity.

19 KATHERINE ROGERS: I think we might be going back  
20 to 1.

21 COMMISSIONER PATTI KILLINGSWORTH: Is it 1?  
22 Yeah, I'm sorry. You're right.

1 KATHERINE ROGERS: Okay.

2 COMMISSIONER PATTI KILLINGSWORTH: Wrong number.  
3 Same place. So right after the word "requested," which is  
4 the first change, and then a second change, which is in  
5 romanette 2/ii, where we say adverse determinations, again  
6 I would add "based on medical necessity" must be made. And  
7 then just a slight reordering of words, if you will, based  
8 on individualized determinations of medical necessity.

9 KATHERINE ROGERS: Okay. I got that. I wonder  
10 if one other option would be to place it earlier in this  
11 paragraph, since item 1 also refers to adverse  
12 determinations. So perhaps placing it before that, so the  
13 guidance should clarify further that for determinations of  
14 medical necessity, 1, 2, and 3.

15 COMMISSIONER PATTI KILLINGSWORTH: That would  
16 also work. I do think that the distinction in number 2  
17 still matters with regard to individualized determinations  
18 of medical necessity, that it has to be based on that  
19 individual's medical records.

20 KATHERINE ROGERS: So speaking to emphasizing it  
21 in item 2 specifically, or are you suggesting a different  
22 edit?

1           COMMISSIONER PATTI KILLINGSWORTH: No. It's in  
2 item 2. So even if we make the broader change to that last  
3 sentence and put it before 1, 2, and 3, so it applies  
4 across all, I still think there should be a reference to  
5 individualized determinations of medical necessity in 2.

6           KATHERINE ROGERS: So maybe flipping around some  
7 of the language in 2? So instead of based on  
8 determinations of individualized medical necessity, based  
9 on an individualized determination of medical necessity?

10           COMMISSIONER PATTI KILLINGSWORTH: Yeah, it  
11 probably doesn't matter a whole lot. I think the term that  
12 may be more familiar to people may be "individualized  
13 determinations of medical necessity." But I think either  
14 one works. We just need to make sure that we keep that  
15 part there.

16           KATHERINE ROGERS: Okay. I got it. Thank you  
17 for bearing with me on that.

18           COMMISSIONER PATTI KILLINGSWORTH: Of course.  
19 Thank you.

20           CHAIR VERLON JOHNSON: Thank you, Katherine.  
21 Thank you, Patti. Dennis, and then Adrienne.

22           COMMISSIONER DENNIS HEAPHY: Adrienne, you go

1 first.

2           COMMISSIONER ADRIENNE MCFADDEN: Thanks, Dennis.  
3 I think actually Patti's edits will cover most of my  
4 comments, but I would echo, one, I appreciate Patrick and  
5 Katherine, you all's ability to incorporate our feedback  
6 from the last session on this chapter, to really  
7 incorporate the medical necessity language here, which I  
8 think is important. I do think the intention for making  
9 sure that we have expertise involved in adverse  
10 determinations that are based on medical necessity is  
11 really the crux of what we are intending to convey in  
12 Recommendation 1. So I think Patti's suggested language  
13 will help to clarify that.

14           So my comments were really just to make sure that  
15 we maybe tweak the language a little bit for clarification  
16 around that point. Thank you.

17           CHAIR VERLON JOHNSON: Thank you, Adrienne. And  
18 then Dennis.

19           COMMISSIONER DENNIS HEAPHY: As a point of  
20 recommendations I just think it's important to recognize  
21 the complexity of medical necessity guidelines, and that  
22 there are folks who may not have the diagnosis required

1 under medical necessity guidelines but actually have the  
2 symptoms.

3           And that at some point we have a whole other  
4 conversation about the role of the plan itself, the care  
5 coordinators in the plans, in working with utilization  
6 management in explaining how a decision was made. So the  
7 first, first step in addressing an automated decision to be  
8 made, but then we have to take a deeper dive as we go along  
9 and look like what can we do beyond just the medical  
10 necessity guidelines in having a medical provider making  
11 that decision. Thanks. Especially since, as folks have  
12 pointed out, so few people appeal decisions. It's just so  
13 rare that people appeal. So I think we have an obligation  
14 to ensure that we will do what we can to write language  
15 that will support the least number of denials as possible,  
16 especially denials that are made based on administrative  
17 issues or other causes, other than medical necessity. But  
18 thanks for all the work.

19           CHAIR VERLON JOHNSON: Thank you, Dennis.  
20 Carolyn.

21           COMMISSIONER CAROLYN INGRAM: Thank you. I  
22 support the recommendations with the changes that Patti

1 recommended. I just wanted to add, to make sure that we  
2 make it clear in the chapter that we are not talking about  
3 people's eligibility or if benefits are not covered in a  
4 benefit package. We are talking specifically about those  
5 adverse determinations related to that section of the CFR.  
6 So that's all I've got. Thank you.

7 CHAIR VERLON JOHNSON: Thank you so much. Anyone  
8 else have a comment on the chapter, on the recommendations,  
9 anything you heard from your fellow Commissioners? Mike?  
10 Mike, you're on mute right now.

11 COMMISSIONER MICHAEL NARDONE: Sorry, I got it.  
12 Sorry. I just wanted to say, just in terms of the overall  
13 chapter, that I guess what I want to make sure, I guess,  
14 maybe in continuing work, that we are looking at kind of  
15 revisiting our principles which relate to kind of some of  
16 the benefits, potential benefits of AI, but also the need  
17 for a federal structure, Medicaid decision-making policy  
18 that allows to be flexible in addressing AI.

19 You know, I don't know that that latter point  
20 around the infrastructure was really reflected in the  
21 concluding section. So I just wanted to mention that.

22 Some of the things we're talking about here are

1 like regulations. They take time to develop, and in the  
2 meantime, AI is barreling full speed ahead. So I think  
3 some thought given to what structures or infrastructure we  
4 need to kind of stay on top of this is important and should  
5 be mentioned in the chapter.

6 CHAIR VERLON JOHNSON: Thank you, Mike. Any  
7 other Commissioners? Any other comments or thoughts?

8 [No response.]

9 CHAIR VERLON JOHNSON: Okay. Katherine, Patrick,  
10 anything else that you need or clarification from us?

11 KATHERINE ROGERS: I don't think so.

12 PATRICK JONES: No. The feedback was helpful.

13 CHAIR VERLON JOHNSON: Perfect. Thank you so  
14 much again for your work on this. We appreciate it. And  
15 Mike, your hand is still up, so I just wanted to make sure  
16 you didn't have any other comments. Okay. Thank you.

17 All right. We will move on to our next session.  
18 In this one, we're going to be talking about PACE and the  
19 role of the state Medicaid agency, just continuing the work  
20 that we have here, and in this particular session, as well  
21 as the previous one, we're going to review a draft chapter  
22 and recommendations, which the Commissioners can vote on a

1 little bit later today.

2 So, with that, I'll turn it over to Brian and I  
3 believe Michelle. Okay. There we go.

4 **### EXPLORING THE ROLE OF THE STATE MEDICAID AGENCY**  
5 **IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE**  
6 **ELDERLY (PACE)**

7 \* BRIAN O'GARA: Yes. Good afternoon,  
8 Commissioners.

9 So today, Michelle and I will be presenting a  
10 review of our draft chapter as well as related  
11 recommendations for exploring the role of the state  
12 Medicaid agency and the program of all-inclusive care for  
13 the elderly, or PACE.

14 As a refresher, the goal of this work is to  
15 assess states' authority and capacity to oversee PACE  
16 organizations, including legal responsibilities, oversight  
17 tools, operational resources and constraints, and how  
18 states measure and evaluate Medicaid service quality for  
19 PACE participants.

20 We'll begin the presentation with a summary of  
21 our findings included in the chapter, as well as a  
22 discussion on the three recommendations, and we'll end with

1 some next steps.

2           These findings are based on our review of key  
3 federal and state oversight documents, which we presented  
4 in detail in January, as well as stakeholder interviews  
5 with state Medicaid officials, CMS officials, and PACE  
6 experts, which we presented in March.

7           Our review of the interviews and key documents  
8 revealed several themes: first, that there's wide  
9 variation in how states conduct PACE oversight, including  
10 differences in roles, the use of program agreements and  
11 oversight tools; second, that data collection and reporting  
12 are limited and not standardized, making it hard to measure  
13 performance consistently; third, that many states face  
14 capacity constraints, especially as programs grow; and  
15 finally, that coordination between CMS and states is  
16 uneven, leading to some duplication and misalignment in  
17 oversight activities.

18           Based on these findings, along with stakeholder  
19 and commissioner feedback, we developed three policy  
20 recommendations to address two key challenges.

21           First, to reduce duplication and improve  
22 coordination audits, CMS should update audit protocols and

1 through program agreements to support joint federal, state  
2 audits.

3           Second, to increase transparency around PACE  
4 performance, CMS should publicly release existing  
5 performance data. Separately, CMS should also develop a  
6 standardized national quality measure set for PACE  
7 organizations.

8           Our first recommendation directs CMS to update  
9 its audit processes and program agreements to support joint  
10 federal and state audits of PACE programs. That planning  
11 together, sharing document requests, and reviewing  
12 materials should be conducted concurrently. While federal  
13 law requires CMS to work in collaboration with states,  
14 current guidance does not clearly define how audit  
15 coordination should occur. This recommendation formalizes  
16 that process.

17           Audits are central oversight tools for both CMS  
18 and states. As such, CMS and states are currently well-  
19 positioned to share more data using existing systems.  
20 Joint audits would reduce duplication and administrative  
21 burden by reviewing overlapping requirements at the same  
22 time while still allowing for independent findings when

1 needed.

2           The Congressional Budget Office does not estimate  
3 a direct effect on federal spending from this  
4 recommendation. Less duplication and greater coordination  
5 could reduce duplication and improve access to federal  
6 audit findings. For PACE organizations, it could reduce  
7 administrative burden and streamline corrective action  
8 processes, and overall, improved coordination could  
9 strengthen oversight and help ensure enrollees receive  
10 appropriate care.

11           And with that, I'll turn it to Michelle.

12 \*           MICHELLE CONWAY: Thanks, Brian.

13           Our next recommendation directs CMS to aggregate  
14 and publicly release in a user-friendly format on the CMS  
15 website existing PACE program performance data.

16           Next slide, please.

17           Making PACE data public would help beneficiaries  
18 compare options and make more informed decisions. It would  
19 also strengthen evaluation by allowing policymakers and  
20 researchers to assess outcomes and effectiveness. For CMS  
21 and states, it would make it easier to identify trends,  
22 benchmark performance, and address issues more proactively.

1           Next slide, please.

2           Again, CBO does not estimate a direct effect on  
3 federal spending. For states, they could benefit from  
4 better visibility into program performance and public  
5 reporting, but also support oversight by making it easier  
6 to track trends and compare programs. For PACE  
7 organizations, this creates an opportunity to demonstrate  
8 performance with limited additional burden since this does  
9 not create new reporting requirements, and for  
10 beneficiaries, greater transparency would help them better  
11 understand and compare PACE with other LTSS options.

12           Now we'll move to our final recommendation, 6.3.  
13 This recommendation directs CMS to develop a standardized  
14 national quality measure set for PACE organizations that is  
15 made publicly available in an accessible format.

16           The recommendation also directs CMS to follow  
17 three key principles in developing this measure set:  
18 engage stakeholders collaboratively, minimize reporting  
19 burden by focusing on the most meaningful measures, and  
20 prioritize standardized measures at an equal comparability  
21 across programs when feasible.

22           Many stakeholders expressed interest in the

1 development of a standardized national PACE quality measure  
2 set. Some states and the National PACE Association have  
3 done their own work on developing PACE quality measures,  
4 but the absence of a federally required standardized  
5 measure set limits CMS's and states' ability to assess  
6 program performance consistently, compare across  
7 organizations and states, and identify systemic quality  
8 issues.

9 CMS is well positioned to act as a convener and  
10 should include quality measurement and PACE experts in  
11 their work on implementing this recommendation. CMS has  
12 also undertaken work to create a standardized national HCBS  
13 quality measure set to hold valuable lessons for  
14 development of a PACE quality measure set.

15 Based on our findings, we identified the  
16 following principles for our national PACE quality measure  
17 set.

18 First, the process should be collaborative. CMS  
19 should develop the measure set with extensive input from  
20 states, PACE organizations, participants and their families  
21 or caregivers, quality experts, researchers, and other  
22 stakeholders.

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

6           And finally, the measure set should prioritize  
7 comparability when possible. Small population size may be  
8 a challenge, but CMS should prioritize including quality  
9 measures that are also used in other programs serving  
10 dually eligible individuals to allow for an apples-to-  
11 apples comparison where possible.

12           Again, CBO does not estimate a direct effect on  
13 federal spending. For states, this recommendation would  
14 reduce burden because states would no longer need to create  
15 their own PACE quality measures.

16           For PACE organizations, this would likely create  
17 some initial burden as they adjust to new reporting  
18 requirements, and for enrollees, with full implementation  
19 of this recommendation, they should see improvements in  
20 quality of care as PACE organizations are incentivized to  
21 improve outcomes. And depending on whether quality  
22 measures include some measures in common with other

1 programs, enrollees may be able to make comparisons across  
2 programs as well.

3           And finally, our next steps, we will publish our  
4 chapter in the June 2026 report to Congress and welcome  
5 Commissioner questions and feedback on both the content and  
6 tone of the chapter and on the recommendation language and  
7 implications.

8           I'll turn it back to the Commission. Thank you.

9           CHAIR VERLON JOHNSON: All right. Thank you so  
10 much, Brian and Michelle, for your work on PACE, really  
11 getting us to this point. We really, really do appreciate  
12 it.

13           I mean, as a high level, I think these  
14 recommendations are really intended to strengthen  
15 accountability and transparency in the program for PACE,  
16 but also really make us for this able to -- when we think  
17 about oversight and quality measurements, it kind of  
18 continues to expand. It really does what it's supposed to  
19 do.

20           So, with that, I'd be interested in hearing from  
21 Commissioners about whether you think there are additional  
22 language tweaks that you need or if you have other thoughts

1 on the recommendations or any other feedback that you might  
2 have.

3           So, with that, I'll turn it over to  
4 Commissioners.

5           All right. We have Mike Nardone. Mike?

6           Oh, you're on mute still.

7           COMMISSIONER MICHAEL NARDONE: Sorry about that.

8           CHAIR VERLON JOHNSON: That's okay.

9           COMMISSIONER MICHAEL NARDONE: So thanks, Brian  
10 and Michelle, for this work.

11           I appreciate the change that I think you made  
12 between the last version of the recommendations that we saw  
13 and this set of recommendations with respect to No. 3,  
14 because you added, I think, if I'm reviewing this  
15 correctly, the language around, you know, in developing the  
16 data sets, the quality measure sets, that you engage  
17 stakeholders collaboratively, including PACE organizations,  
18 given some of the things we've talked about, about the  
19 differences in models and how can we ensure that the  
20 information is comparable. So I appreciate that change.

21           I wondered if on Recommendation 6.2 whether or  
22 not we need to, perhaps in the body of the text, talk about

1 -- what I'm a little concerned about, the publishing of  
2 some of this data around HPMS. HPMS isn't so much -- like,  
3 we should have available data that allows us to compare  
4 PACE programs. But I want to make sure that the data that  
5 we're providing does help us to compare, to make some  
6 comparisons, is meaningful, can be easily interpreted,  
7 right?

8           Like, some of the data that's going into HPMS is  
9 around some data elements around, for instance, medical --  
10 I believe it was transportation accidents, right? So I  
11 just want to make sure that when we're looking at this,  
12 that there's some discussion of that in the text.

13           I tried to come up with, like, a really one-word  
14 pithy way of adding it to the recommendation, and I was  
15 coming -- I wasn't coming up with something that was really  
16 easily stated. But I think what we're looking for is  
17 something that is truly comparative and is relevant and  
18 meaningful, right? It's not just examining existing HPMS  
19 data that is available and presented.

20           Am I clear on that, Brian? I know that's a lot  
21 there, but I mean, I just --

22           BRIAN O'GARA: Yes. Yes, it's clear.

1           COMMISSIONER MICHAEL NARDONE: Do you see where  
2 I'm going with that?

3           BRIAN O'GARA: Yeah. We understand. We can take  
4 that back.

5           COMMISSIONER MICHAEL NARDONE: Okay.

6           The other thing, I know a lot of this is around -  
7 - and I think this is appropriate -- I think this is really  
8 good information on kind of the need to have more  
9 transparency around PACE and the quality and be able to  
10 ensure that we are kind of doing an apples-to-apples  
11 comparison.

12           In previous presentations, we've also had some  
13 presentations around some of the studies that have been  
14 done around the relevant benefit of PACE. And at least  
15 earlier on, I think as we're talking about some of the  
16 concerns that Commissioners raised, which are very  
17 legitimate and I think come through loud and clear, I think  
18 it's also important just to at least reference some of the  
19 past studies that have been done around the outcomes that  
20 have been achieved, understanding there are limitations to  
21 that study. And we've kind of talked about that, but I  
22 just want to make sure there's the right balance at the

1 beginning of the chapter as well.

2 CHAIR VERLON JOHNSON: Thank you, Mike.

3 Appreciate that.

4 Any other thoughts from other Commissioners?

5 Okay. Carolyn.

6 COMMISSIONER CAROLYN INGRAM: Can you just remind

7 us again how many individuals are in PACE nationwide?

8 BRIAN O'GARA: Yes. I believe it's about 89,000.

9 I mean, I can pull the figure up.

10 COMMISSIONER CAROLYN INGRAM: No, that's good. I

11 just wanted to get a -- compared to people in managed long-

12 term care programs, it's a small percentage. So I just

13 wanted to make sure I had the numbers right. Thank you.

14 CHAIR VERLON JOHNSON: Thank you, Carolyn.

15 Any additional Commissioners? Okay.

16 COMMISSIONER DENNIS HEAPHY: This is Dennis.

17 Sorry.

18 CHAIR VERLON JOHNSON: Oh, no problem. Go ahead,

19 Dennis.

20 COMMISSIONER DENNIS HEAPHY: Maybe I missed it,

21 but hopefully, this will lead to the best practices

22 nationally and how PACE programs work, so it's not just a

1 report card, but really moving toward a set of best  
2 practices, not just within each state, but across states.  
3 Every PACE program is different, and every state is  
4 different. So there are some best practices that we can  
5 garner regardless of the Medicaid services that a certain  
6 state may have and another state may not. So thanks.

7 CHAIR VERLON JOHNSON: Thank you, Dennis.

8 And I'm looking to see if there's any other  
9 Commissioners. Seeing not.

10 So, Brian and Michelle, again, thank you.  
11 Anything else you might need from us?

12 BRIAN O'GARA: No. I think that feedback was  
13 very helpful. Thank you.

14 CHAIR VERLON JOHNSON: All right. Thank you both  
15 again.

16 So, with that, I'm going to turn it over to our  
17 Vice Chair for the next session. So, Bob, you're up.

18 VICE CHAIR ROBERT DUNCAN: Thank you, Madam  
19 Chairwoman.

20 I'm excited to bring the team up. We're going to  
21 have Sheila and Joanne bring us up to speed on the  
22 finalizing the chapter for our access to appropriate

1 residential treatment services so they can get that wrapped  
2 up for the June report and then bring forth three  
3 recommendations for votes.

4 So, with that, Sheila, I'll turn it over to you.

5 **### ACCESS TO APPROPRIATE RESIDENTIAL TREATMENT**  
6 **SERVICES FOR YOUTH IN MEDICAID**

7 \* SHEILA SHAHEED: Thank you, Vice Chairman. So  
8 good afternoon, Commissioners.

9 Today we are returning --

10 VICE CHAIR ROBERT DUNCAN: Oh, we lost you,  
11 Sheila. There we go.

12 SHEILA SHAHEED: Sorry. I was on mute.

13 So thank you, Commissioners. So good afternoon.

14 And today, we're returning to review our draft  
15 chapter and recommendations on appropriate access to  
16 residential treatment for children in Medicaid for our June  
17 2026 report to Congress, and these policy recommendations  
18 have been refined based on Commission feedback that was  
19 given throughout our analytic cycle.

20 And so we're going to review our draft chapter,  
21 draft recommendations, and next steps.

22 And so our chapter provides an overview of key

1 federal laws that are in place, such as the Americans with  
2 Disabilities Act of 1990, or the ADA, or *Olmstead v. L.C.*,  
3 to ensure that children with Medicaid receive appropriate  
4 access to necessary behavioral health services in the least  
5 restrictive settings possible.

6           And the chapter also defines PRTFs, QRTPs, and  
7 explains each respective settings role in providing this  
8 intensive level of care for Medicaid beneficiaries.

9           And so our chapter also provides an overview of  
10 key federal rules, such as EPSDT, the IMD exclusion,  
11 accreditation and certification standards for PRTFs and  
12 QRTPs, and how all of these rules affect access to  
13 residential treatment for children and Medicaid.

14           And so our chapter describes the lack of easily  
15 attainable and specific information about the facilities  
16 that are serving Medicaid beneficiaries and explains that  
17 difficulty finding information makes it challenging for  
18 families and providers that are attempting to understand  
19 available treatment options.

20           Existing information sources provide some, but  
21 not the full complement of information that families and  
22 providers need to understand whether a particular facility

1 can meet a child's needs.

2           The chapter describes existing federal database  
3 efforts for collecting facility information, such as  
4 SAMHSA's FindTreatment.gov, and it also describes federal  
5 bed registry efforts, including the Centers for Disease  
6 Control and Prevention, or CDC's Hospital Bed Capacity  
7 Project.

8           The chapter also describes various state efforts  
9 to provide facility and bed information, including both bed  
10 registries and dashboards. And the chapter also provides  
11 considerations for developing and maintaining a real-time  
12 public bed registry.

13           And so our chapter also describes the limits of  
14 data available to understand the use and users of  
15 residential treatment services, including for non-PRTF  
16 facilities and out-of-state facilities. The chapter also  
17 describes some of the potential benefits of improved youth  
18 residential treatment services data collection and  
19 reporting, including states and policymakers being better  
20 able to understand the frequency and demographic  
21 characteristics of children that are usually referred for  
22 and receive treatment in a residential treatment facility.

1           And so our chapter also notes that there is no  
2 single data source on the use of out-of-state residential  
3 care, making it difficult to get a complete picture about  
4 the circumstances surrounding out-of-state placement,  
5 including length of stay and post-discharge outcomes.

6           Our chapter notes that securing appropriate  
7 residential treatment options can be challenging for  
8 children with more complex needs, which can lead to out-of-  
9 state placements.

10           And some state Medicaid officials that we spoke  
11 with during our interviews also reported that out-of-state  
12 placements can make it difficult for children to maintain  
13 connections with their families and transition back to  
14 their respective states of residence.

15           And so, as noted, out-of-state placements can  
16 make it difficult for children to maintain those  
17 connections, and discharge planning can help facilitate  
18 transitions from inpatient settings to other health care  
19 settings, including community-based providers. Our chapter  
20 includes examples from CMS, states, and pediatric  
21 organizations on the importance of discharge planning, and  
22 our chapter also notes that there are instances when a

1 beneficiary may be ready for discharge but is unable to  
2 find an appropriate community provider, leading to delayed  
3 discharge and the potential deterioration of the youth's  
4 condition.

5           And so now I'll go over our three draft policy  
6 recommendations.

7           Draft Recommendation 1: Recommend Congress to  
8 require HHS to develop and maintain a directory of youth  
9 residential treatment facilities.

10           To ensure that states, families, and providers  
11 have complete, accurate, and up-to-date information about  
12 residential treatment facilities and bed availability,  
13 Congress should require that the Secretary of the U.S.  
14 Department of Health and Human Services, or HHS, develop,  
15 maintain, and make publicly available a federally  
16 administered, up-to-date, real-time registry of youth  
17 residential treatment facilities serving Medicaid  
18 beneficiaries. The Secretary should work with HHS  
19 agencies, including CMS and SAMHSA, state Medicaid  
20 agencies, state behavioral health agencies, and other  
21 stakeholders to develop and maintain this registry. At a  
22 minimum, this registry should include information on the

1 behavioral health conditions facilities specialize in  
2 treating, ages served, regularly updated bed availability  
3 as soon as possible after a bed becomes available for in-  
4 and out-of-state Medicaid beneficiaries, and accessibility  
5 of facilities and services for individuals with  
6 disabilities. The Secretary should leverage information  
7 that is already being collected by federal agencies and  
8 states, while also integrating other information that is  
9 needed to determine whether the facility can meet  
10 beneficiary need.

11           And so the current process of finding a  
12 residential treatment -- residential placement for a child  
13 who requires it can take several hours to several days,  
14 which, in the case of children in crisis and in the ED, can  
15 lead to ED overstays.

16           Recommendation 1 is intended to address the  
17 challenges that states, providers, and families face in  
18 identifying a residential treatment option with the  
19 capability and capacity to serve youth with Medicaid by  
20 having HHS lead and coordinate efforts to develop and  
21 maintain a registry of facilities.

22           HHS would engage and seek input from appropriate

1 stakeholders on all aspects of development, including, for  
2 example, technical specifications of the registry,  
3 applicability of the registry, i.e., which facility should  
4 report, reporting parameters such as frequency of reporting  
5 or mode of reporting, and developing documentation and  
6 guidance reporting into and using information from the  
7 registry.

8           There currently is no federal requirement that  
9 relates to CMS or a state's role in facilitating access to  
10 this type of information for beneficiaries. Although some  
11 information is collected by federal agencies and some  
12 variable information is collected by states, not all  
13 information is easily accessible or attainable for all  
14 providers or for beneficiaries and caregivers, and this  
15 information does not provide all that is needed to secure a  
16 placement when necessary.

17           And so this recommendation is not estimated to  
18 affect federal spending -- federal direct spending, and  
19 states may experience greater -- well, states, enrollees,  
20 plans, and providers may all experience greater ease in  
21 identifying facilities that have available beds. States  
22 may be asked to take on some additional responsibilities,

1 such as educating providers and users of the registry and  
2 monitoring use of the registry, and facility -- providers  
3 and facilities may have to update the bed registry  
4 according to specifications.

5           Okay. Draft Recommendation 2. Recommend CMS to  
6 report on the use of residential treatment services,  
7 including non-PRTFs and out-of-state providers.

8           To ensure that reliable, consistently collected  
9 data are publicly available, the Secretary of the U.S.  
10 Department of Health and Human Services should direct the  
11 Centers for Medicare and Medicaid Services to regularly  
12 report on the use of residential treatment services by  
13 children and youth in Medicaid, including services provided  
14 by PRTFs, non-PRTFs, and out-of-state residential treatment  
15 providers. This report should provide available data on  
16 the characteristics of youth using the services, including  
17 demographics, disability and co-occurring conditions,  
18 urbanicity and rurality; types of services used; average  
19 length of stay; and discharge outcomes. The report should  
20 include data on the use of emergency departments for  
21 behavioral health needs, such as emergency department  
22 boarding by youth with Medicaid. If data are unavailable

1 to report on key measures, CMS should develop a plan for  
2 collecting and reporting on the data elements. CMS should  
3 engage states, providers, and other stakeholders in  
4 developing the data collection and reporting efforts.

5           And so Recommendation 2 is intended to increase  
6 data availability on the use and users of residential  
7 treatment services, particularly children, in this case,  
8 and out-of-state facility use. There is limited reporting  
9 available on the use of these services by children,  
10 particularly those out-of-state, and having this data could  
11 provide greater insight into what is and is not working and  
12 might provide some ability for states to identify ways to  
13 target needed interventions.

14           Similar to Option 1, there are no federal rules  
15 currently requiring this kind of reporting from CMS. Some  
16 residential treatment services' data are not currently  
17 readily available and may require CMS to develop a plan for  
18 working with states and other stakeholders to collect them.  
19 For example, certain facilities, such as QRTPs, do not have  
20 a specific place of service code for claims and may be  
21 difficult to identify and need administrative data.

22           Additionally, some measures that are not

1 regularly reported may require an assessment of data  
2 availability and the quality and feasibility of reporting.  
3 An example of that would be average length-of-stay data or  
4 outcomes associated with out-of-state discharges.

5           And so CBO estimates that this recommendation  
6 would increase federal direct spending by less than \$10  
7 million over the 2026-to-2036 period. States may have to  
8 take on additional data collection and reporting, and they  
9 may also experience some costs associated with system  
10 changes. However, they will have new information on the  
11 use of residential treatment services.

12           Providers may also incur some resource  
13 expenditures related to system changes or staff time, and  
14 we do not anticipate any direct effects on enrollees or  
15 plans.

16           Recommendation 3: Recommend CMS to revise  
17 federal rules to establish minimum requirements for  
18 discharge planning.

19           To ensure that youth discharged from out-of-state  
20 residential treatment facilities return to their home  
21 states and communities and receive needed services, the  
22 Secretary of HHS should direct CMS to amend 42 CFR 441.155

1 to establish minimum requirements for discharge planning  
2 processes that mandate that the process involves all  
3 relevant actors, including providers, plans, families, and  
4 caretakers; and identifies an appropriate community  
5 provider or alternative residential placement prior to  
6 discharge and that this alternate placement has  
7 availability to accept the beneficiary. CMS should also  
8 clarify what entities are responsible for initiating and  
9 overseeing the discharge planning for an out-of-state  
10 beneficiary and establish minimum requirements for  
11 coordinating and sharing information between the out-of-  
12 state provider and the post-discharge providers.

13           And so the objective of this last recommendation  
14 is to provide greater clarity around federal expectations  
15 for discharge planning to promote a smoother discharge from  
16 a facility, particularly those out of state, back to a  
17 child's community in their home state.

18           Federal PRTF rules under 42 CFR 441.155 currently  
19 identify discharge planning, including coordination with  
20 other services upon discharge if needed, as a required  
21 component of plans of care, but do not elaborate on the  
22 requirements for those discharge plans or planning

1 processes.

2 CMS has highlighted the importance of discharge  
3 planning and beneficiaries returning to their home  
4 communities upon discharge in the context of other CMS  
5 programs, including Medicare.

6 And Medicare rules for hospital discharge are  
7 more specific and include conditions of participation  
8 specifically related to discharge planning that require but  
9 are not limited to connecting beneficiaries with community-  
10 based services and reporting any discharge-planning  
11 conversations into beneficiaries' records.

12 While the Medicare hospital discharge rules are  
13 an example of more detailed discharge requirements, they do  
14 not explicitly address unique considerations for discharge  
15 from an out-of-state hospital.

16 And discharge planning policies do exist at the  
17 state level, or at least in certain states, but these  
18 policies are generally linked to state-licensed activities  
19 and not Medicaid requirements.

20 And so CBO estimates that this recommendation  
21 would increase federal direct spending by less than \$10  
22 million over the 2026 to 2036 period.

1           States would need to -- states may need to  
2 develop and disseminate guidance to plans and providers  
3 regarding discharge planning, and they may also need to  
4 engage in oversight and monitoring.

5           And enrollees and out-of-state placement and  
6 their families will have a clearer understanding of how  
7 discharge plans should be developed and may also experience  
8 improved transitions back to their communities.

9           Plans would need to establish guidance for  
10 network and non-network providers regarding discharge  
11 planning and coordinating the return to community of youth,  
12 and plans would also get information about the ongoing  
13 treatment needs of youth in out-of-state facilities.

14           And finally, providers may need to spend more  
15 time on discharge planning than they currently do, and  
16 post-discharge providers will have better information about  
17 the health care needs of youth coming into their care from  
18 any out-of-state facility.

19           So next steps. And so this draft -- these draft  
20 recommendations will be subject to a vote later today, and  
21 our chapter -- this chapter will be included in the June  
22 2026 report to Congress, and so any feedback on clarity and

1 tone on the chapter are welcome. And so thank you all for  
2 listening, and I'll pass it back to the Vice Chairman.

3 Thank you.

4 VICE CHAIR ROBERT DUNCAN: Thank you, Sheila.  
5 Appreciate the work. And, Joanne, you as well.

6 All right. Commissioners, they've taken our  
7 feedback over the last several meetings as they have  
8 drafted this chapter. I want to see if you have any  
9 recommendations or you feel that they have captured our  
10 intent and ready to move to a vote at the end of the day.

11 So, yes, Dennis.

12 COMMISSIONER DENNIS HEAPHY: Sorry about that.

13 VICE CHAIR ROBERT DUNCAN: No problem.

14 COMMISSIONER DENNIS HEAPHY: I really appreciate  
15 the chapter and the recommendations.

16 You have peppered through the entire document,  
17 ways that the states have to make sure the programs are  
18 accessible to different populations, IDD and different  
19 groups. But what I would love to see is something stronger  
20 at the top, like a sentence or two that says that, because  
21 of the population and intersection of disability, physical  
22 or other disabilities, that it's really incumbent on states

1 to ensure that the program they're sending someone to  
2 provides communication access for folks with deaf and hard  
3 of hearing or folks who are autistic or maybe communicate.

4 Also, in terms of just physical accessibility,  
5 the bar is very high, because you're sending these youth  
6 out there.

7 Also, just the cultural competency piece,  
8 ensuring that there's really race, ethnicity -- that,  
9 again, these are kids. We're sending them to another  
10 state. The bar is needed much higher. It's high anywhere,  
11 to be high anyway. But for youth, it's got to be  
12 tremendously high, because I can't imagine how traumatic it  
13 would be to be sent to another state, as I'm already  
14 experiencing a psychiatric issue. And so it's like, how do  
15 we just make a clear statement about these things?

16 So thanks.

17 VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

18 Any other comments or feedback from my fellow  
19 Commissioners? Mike.

20 COMMISSIONER MICHAEL NARDONE: I'm going to  
21 remember to put my -- I took my microphone off this time,  
22 so I remember that.

1           I just had a few brief comments. So, on the  
2 rationale for Recommendation 1 -- so this is in the text of  
3 the document -- I would just suggest that in addition to --  
4 you know, this is the section where you're asking for  
5 information on how to implement this registry. I would  
6 want to see something in there about recommendations around  
7 how to overcome some of the barriers that have been found  
8 in other initiatives of this type, such as recruiting of  
9 providers to participate. I think that's an important bit  
10 of information that we should be collecting, as well as one  
11 of the issues or one of the things I think is important in  
12 developing the registry is not just information on  
13 monitoring, monitoring of the registry, but also what are  
14 the resources that are required to maintain this on an  
15 ongoing basis? Because it seems to me that's one of the  
16 areas that I think was raised as an area of concern, and I  
17 just think we should note that in the text as we're talking  
18 about the rationale and what some of the information is  
19 that this should be looking to develop.

20           On the Recommendation 2, I like the -- I mean, I  
21 like where you're going with that in terms of the  
22 information that you're trying to collect. My concern was

1 there was a bit of disconnect for me because between the  
2 recommendation as well as when we move to the rationale,  
3 some of the information that you hope to be able to get  
4 from this reporting.

5           So the reporting was talking about -- some of the  
6 information I'm looking at. I'm going to the text here, so  
7 just bear with me for a minute. But the information, it  
8 sounded like we were looking for -- thank you -- was  
9 around, you know, who's in the various facilities, you  
10 know, the demographics of people in the facilities, average  
11 length of stay, discharge outcomes.

12           In the rationale below, you talk more about  
13 people who are denied coverage, people who are turned away,  
14 what are the gaps, denied admission.

15           I just want to make sure that there's -- it's  
16 obvious that you're looking at something that maybe -- is  
17 maybe broader, that's what's in this recommendation. And  
18 so I think you need to make some sort of transition to that  
19 in the rationale that follows, if that makes sense. And  
20 then one of the things -- so that's just kind of, you know,  
21 just some comments around the chapter.

22           The other thing, I just want to kind of put in a

1 plug for this, that as we're going to the next level of  
2 analysis, because this is such an important body of work --  
3 and there's a lot more to it that, you know, we're  
4 anticipating. We kind of got a preview of that last month  
5 around intensive home- and community-based services. I  
6 just want to make sure that one of the areas we're looking  
7 at -- and we can discuss this further as we go down the  
8 road -- as you do interviews is -- I'm not sure that the  
9 intensive community services capture everything that this  
10 population needs, certainly some of the more complex  
11 populations.

12           And I'm concerned that people who have co-  
13 occurring conditions of IDD, mental health issues, that  
14 some of the things that we're referring to in the intensive  
15 community-based services aren't necessarily encompassed in  
16 that list of the five services that we talked about last  
17 time. And so I think there needs to be a little further  
18 conversation about that, because I think that what we're  
19 trying to do, we want to try to prevent out-of-state  
20 placements, right? And we want to have community-based  
21 alternatives, and we want to understand what are some of  
22 the models for -- at least I would love to understand what

1 are some of the models for providing some of those home-  
2 and community-based services in the community, and what  
3 some of the barriers are to kind of implementing that so we  
4 don't have as many people placed out-of-state.

5 And I just wanted to put that plug in, kind of  
6 pin in that. I'm sure we'll come back to that as we're  
7 moving forward with this work, and I'm happy to talk to you  
8 about that more. So thanks.

9 VICE CHAIR ROBERT DUNCAN: Thank you, Mike.

10 Any other Commissioners?

11 [No response.]

12 VICE CHAIR ROBERT DUNCAN: Seeing none, Madam  
13 Chairwoman, I'll turn it back over to you to discuss --

14 COMMISSIONER DENNIS HEAPHY: I just noticed --

15 VICE CHAIR ROBERT DUNCAN: Oh, go ahead, Dennis.

16 COMMISSIONER DENNIS HEAPHY: I'm sorry.

17 VICE CHAIR ROBERT DUNCAN: Go ahead, Dennis.

18 COMMISSIONER DENNIS HEAPHY: The last two  
19 sentences, it would seem should develop a plan for  
20 collecting publicly reporting so we should engage states  
21 and providers, it seems like some of the language should be  
22 cleaned up. I'm just noticing it now, but it's not a big

1 deal. I'm just rereading it now. Thanks.

2 VICE CHAIR ROBERT DUNCAN: Thank you.

3 Anyone else?

4 [No response.]

5 VICE CHAIR ROBERT DUNCAN: If not, then, Madam  
6 Chairwoman, I'll turn it back over to you on community  
7 engagement.

8 CHAIR VERLON JOHNSON: All right. Thank you so  
9 much, Bob, and thank you, Sheila and Joanne. We appreciate  
10 it.

11 As Bob said, we're going to talk about community  
12 engagement requirements. This session will provide  
13 additional information on the implications of the  
14 recommendations, including some updated information from  
15 the CBO, ahead of our vote today. So with that, let me  
16 turn it over to Melinda and Janice.

17 **### IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS IN**  
18 **MEDICAID**

19 \* MELINDA BECKER ROACH: Good afternoon,  
20 Commissioners. In April, Janice and I presented a draft  
21 chapter on implementing community engagement, or CE,  
22 requirements in Medicaid. The draft chapter includes

1 principles for implementing CE requirements and a  
2 recommendation for monitoring and evaluation. We have  
3 since revised the draft chapter, based on your feedback,  
4 including incorporating an estimate of how the  
5 recommendation would affect federal direct spending.

6 Today I will present the revised recommendation,  
7 rationale, and implications in preparation for your vote  
8 later today.

9 The draft recommendation now reads:

10 The Secretary of the U.S. Department of Health  
11 and Human Services should direct the Centers for Medicare &  
12 Medicaid Services to develop a transparent plan for  
13 monitoring and evaluating community engagement requirements  
14 in Medicaid. The monitoring plan should provide insight  
15 into how such policies affect eligibility and enrollment.  
16 CMS should identify new metrics for state reporting and  
17 build upon existing data collection to minimize  
18 administrative burden. The evaluation plan should outline  
19 CMS's approach to evaluating the effect of CE requirements  
20 on employment, health, and state and federal administrative  
21 spending. CMS should ensure timely publication of  
22 monitoring and evaluation results to inform policy and

1 operational decision-making.

2           Specific changes to the rationale are noted in  
3 your meeting materials. However, the key points remain  
4 largely unchanged. MACPAC's research clearly highlighted  
5 the importance of monitoring changes in eligibility and  
6 enrollment following CE implementation. CMS has indicated  
7 that they are working on a monitoring plan, though it is  
8 unclear if those plans or resulting state reporting will be  
9 made public.

10           With input from stakeholders, CMS should develop  
11 and make public a monitoring plan that includes new,  
12 meaningful metrics for tracking changes in eligibility and  
13 enrollment associated with CE. In developing this plan,  
14 CMS should consider building on existing reporting  
15 mechanisms to collect new data while minimizing state  
16 reporting burdens. CMS should further ensure that state  
17 reporting is made available to the public on a monthly  
18 basis.

19           Our research also underscores the need for  
20 federal evaluation to understand how CE requirements affect  
21 employment, health, and administrative spending. CMS has  
22 experience leading federal evaluations and should draw upon

1 that experience, as well as stakeholder input, when  
2 developing an evaluation plan for CE.

3 In addition to carrying out and making public the  
4 results of the full-scale, multiyear evaluation, CMS should  
5 prioritize rapid cycle evaluation reports that provide  
6 timely, actionable insights to support continuous  
7 improvement. These reports could, for example, document  
8 key features of state approaches, including their processes  
9 for determining medical frailty, provide insight into the  
10 experience of individual subject to CE requirements, and  
11 examine the downstream effects on providers and managed  
12 care organizations.

13 The implications have been updated to include the  
14 Congressional Budget Office's estimate that the  
15 recommendation would increase federal direct spending by  
16 less than \$10 million over 10 years. That reflects  
17 estimated federal direct spending above the \$8.3 trillion  
18 baseline estimate of federal Medicaid spending over the  
19 same period.

20 The projected increase in federal direct spending  
21 would result from the federal match for administrative  
22 costs associated with required monitoring activities,

1 specifically, states collecting data in standardized format  
2 and reporting new metrics.

3           Commissioners will have an opportunity to vote on  
4 the recommendation toward the end of today's meeting. If  
5 approved, the recommendation will be included in the  
6 Commission's June Report to Congress.

7           Thank you, and I will turn it back to the chair.

8           CHAIR VERLON JOHNSON: Thank you so much. We  
9 appreciate it. Okay. Let me open it up for any comments  
10 or questions from our Commissioners. All right, Carolyn.

11           COMMISSIONER CAROLYN INGRAM: Thank you. The  
12 only question I had, and I know this is in the chapter and  
13 I appreciate your comments about looking at the effects of  
14 the CE requirements on providers, specifically rural  
15 providers, hospitals, and managed care companies as the  
16 risk pool changes with these changes.

17           I'm wondering if in the recommendation we could  
18 add the language, at the very -- if you go to the  
19 recommendation, the second-to-last sentence, that the  
20 evaluation plan should outline CMS's approach to evaluating  
21 the effect of CD requirements on employment, health, and  
22 state and federal, you have administrative spending. Maybe

1 administrative and program spending, so that we account for  
2 what happens with the issues that are going to be requiring  
3 probably increase in rates due to the differentiation and  
4 risk pools and some of the losses that are going to happen  
5 to some of the rural providers. So I'm wondering if that  
6 would take care of it.

7 MELINDA BECKER ROACH: We can absolutely take  
8 that back to consider incorporating. I think it would be  
9 helpful to get additional feedback, as well, since I know  
10 we have a limited period before the Commission is slated to  
11 vote.

12 CHAIR VERLON JOHNSON: All right. Thank you.  
13 Let's see, Mike, do you have some additional feedback?

14 COMMISSIONER MICHAEL NARDONE: Yeah. I would  
15 support that. I guess the one thing I noticed when we made  
16 the change and moved the recommendation from what we looked  
17 at last month is we split out the monitoring from the  
18 evaluation, which was a very good change that I think a lot  
19 of the Commissioners commented on. I think we also had  
20 kind of, in addition to program and administrative  
21 spending, I think we also had a little more flexibility on  
22 maybe other issues that maybe should be included in the

1 evaluation. And I think the language we had was, among  
2 other outcomes of interest.

3 I guess what I was just wondering is, I think  
4 there are other things we might want to look at in the  
5 evaluation plan, not just these three things. So I'm  
6 wondering if we want to kind of maybe include that  
7 outlining CMS's approach, these are things to include in  
8 the outline but not necessarily the only things. So it's a  
9 little different point from Caroline's, which I would  
10 support, as well, but I think there might be other things  
11 we want to build into the evaluation plan.

12 CHAIR VERLON JOHNSON: Any thoughts, Melinda or  
13 Janice?

14 MELINDA BECKER ROACH: I think we can pull up the  
15 language, the other recommendation that we presented last  
16 month, to your point, Mike, and see how we can maybe  
17 incorporate that into the existing recommendation language  
18 and potentially expand upon the list of things that would  
19 be looked at through the evaluation.

20 EXECUTIVE DIRECTOR KATE MASSEY: Mike, do you  
21 have specific word edits that you're recommending?

22 COMMISSIONER MICHAEL NARDONE: Yeah. Well, we

1 had the language. We could say should include CMS's  
2 approach to evaluating, so it's not just the only thing.  
3 Or it could be the language we picked up from last time,  
4 which was among other outcomes of interest. That's what  
5 was in the recommendation last time.

6 EXECUTIVE DIRECTOR KATE MASSEY: Right, and I  
7 think we took that out because it wasn't very specific.  
8 What you're talking about is that this is a baseline that  
9 we're publishing in the recommendation language. We could  
10 incorporate, at a minimum.

11 COMMISSIONER MICHAEL NARDONE: Yes. That would  
12 do it.

13 CHAIR VERLON JOHNSON: Okay. So like --

14 COMMISSIONER MICHAEL NARDONE: At a minimum, the  
15 evaluation --

16 CHAIR VERLON JOHNSON: Okay. At a minimum it  
17 should include these three things.

18 COMMISSIONER MICHAEL NARDONE: Yep.

19 CHAIR VERLON JOHNSON: Okay. Thank you, Mike.

20 COMMISSIONER DENNIS HEAPHY: That includes  
21 Caroline's recommendation, as well.

22 CHAIR VERLON JOHNSON: Yes. Any other thoughts

1 at all about the language of the recommendation as written?

2 [No response.]

3 CHAIR VERLON JOHNSON: Okay. I don't see any  
4 more hands, so thank you again for the work you've done on  
5 this, and if you have any other questions for us before you  
6 step away, to make those edits?

7 MELINDA BECKER ROACH: I'd like to just confirm  
8 if that's okay, that we have the requested changes. So I  
9 noted that the evaluation plans should include, at a  
10 minimum, CMS's approach to evaluating the effect of CE  
11 requirements on employment, health. And then I wanted to  
12 clarify if we are also modifying the state and federal  
13 piece to include administrative and program spending. I  
14 just wanted to confirm if that's right.

15 COMMISSIONER MICHAEL NARDONE: Yes.

16 MELINDA BECKER ROACH: Okay. Thank you very  
17 much.

18 CHAIR VERLON JOHNSON: Thank you. Well, thank  
19 you both again. We appreciate it.

20 So with that I'm going to turn it over to the  
21 Vice Chair for the next session.

22 VICE CHAIR ROBERT DUNCAN: Thank you, Madam

1 Chair. We're going to bring it home with our last session  
2 before we go to public comment and vote, on Children and  
3 Youth with Special Health Care Needs and Transitions to  
4 Adulthood. We've got Linn and Ava joining us again to  
5 bring us up with some of the information supplied since our  
6 last conversation.

7 With that, I'll turn it over to you.

8 **### CHILDREN AND YOUTH WITH SPECIAL CARE NEEDS**  
9 **(CYSHCN) TRANSITIONS TO ADULT COVERAGE**

10 \* LINN JENNINGS: Thank you. All right. Well,  
11 good afternoon, Commissioners. Today I'll provide an  
12 update on our recommendations and implications for a  
13 chapter on children and youth with special health care  
14 needs and their transitions to adult Medicaid coverage.

15 First, I will provide a brief summary of our six  
16 recommendations, and then I will review the three  
17 recommendations that have updated federal spending  
18 estimates from CBO, and then finish with next steps.

19 As a reminder, in April we presented our draft  
20 chapter and six recommendations, rationale, and  
21 implications. For the draft chapter we have incorporated  
22 your feedback from the April meeting, and we have included

1 specifics about those updates in your materials.

2           For Recommendations 1, 2, and 6, we received  
3 federal spending estimates from CBO in advance of the April  
4 meeting, and presented those in April. So for those three  
5 recommendations, CBO estimated no direct effect on federal  
6 spending.

7           We have now also received estimates from CBO on  
8 Recommendations 3, 4, and 5, and for Recommendation 5,  
9 which does have an estimated direct effect on federal  
10 spending, I just want to note that what we received from  
11 CBO is just a range, and they do not share underlying  
12 assumptions for the estimated range.

13           In the next few slides I'll review the three  
14 recommendations and the federal implications. I also want  
15 to note that we have included on the slides the  
16 implications for states, beneficiaries, providers and  
17 plans. But since they haven't changed since the April  
18 presentation, I won't review those again today.

19           So we'll go through the three recommendations.

20           Recommendation 3 reads:

21           To ensure the accuracy of information provided by  
22 the Social Security Administration (SSA) to Medicaid

1 beneficiaries enrolled in Supplemental Security Income  
2 (SSI)-related eligibility pathways who are being notified  
3 that they are losing eligibility for SSI, the Secretary of  
4 the U.S. Department of Health and Human Services, through  
5 the Centers for Medicare & Medicaid Services, should  
6 coordinate with SSA to review and update model notice  
7 language pertaining to Medicaid in SSA's Program Operations  
8 Manual System manual paragraphs. The model language should  
9 clearly indicate that the individual may retain their  
10 Medicaid coverage while the state Medicaid agency takes  
11 steps to redetermine the individual on a new basis of  
12 eligibility. Additionally, the model language should  
13 describe, in general terms, the steps the individual needs  
14 to follow to complete the Medicaid redetermination that are  
15 specific to 1634, SSI criteria, and 209(b) states.

16 For this recommendation, CBO does not estimate a  
17 direct effect on federal spending. However, CMS would have  
18 to commit time and resources to review and update the SSA  
19 notice language and ensure ongoing coordination with SSA.

20 Moving on to Recommendation 4, which reads:

21 State Medicaid agencies should implement optional  
22 Medicaid eligibility for children and youth with special

1 health care needs (CYSHCN) up to age 21 who are not  
2 otherwise eligible for and enrolled in mandatory coverage  
3 or optional full Medicaid coverage under the state plan (42  
4 CFR 435.222 and 42 CFR 435.223). CYSHCN include, but are  
5 not limited to, children who are enrolled in Medicaid  
6 through Supplemental Security Income (SSI)-related  
7 eligibility pathways who are not eligible for SSI as adults  
8 and are transitioning to non-SSI related pathways when they  
9 reach age 19, the Katie Beckett pathway for children with  
10 disabilities, those eligible for Medicaid under the Tax  
11 Equity and Fiscal Responsibility Act, and children who  
12 qualify to receive an institutional level of care.

13 For this recommendation, CBO does not estimate a  
14 direct effect on federal spending. CMS would have to  
15 commit time and resources to reviewing state plan  
16 amendments.

17 Recommendation 5 reads:

18 To ensure children and youth with special health  
19 care needs (CYSHCN) receive a full 12-month continuous  
20 eligibility period in their final year of child Medicaid  
21 eligibility, Congress should amend § 1902(e)(12) of the  
22 Social Security Act to require states to provide CYSHCN

1 with a 12-month continuous eligibility period that lasts a  
2 full 12 months from the date of the eligibility  
3 determination, even if during the continuous eligibility  
4 period, an individual reaches the upper age limit for the  
5 eligibility pathway by which they are eligible for  
6 Medicaid. This 12-month continuous eligibility period  
7 should apply to all CYSHCN who receive coverage from a  
8 mandatory or optional child eligibility pathway, including  
9 optional pathways covering youth above age 18. CYSHCN  
10 include, but are not limited to, children who are enrolled  
11 in Medicaid through Supplemental Security Income (SSI)-  
12 related eligibility pathways who are not eligible for SSI  
13 as adults and are transitioning to non-SSI related pathways  
14 when they reach age 19, the Katie Beckett pathway for  
15 children with disabilities, those eligible for Medicaid  
16 under the Tax Equity and Fiscal Responsibility Act, and  
17 children who qualify to receive an institutional level of  
18 care.

19 For this recommendation, CBO estimates that it  
20 would increase federal direct spending between \$250 million  
21 and \$2 billion over the budget period. For context, this  
22 is additional spending above the baseline estimate of

1 federal Medicaid spending during the same period, which is  
2 about \$8.3 trillion.

3 For next steps, we welcome Commissioner Feedback  
4 on these recommendation implications updates, and will  
5 return later this afternoon for a vote on all six  
6 recommendations, and the chapter will be published in the  
7 June Report to Congress.

8 VICE CHAIR ROBERT DUNCAN: Thank you, Linn. All  
9 right, Commissioners, we have got the six recommendations,  
10 the language that we have given feedback on. Any comments  
11 or any additions?

12 [No response.]

13 VICE CHAIR ROBERT DUNCAN: Seeing none. Linn,  
14 Ava, thank you for the great work getting us to this point.  
15 And I will turn it back over to the Chair to take us into  
16 Public Comments.

17 CHAIR VERLON JOHNSON: All right. Thank you so  
18 much. As the Vice Chair mentioned, that was our last  
19 session, so we will now go to the floor for public  
20 comments. We do invite all of you in the audience to raise  
21 your hand if you would like to offer a comment. Please  
22 make sure you introduce yourself and the organization you

1 represent, and we do ask that you keep your comments to  
2 three minutes, or less.

3 All right. It looks like we have three speakers  
4 thus far. Let's go to Katie Pahner.

5 **### PUBLIC COMMENT**

6 \* KATIE PAHNER: Madam Chair, good evening. My  
7 name is Katie Pahner, and I represent the National PACE  
8 Association, the trade association for more than 200 PACE  
9 organizations serving older adults with complex care needs  
10 across the country.

11 PACE operates as a unique, three-way partnership  
12 among PACE organizations, states, and the federal  
13 government. NPA deeply values MACPAC's consideration of  
14 how policy options affect all three partners in delivering  
15 high-quality, community-based care.

16 NPA supports the three draft policy  
17 recommendations presented today, and calls upon  
18 Commissioners to approve all three recommendations.  
19 Regarding Recommendation 6.1, which calls for joint  
20 facilitation of audits of PACE organizations with state  
21 administering agencies, NPA has heard from both states and  
22 PACE organizations about the importance of a collaborative

1 approach to PACE oversight. As we have noted in prior  
2 meetings, variation in state administration increases  
3 administrative burden, and programs are eager to understand  
4 national variation to better align state and federal  
5 requirements. NPA supports MACPAC's efforts to enhance  
6 coordinated oversight between CMS and states, including  
7 exploring mechanisms that build on prior joint audit  
8 models, to reduce duplication and improve consistency  
9 across jurisdictions.

10           With respect to the second recommendation, to  
11 make existing PACE program performance data available,  
12 leveraging existing CMS PACE data is a practical and  
13 efficient path to greater transparency. However, as  
14 Commissioner Nardone aptly pointed out in his remarks  
15 today, it is very critical that only data that are  
16 appropriate, reliable, and contextually meaningful be made  
17 public to ensure accurate interpretation. When  
18 thoughtfully applied, PACE data can support a meaningful  
19 assessment of the PACE model's effectiveness and inform the  
20 development of a national PACE quality measurement  
21 framework.

22           And finally, looking ahead, regarding the third

1 draft recommendation, NPA strongly supports developing a  
2 standardized national quality measurement set for PACE.  
3 While PACE already operates under robust federal oversight,  
4 including CMS audits, there is a clear opportunity to have  
5 PACE-specific performance measures that are meaningful,  
6 actionable, person-centered, and calibrated to this  
7 population's complexity without adding unnecessary  
8 administrative burden.

9           Again, we appreciate MACPAC's recommendations.  
10 These are the right steps, and we are committed to  
11 supporting their implementation. We look forward to the  
12 Commission's forthcoming Report to Congress, and welcome  
13 the opportunity to continue this dialogue. Thank you.

14           EXECUTIVE DIRECTOR KATE MASSEY: Verlon, you are  
15 on mute.

16           CHAIR VERLON JOHNSON: Oh, thank you for that.  
17 With that, thank you, Katie, for your remarks, and we have  
18 Arvind Goyal from Illinois, to hear your remarks.

19           ARVIND GOYAL: Thank you very much, Madam Chair  
20 and Commissioners. Thank you for the opportunity. This is  
21 Arvind Goyal. I am Medical Director for Illinois Medicaid  
22 program and also volunteer faculty at a medical school,

1 teaching medical students.

2 I wanted to appreciate the discussion that I've  
3 heard over your previous meetings and today's meeting about  
4 prior authorization in Medicaid, and today, of course, was  
5 mostly on automation.

6 But I did want to make this comment maybe for  
7 your consideration in the future or today if you feel  
8 appropriate. Physicians and other medical providers who  
9 request prior authorization for services needed by their  
10 patients, their Medicaid patients, usually have no other  
11 options in case of an adverse determination by AI or  
12 otherwise, except to withhold those services they  
13 previously recommended. They can appeal, but what if the  
14 appeal is denied also? And the providers in some such  
15 cases may be found liable, in case of unacceptable outcomes  
16 resulting from those denials or withheld services.

17 I wish the Commission would, at some point in  
18 time, consider a recommendation that those denials come  
19 with some responsibility on the part of the payer and some  
20 participation of the payer in that liability for adverse  
21 outcomes.

22 Thank you for listening to me. I hope it does

1 reach the litmus of your discussion at some point. But  
2 thank you very kindly for the opportunity.

3 CHAIR VERLON JOHNSON: Thank you for your  
4 comments. We appreciate it.

5 Next up we have Hugo Dwyer.

6 HUGO DWYER: Dwyer. Thank you. Hugo Dwyer, VOR,  
7 Voice of Reason. We are a national nonprofit organization  
8 that advocates for high-quality care for individuals with  
9 intellectual disabilities and autism.

10 I like the recommendations. I would like to  
11 address the third recommendation, appropriate access to  
12 residential services, especially Recommendation 1 that  
13 talks about making data available.

14 I am just a little confused as to what level of  
15 data is available, how timely it is, and who it is  
16 available to, if it is available to the general public so  
17 they can see where there are beds available, or if it's  
18 just available to state DD directors so that they can  
19 allocate sources as they need to.

20 Also, the level of timing. If a bed opens up in,  
21 say, central Ohio, how long does it take before that bed  
22 becomes available on the data? Does it happen immediately?

1 Does it happen monthly? Or quarterly? The faster it  
2 becomes available, obviously, the more flexible the system  
3 is and the easier it is to use that data to address the  
4 needs of the next person on the list.

5 Also, what level of reporting is there? Just  
6 knowing that there is a bed available is not as good as  
7 knowing there is a bed available in a facility that has  
8 staff that are capable of doing feeding tubes or some sort  
9 of medical procedure. And I think that level of reporting  
10 would be good.

11 So those are just things to think about when you  
12 make your recommendation. You might want to determine how  
13 specific and how timely the reporting should be. Thank you  
14 very much, and these are great recommendations. Thank you.

15 CHAIR VERLON JOHNSON: Thank you, and thank you  
16 so much for your comments. We appreciate it.

17 Next up we have Peggy McManus.

18 PEGGY McMANUS: Yes. Thank you very much. Can  
19 you hear me? Great. I'm Peggy McManus with the National  
20 Alliance to Advance Adolescent Health, and I also co-direct  
21 Got Transition. I have no comments on the wonderful  
22 transition recommendations, but two comments on the prior

1 authorization and the residential treatment, from my  
2 experience in the child health community.

3 I was wondering if it is possible to make clearer  
4 that federal policy recommendations for prior authorization  
5 should be in general, and then specific to EPSDT. There  
6 are different requirements for EPSDT, and we are seeing  
7 repeated problems with that. So if the Commission could  
8 call out, for all the four recommendations, EPSDT  
9 specificity, that would be terrific.

10 On the residential treatment, I wonder if there  
11 is anything around the use of, for those under 21, the  
12 coverage authorities like, for example, targeted case  
13 management, that could be used to align or link these young  
14 people to special ed services for those 18 and older, for  
15 those needing developmental disability services, and other  
16 support services, so that we are linking them up with adult  
17 public program services.

18 Those are my comments. Thank you.

19 CHAIR VERLON JOHNSON: Thank you so much. We  
20 appreciate your comments.

21 Next up we have Priscilla Easterling.

22 PRISCILLA EASTERLING: Good afternoon and thank

1 you for the opportunity to speak today. My name is  
2 Priscilla Easterling, and I serve as the Director of  
3 Outreach and Enrollment at Kentucky Voices for Health, a  
4 state-wide health policy organization working with  
5 consumers, assisters, advocates, and community partners  
6 across Kentucky on health coverage and Medicaid access. I  
7 also bring direct enrollment experience. I worked in  
8 Virginia for three years as a health insurance navigator,  
9 helping families enroll through healthcare.gov, and since  
10 2020, I have been a certified connector in Kentucky's  
11 state-based marketplace. I have helped people navigate  
12 eligibility, renewal notices, documentation requests,  
13 system errors, and administrative barriers.

14           The recommendations MACPAC is development will  
15 matter at the point of implementation. They will affect  
16 not only whether people are eligible for Medicaid but  
17 whether they can successfully stay enrolled. From what we  
18 see on the ground, many coverage losses are procedural.  
19 People lose coverage because a notice was confusing,  
20 paperwork did not arrive, a portal did not work, a document  
21 did not upload, a call center was hard to reach, or system  
22 information did not update correctly. That is why we urge

1 MACPAC to recommend clear, enforceable guardrails,  
2 especially at states that are at the early implementation  
3 of community engagement requirements.

4           First, states should not only attempt ex parte  
5 renewals, but they should be expected to maximize them,  
6 track effectiveness, and use available data before shifting  
7 the burden back to beneficiaries. We saw during unwinding  
8 that automatic renewal performance varied widely across  
9 states, which means implementation choices matter. MACPAC  
10 should encourage guidance that moves states towards the  
11 strongest performing models rather than treating ex parte  
12 as a checkbox.

13           Second, notices must be clear, plain language,  
14 accessible, and actionable. People need to understand what  
15 is being asked, why it matters, what deadline applies,  
16 where to get help. That also means real access to  
17 assisters, call centers, and community partners before  
18 coverage is at risk.

19           Third, protections like good cause exemptions,  
20 medical frailty determinations, reasonable accommodations  
21 and self-attestation must be clearly defined and  
22 operationally realistic. These protections only work if

1 people know they exist and can actually use them.

2           And one point is especially important. People  
3 need to know what kind of Medicaid they qualify for.  
4 States should be required to clearly communicate a person's  
5 eligibility type, whether Medicaid expansion, traditional  
6 Medicaid, a waiver, or another pathway, at enrollment,  
7 redetermination, and any time a change in circumstances  
8 changes their eligibility. This is foundational.  
9 Eligibility type affects what rules apply, what notices  
10 mean, what requirements one may face, and what happens if  
11 their circumstances change. It also matters for mixed  
12 households, where family members may be subjected to  
13 different Medicaid rules, timelines, or reporting  
14 requirements.

15           And finally, accountability has to be built in  
16 from the beginning. They should publicly report on  
17 procedural terminations, coverage losses, call center  
18 access, appeals, reinstatements, and outcomes,  
19 disaggregated where possible by geography and demographics.  
20 Medicaid policy is only as strong as its implementation.  
21 Eligible people should not lose coverage because the  
22 process is confusing, inaccessible, or administratively

1 fragile.

2 Thank you for your time and your work on these  
3 issues.

4 CHAIR VERLON JOHNSON: Thank you so much,  
5 Priscilla, for your comments. I will see if there are any  
6 other individuals who would like to make a comment.

7 [No response.]

8 CHAIR VERLON JOHNSON: Okay, hearing none, I just  
9 want to remind you that if you do have additional comments  
10 that were not able to tell us today you can definitely go  
11 to our website, MACPAC.gov, and submit your comments there.

12 **### VOTE ON RECOMMENDATIONS FOR THE JUNE REPORT TO**  
13 **CONGRESS**

14 CHAIR VERLON JOHNSON: With that we will now move  
15 into our voting session on the recommendations for our June  
16 report. Today's votes will cover automation, Medicaid  
17 prior auth, PACE, children's residential services,  
18 community engagements, and transitions for children and  
19 youth with special health care needs.

20 But before we proceed, I want to note that  
21 MACPAC's conflict of interest rule does apply. As required  
22 by statute, Commissioners represent a wide range of

1 backgrounds and bring diverse perspectives as well as  
2 reportable interests to their service. Our conflict of  
3 interest policy is designed to ensure that any financial or  
4 other interest that could rise to the level of potential  
5 conflict are disclosed and appropriately reviewed in  
6 connection with the vote.

7           Commissioners are required to report relevant  
8 interests at the time of candidacy and annually thereafter,  
9 and those disclosures, which are publicly available, form  
10 the basis for determining whether a potential conflict  
11 exists for a specific vote.

12           In advance of a voting meeting, the Conflict of  
13 Interest Committee, which I appoint as Chair, and which  
14 reflects a mix of Commissioners, review the reportable  
15 interests on file, and any other relevant information.

16           So before we proceed, I just want to briefly  
17 remind you, or let you know, that on April 22, 2026, the  
18 MACPAC Conflict of Interest Committee met by conference  
19 call and reviewed the Commissioners' reportable interests  
20 under that standard. The committee determined that no  
21 Commissioner has a potential or actual conflict of interest  
22 related to the recommendations under consideration today.

1           The members of the Conflict of Interest Committee  
2 consists of Bob Duncan, who is the Vice Chair of the  
3 Commission and the Chair of the committee, Sonja Bjork,  
4 Doug Brown, Jennifer Gerstorff, Angelo Giardino, Tim Hill,  
5 and Andrienne McFadden.

6           I will now turn it over to our Executive  
7 Director, Kate Massey and her team, to walk us through the  
8 recommendations and facilitate the vote. Kate?

9 \*           EXECUTIVE DIRECTOR KATE MASSEY: Great. So can  
10 we tee up the first recommendation? And one of the things  
11 that I will say as we are getting this ready is that we  
12 have had several language changes, and the analysts will  
13 talk you through the specific word edits that will also be  
14 highlighted in red.

15           Okay. Turn it over to Patrick and Katherine.  
16 We'll vote by recommendation.

17           PATRICK JONES: Thanks, Kate. Based on earlier  
18 Commissioner feedback we have modified the texts of  
19 Recommendations 1 and 2, to ensure the intent of the  
20 recommendation is clear in its specificity to  
21 determinations related to medical necessity. We inserted  
22 the language in red earlier in the text than we discussed

1 previously, to ensure it was broadly clear and did not  
2 imply additional modification of the regulatory text at 42  
3 CFR 438.210.

4           And with that I will get into our first  
5 recommendation.

6           Recommendation 2.1:

7           The Secretary of the U.S. Department of Health  
8 and Human Services should direct the Centers for Medicare &  
9 Medicaid Services to issue guidance to state Medicaid  
10 agencies and Medicaid managed care plans clarifying that,  
11 for determinations of medical necessity, the language at 42  
12 CFR 438.210(b)(3) requires an individual with appropriate  
13 expertise to review and authorize all decisions to deny  
14 service authorizations or to authorize a service in an  
15 amount, duration or scope than is less than requested,  
16 including those proposed by automated systems.  
17 This guidance should clarify further that (1) adverse  
18 determinations may not be made by automation tools alone;  
19 (2) adverse determinations must be made based on  
20 individualized determinations of individual medical  
21 necessity; and (3) all existing regulatory requirements  
22 related to adverse determinations apply whether or not

1 automation is used in the process of issuing an  
2 authorization decision.

3 EXECUTIVE DIRECTOR KATE MASSEY: Okay, great. So  
4 we'll vote on this recommendation.

5 Heidi Allen?

6 COMMISSIONER HEIDI ALLEN: Yes.

7 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

8 COMMISSIONER SONJA BJORK: Yes.

9 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

10 COMMISSIONER DOUG BROWN: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

12 VICE CHAIR ROBERT DUNCAN: Yes.

13 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer

14 Gerstorff?

15 COMMISSIONER JENNIFER GERSTORFF: Yes.

16 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

17 COMMISSIONER ANGELO GIARDINO: Yes.

18 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

19 COMMISSIONER APRIL HARTMAN: Yes.

20 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

21 COMMISSIONER DENNIS HEAPHY: Yes.

22 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?

1 COMMISSIONER TIMOTHY HILL: Yes.

2 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?

3 COMMISSIONER CAROLYN INGRAM: Yes.

4 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?

5 COMMISSIONER ANNE KARL: Yes.

6 EXECUTIVE DIRECTOR KATE MASSEY: Patti

7 Killingsworth?

8 COMMISSIONER PATTI KILLINGSWORTH: Yes.

9 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

10 COMMISSIONER JOHN MCCARTHY: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne

12 McFadden?

13 COMMISSIONER ADRIENNE MCFADDEN: Yes.

14 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

15 COMMISSIONER MICHAEL NARDONE: Yes.

16 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

17 COMMISSIONER JAMI SNYDER: Yes.

18 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

19 CHAIR VERLON JOHNSON: Yes.

20 EXECUTIVE DIRECTOR KATE MASSEY: Great, 17 in

21 favor.

22 Patrick, we can go to the next recommendation.

1 Also, I think your camera might be off.

2 PATRICK JONES: Yeah, I'm seeing that now. Would  
3 you like me to take a second to fix that?

4 EXECUTIVE DIRECTOR KATE MASSEY: Sure.

5 PATRICK JONES: Okay, great. Give me one moment.

6 [Pause.]

7 PATRICK JONES: Okay. Sorry about that.

8 Moving on to Recommendation 2.2, which reads:

9 The Secretary of the U.S. Department of Health  
10 and Human Services should direct the Centers for Medicare &  
11 Medicaid Services to amend the regulations at 42 CFR  
12 440.230 to provide that, for determinations of medical  
13 necessity and fee-for-service Medicaid programs, any  
14 decision to deny a service authorization request or to  
15 authorize a service in an amount, duration, or scope that  
16 is less than requested, be made by an individual who has  
17 appropriate expertise in addressing the enrollee's medical,  
18 behavioral health, or long-term services and supports  
19 needs.

20 EXECUTIVE DIRECTOR KATE MASSEY: Fantastic.  
21 Heidi Allen?

22 COMMISSIONER HEIDI ALLEN: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?  
2 COMMISSIONER SONJA BJORK: Yes.  
3 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?  
4 COMMISSIONER DOUG BROWN: Yes.  
5 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?  
6 VICE CHAIR ROBERT DUNCAN: Yes.  
7 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
8 Gerstorff?  
9 COMMISSIONER JENNIFER GERSTORFF: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
11 COMMISSIONER ANGELO GIARDINO: Yes.  
12 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
13 COMMISSIONER APRIL HARTMAN: Yes.  
14 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
15 COMMISSIONER DENNIS HEAPHY: Yes.  
16 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
17 COMMISSIONER TIMOTHY HILL: Yes.  
18 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
19 COMMISSIONER CAROLYN INGRAM: Yes.  
20 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
21 COMMISSIONER ANNE KARL: Yes.  
22 EXECUTIVE DIRECTOR KATE MASSEY: Patti

1 Killingsworth?

2 COMMISSIONER PATTI KILLINGSWORTH: Yes.

3 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

4 COMMISSIONER JOHN MCCARTHY: Yes.

5 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne

6 McFadden?

7 COMMISSIONER ADRIENNE MCFADDEN: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

9 COMMISSIONER MICHAEL NARDONE: Yes.

10 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

11 COMMISSIONER JAMI SNYDER: Yes.

12 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

13 CHAIR VERLON JOHNSON: Yes.

14 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 17 in

15 favor.

16 PATRICK JONES: Great. Moving on to

17 Recommendation 2.3:

18 The Secretary of the U.S. Department of Health

19 and Human Services should direct the Centers for Medicare &

20 Medicaid Services to issue guidance to state Medicaid

21 agencies and Medicaid managed care plans specifying ways in

22 which existing regulatory oversight processes, including

1 the external quality review process and mandated plan  
2 reporting required for Managed Care Program Annual Reports,  
3 can be used to create effective oversight of managed care  
4 plans' use of automation in utilization management.

5 EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Patrick.  
6 Heidi Allen?

7 COMMISSIONER HEIDI ALLEN: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

9 COMMISSIONER SONJA BJORK: Yes.

10 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

11 COMMISSIONER DOUG BROWN: Yes.

12 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

13 VICE CHAIR ROBERT DUNCAN: Yes.

14 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer

15 Gerstorff?

16 COMMISSIONER JENNIFER GERSTORFF: Yes.

17 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

18 COMMISSIONER ANGELO GIARDINO: Yes.

19 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

20 COMMISSIONER APRIL HARTMAN: Yes.

21 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

22 COMMISSIONER DENNIS HEAPHY: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
2 COMMISSIONER TIMOTHY HILL: Yes.  
3 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
4 COMMISSIONER CAROLYN INGRAM: Yes.  
5 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
6 COMMISSIONER ANNE KARL: Yes.  
7 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
8 Killingsworth?  
9 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?  
11 COMMISSIONER JOHN MCCARTHY: Yes.  
12 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
13 McFadden?  
14 COMMISSIONER ADRIENNE MCFADDEN: Yes.  
15 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?  
16 COMMISSIONER MICHAEL NARDONE: Yes.  
17 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?  
18 COMMISSIONER JAMI SNYDER: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.  
20 CHAIR VERLON JOHNSON: Yes.  
21 EXECUTIVE DIRECTOR KATE MASSEY: Great, 17 in  
22 favor.

1 PATRICK JONES: Moving on to Recommendation 2.4:  
2 State Medicaid agencies should amend their  
3 Medicaid managed care plan contracts, on a timeline that is  
4 practicable, to require disclosure or other reporting of  
5 the use of automation in plans' coverage and authorization  
6 processes described at 42 CFR 438.210. Disclosure should  
7 facilitate state visibility into the applications of  
8 automation tools and other meaningful elements of  
9 automation, such as plans' protocols for testing,  
10 evaluation, and oversight. To the extent possible, states  
11 should modify existing reporting requirements or existing  
12 oversight processes to minimize additional administrative  
13 burden.

14 EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Patrick.  
15 Heidi Allen?

16 COMMISSIONER HEIDI ALLEN: Yes.

17 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

18 COMMISSIONER SONJA BJORK: Yes.

19 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

20 COMMISSIONER DOUG BROWN: Yes.

21 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

22 VICE CHAIR ROBERT DUNCAN: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
2 Gerstorff?  
3 COMMISSIONER JENNIFER GERSTORFF: Yes.  
4 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
5 COMMISSIONER ANGELO GIARDINO: Yes.  
6 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
7 COMMISSIONER APRIL HARTMAN: Yes.  
8 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
9 COMMISSIONER DENNIS HEAPHY: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
11 COMMISSIONER TIMOTHY HILL: Yes.  
12 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
13 COMMISSIONER CAROLYN INGRAM: Yes.  
14 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
15 COMMISSIONER ANNE KARL: Yes.  
16 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
17 Killingsworth?  
18 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?  
20 COMMISSIONER JOHN MCCARTHY: Yes.  
21 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
22 McFadden?

1 COMMISSIONER ADRIENNE MCFADDEN: Yes.

2 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

3 COMMISSIONER MICHAEL NARDONE: Yes.

4 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

5 COMMISSIONER JAMI SNYDER: Yes.

6 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

7 CHAIR VERLON JOHNSON: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Great, 17 in

9 favor.

10 Okay, so we will move the PACE recommendations.

11 BRIAN O'GARA: Recommendation 6.1 reads:

12 The Secretary of the U.S. Department of Health  
13 and Human Services should direct the Centers for Medicare &  
14 Medicaid Services to update audit protocols and three-way  
15 program agreements to facilitate joint audits of PACE  
16 organizations with state administering agencies. Audit  
17 coordination should include joint planning of audit scopes,  
18 sharing documentation requests, and reviewing evidence  
19 concurrently, while preserving CMS's responsibility for  
20 assessing federal requirements and states' responsibility  
21 for assessing state-specific requirements.

22 EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Brian.

1 Okay, we are voting on 6.1. Heidi Allen?  
2 COMMISSIONER HEIDI ALLEN: Yes.  
3 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?  
4 COMMISSIONER SONJA BJORK: Yes.  
5 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?  
6 COMMISSIONER DOUG BROWN: Yes.  
7 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?  
8 VICE CHAIR ROBERT DUNCAN: Yes.  
9 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
10 Gerstorff?  
11 COMMISSIONER JENNIFER GERSTORFF: Yes.  
12 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
13 COMMISSIONER ANGELO GIARDINO: Yes.  
14 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
15 COMMISSIONER APRIL HARTMAN: Yes.  
16 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
17 COMMISSIONER DENNIS HEAPHY: Yes.  
18 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
19 COMMISSIONER TIMOTHY HILL: Yes.  
20 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
21 COMMISSIONER CAROLYN INGRAM: Yes.  
22 VICE CHAIR ROBERT DUNCAN: Did we lose Kate?

1 [Pause.]

2 VICE CHAIR ROBERT DUNCAN: Now she's back.

3 CHAIR VERLON JOHNSON: You're back, Kate. We lost  
4 you.

5 EXECUTIVE DIRECTOR KATE MASSEY: Sorry. Anne  
6 Karl?

7 COMMISSIONER ANNE KARL: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
9 Killingsworth?

10 COMMISSIONER PATTI KILLINGSWORTH: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

12 COMMISSIONER JOHN MCCARTHY: Yes.

13 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
14 McFadden?

15 COMMISSIONER ADRIENNE MCFADDEN: Yes.

16 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

17 COMMISSIONER MICHAEL NARDONE: Yes.

18 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

19 COMMISSIONER JAMI SNYDER: Yes.

20 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

21 CHAIR VERLON JOHNSON: Yes.

22 EXECUTIVE DIRECTOR KATE MASSEY: Okay. That's 17

1 in favor.

2 Brian, we'll go to 6.2:

3 MICHELLE CONWAY: Recommendation 6.2 reads:

4 The Secretary of the U.S. Department of Health  
5 and Human Services should direct the Centers for Medicare &  
6 Medicaid Services, or CMS, to aggregate and publicly  
7 release, in a user-friendly format on the CMS website,  
8 existing Program for All-Inclusive Care for the Elderly, or  
9 PACE, program data, including data PACE organizations  
10 submit through the CMS Health Plan Management System as  
11 well as enrollee satisfaction data collected as part of  
12 PACE organization quality improvement programs pursuant to  
13 42 CFR 460.134(a)(2).

14 EXECUTIVE DIRECTOR KATE MASSEY: Thanks,  
15 Michelle. Heidi Allen?

16 COMMISSIONER HEIDI ALLEN: Yes.

17 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

18 COMMISSIONER SONJA BJORK: Yes.

19 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

20 COMMISSIONER DOUG BROWN: Yes.

21 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

22 VICE CHAIR ROBERT DUNCAN: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
2 Gerstorff?  
3 COMMISSIONER JENNIFER GERSTORFF: Yes.  
4 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
5 COMMISSIONER ANGELO GIARDINO: Yes.  
6 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
7 COMMISSIONER APRIL HARTMAN: Yes.  
8 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
9 COMMISSIONER DENNIS HEAPHY: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
11 COMMISSIONER TIMOTHY HILL: Yes.  
12 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
13 COMMISSIONER CAROLYN INGRAM: Yes.  
14 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
15 COMMISSIONER ANNE KARL: Yes.  
16 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
17 Killingsworth?  
18 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?  
20 COMMISSIONER JOHN MCCARTHY: Yes.  
21 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
22 McFadden?

1 COMMISSIONER ADRIENNE MCFADDEN: Yes.

2 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

3 COMMISSIONER MICHAEL NARDONE: Yes.

4 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

5 COMMISSIONER JAMI SNYDER: Yes.

6 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

7 CHAIR VERLON JOHNSON: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 17 in

9 favor.

10 MICHELLE CONWAY: Recommendation 6.3 reads:

11 The Secretary of the U.S. Department of Health  
12 and Human Services should direct the Centers for Medicare &  
13 Medicaid Services to amend regulations at 42 CFR 460  
14 Subpart H to develop a standardized, national quality  
15 measure set for Program of All-Inclusive Care for the  
16 Elderly, or PACE, organizations. Quality data should be  
17 compiled and made publicly available in an accessible  
18 format. CMS should follow three key principles when  
19 developing a PACE quality measure set: engage stakeholders  
20 collaboratively; minimize reporting burden by focusing on  
21 the most meaningful measures; and prioritize standardized  
22 measures that enable comparability across programs where

1 feasible.

2 EXECUTIVE DIRECTOR KATE MASSEY: Okay, great.

3 Heidi Allen?

4 COMMISSIONER HEIDI ALLEN: Yes.

5 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

6 COMMISSIONER SONJA BJORK: Yes.

7 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

8 COMMISSIONER DOUG BROWN: Yes.

9 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

10 VICE CHAIR ROBERT DUNCAN: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer

12 Gerstorff?

13 COMMISSIONER JENNIFER GERSTORFF: Yes.

14 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

15 COMMISSIONER ANGELO GIARDINO: Yes.

16 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

17 COMMISSIONER APRIL HARTMAN: Yes.

18 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

19 COMMISSIONER DENNIS HEAPHY: Yes.

20 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?

21 COMMISSIONER TIMOTHY HILL: Yes.

22 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?

1 COMMISSIONER CAROLYN INGRAM: Yes.

2 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?

3 COMMISSIONER ANNE KARL: Yes.

4 EXECUTIVE DIRECTOR KATE MASSEY: Patti

5 Killingsworth?

6 COMMISSIONER PATTI KILLINGSWORTH: Yes.

7 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

8 COMMISSIONER JOHN MCCARTHY: Yes.

9 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne

10 McFadden?

11 COMMISSIONER ADRIENNE MCFADDEN: Yes.

12 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

13 COMMISSIONER MICHAEL NARDONE: Yes.

14 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

15 COMMISSIONER JAMI SNYDER: Yes.

16 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

17 CHAIR VERLON JOHNSON: Yes.

18 EXECUTIVE DIRECTOR KATE MASSEY: Okay. Thanks,

19 everyone, 17 in favor.

20 We'll move to the access to children's

21 residential treatment facilities.

22 SHEILA SHAHEED: Thanks, Kate.

1 Recommendation 1:

2 To ensure that states, families, and providers  
3 have complete, accurate, and up-to-date information about  
4 residential treatment facilities and bed availability,  
5 Congress should require that the Secretary of HHS develop,  
6 maintain, and make publicly available a federally-  
7 administered, up-to-date, real-time registry of youth  
8 residential treatment facilities serving Medicaid  
9 beneficiaries. The Secretary should work with HHS  
10 agencies, including CMS and SAMHSA, state Medicaid  
11 agencies, state behavioral health agencies, and other  
12 stakeholders to develop and maintain this registry. The  
13 registry should include information on the behavioral  
14 health conditions facilities treat, ages served, real-time  
15 updated bed availability for in- and out-of-state Medicaid  
16 beneficiaries, and accessibility of facilities and services  
17 for individuals with disabilities. The Secretary should  
18 leverage information that has already being collected by  
19 federal agencies and states, while also integrating other  
20 information needed to determine whether the facility can  
21 meet beneficiary need.

22 EXECUTIVE DIRECTOR KATE MASSEY: Great. Thanks,

1 Sheila. So we're voting on Recommendation 4.1. Heidi  
2 Allen?

3 COMMISSIONER HEIDI ALLEN: Yes.  
4 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?  
5 COMMISSIONER SONJA BJORK: Yes.  
6 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?  
7 COMMISSIONER DOUG BROWN: Yes.  
8 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?  
9 VICE CHAIR ROBERT DUNCAN: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
11 Gerstorff?

12 COMMISSIONER JENNIFER GERSTORFF: Yes.  
13 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
14 COMMISSIONER ANGELO GIARDINO: Yes.  
15 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
16 COMMISSIONER APRIL HARTMAN: Yes.  
17 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
18 COMMISSIONER DENNIS HEAPHY: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
20 COMMISSIONER TIMOTHY HILL: Yes.  
21 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
22 COMMISSIONER CAROLYN INGRAM: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?

2 COMMISSIONER ANNE KARL: Yes.

3 EXECUTIVE DIRECTOR KATE MASSEY: Patti

4 Killingsworth?

5 COMMISSIONER PATTI KILLINGSWORTH: Yes.

6 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

7 COMMISSIONER JOHN MCCARTHY: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne

9 McFadden?

10 COMMISSIONER ADRIENNE MCFADDEN: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

12 COMMISSIONER MICHAEL NARDONE: Yes.

13 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

14 COMMISSIONER JAMI SNYDER: Yes.

15 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

16 CHAIR VERLON JOHNSON: Yes.

17 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 17 in

18 favor. 4.2?

19 SHEILA SHAHEED: Recommendation 4.2:

20 To ensure that reliable and consistently  
21 collected data are publicly available, the Secretary of the  
22 U.S. Department of Health and Human Services should direct

1 CMS to regularly report on the use of residential treatment  
2 services by children and youth in Medicaid, including  
3 services provided by PRTFs, non-PRTFs, and out-of-state  
4 residential treatment providers. This report should  
5 contain data on the characteristics of youth using the  
6 services including demographics, disability and co-  
7 occurring conditions, urbanicity and rurality, types of  
8 services used, and average length of stay. This report  
9 should include data on the use of emergency departments for  
10 behavioral health needs, such as emergency department  
11 boarding by youth with Medicaid. If these data are  
12 unavailable to report on key measures, CMS should develop a  
13 plan for collecting and publicly reporting on the data  
14 elements. CMS should engage states, providers, and other  
15 stakeholders in developing the data collection and  
16 reporting efforts.

17 EXECUTIVE DIRECTOR KATE MASSEY: Great. Heidi  
18 Allen?

19 COMMISSIONER HEIDI ALLEN: Yes.

20 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

21 COMMISSIONER SONJA BJORK: Yes.

22 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

1 COMMISSIONER DOUG BROWN: Yes.  
2 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?  
3 VICE CHAIR ROBERT DUNCAN: Yes.  
4 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
5 Gerstorff?  
6 COMMISSIONER JENNIFER GERSTORFF: Yes.  
7 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
8 COMMISSIONER ANGELO GIARDINO: Yes.  
9 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
10 COMMISSIONER APRIL HARTMAN: Yes.  
11 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
12 COMMISSIONER DENNIS HEAPHY: Yes.  
13 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
14 COMMISSIONER TIMOTHY HILL: Yes.  
15 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
16 COMMISSIONER CAROLYN INGRAM: Yes.  
17 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
18 COMMISSIONER ANNE KARL: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
20 Killingsworth?  
21 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
22 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

1 COMMISSIONER JOHN MCCARTHY: Yes.

2 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne

3 McFadden?

4 COMMISSIONER ADRIENNE MCFADDEN: Yes.

5 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

6 COMMISSIONER MICHAEL NARDONE: Yes.

7 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

8 COMMISSIONER JAMI SNYDER: Yes.

9 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

10 CHAIR VERLON JOHNSON: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 17 in

12 favor. Then to 4.3.

13 SHEILA SHAHEED: Recommendation 4.3:

14 To ensure that youth discharged from out-of-state

15 residential treatment facilities return to their home

16 states and communities and receive needed services, the

17 Secretary of HHS should direct CMS to amend 42 CFR 441.155

18 to establish minimum requirements for discharge planning

19 processes that mandate that the process involves all

20 relevant actors including providers, plans, families, and

21 caretakers. The requirement should mandate that the

22 process involves identifying an appropriate community

1 provider or alternative residential placement that has the  
2 capacity and capability to accept a beneficiary prior to  
3 discharge. CMS should also clarify what entities are  
4 responsible for initiating and overseeing the discharge  
5 planning process for an out-of-state beneficiary, and  
6 establish minimum requirements for coordinating and sharing  
7 information between the out-of-state provider and the post-  
8 discharge providers.

9 EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Sheila.  
10 Heidi Allen?

11 COMMISSIONER HEIDI ALLEN: Yes.

12 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

13 COMMISSIONER SONJA BJORK: Yes.

14 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

15 COMMISSIONER DOUG BROWN: Yes.

16 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

17 VICE CHAIR ROBERT DUNCAN: Yes.

18 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer

19 Gerstorff?

20 COMMISSIONER JENNIFER GERSTORFF: Yes.

21 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

22 COMMISSIONER ANGELO GIARDINO: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
2 COMMISSIONER APRIL HARTMAN: Yes.  
3 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
4 COMMISSIONER DENNIS HEAPHY: Yes.  
5 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
6 COMMISSIONER TIMOTHY HILL: Yes.  
7 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
8 COMMISSIONER CAROLYN INGRAM: Yes.  
9 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
10 COMMISSIONER ANNE KARL: Yes.  
11 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
12 Killingsworth?  
13 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
14 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?  
15 COMMISSIONER JOHN MCCARTHY: Yes.  
16 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
17 McFadden?  
18 COMMISSIONER ADRIENNE MCFADDEN: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?  
20 COMMISSIONER MICHAEL NARDONE: Yes.  
21 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?  
22 COMMISSIONER JAMI SNYDER: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

2 CHAIR VERLON JOHNSON: Yes.

3 EXECUTIVE DIRECTOR KATE MASSEY: Thanks,  
4 everyone. 17 in favor.

5 Okay. We are going to move to community  
6 engagement.

7 JANICE LLANOS-VELAZQUEZ: Based on Commissioner  
8 feedback we received today we have revised the  
9 recommendation text to support evaluation of outcomes  
10 beyond health, employment, and spending, and we added the  
11 evaluation of program spending to address potential changes  
12 and rates to MCOs and providers.

13 Recommendation 1.1 now reads:

14 The Secretary of the U.S. Department of Health  
15 and Human Services should direct the Centers for Medicare &  
16 Medicaid Services, or CMS, to develop a transparent plan  
17 for monitoring and evaluating community engagement, or CE,  
18 requirements in Medicaid. The monitoring plan should  
19 provide insight into how such policies affect eligibility  
20 and enrollment. CMS should identify new metrics for state  
21 reporting and build upon existing data collection to  
22 minimize administrative burden. The evaluation plan should

1 outline, at a minimum, CMS's approach to evaluating the  
2 effect of CE requirements on employment, health, and state  
3 and federal administrative and program spending. CMS  
4 should ensure timely publication of monitoring and  
5 evaluation results to inform policy and operational  
6 decision making.

7 EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Janice.  
8 Okay. So we are voting on Recommendation 1.1. Heidi  
9 Allen?

10 COMMISSIONER HEIDI ALLEN: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

12 COMMISSIONER SONJA BJORK: Yes.

13 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

14 COMMISSIONER DOUG BROWN: No.

15 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

16 VICE CHAIR ROBERT DUNCAN: Yes.

17 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer

18 Gerstorff?

19 COMMISSIONER JENNIFER GERSTORFF: Yes.

20 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

21 COMMISSIONER ANGELO GIARDINO: Yes.

22 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

1 COMMISSIONER APRIL HARTMAN: Yes.  
2 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
3 COMMISSIONER DENNIS HEAPHY: Yes.  
4 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
5 COMMISSIONER TIMOTHY HILL: Yes.  
6 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
7 COMMISSIONER CAROLYN INGRAM: Yes.  
8 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
9 COMMISSIONER ANNE KARL: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
11 Killingsworth?  
12 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
13 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?  
14 COMMISSIONER JOHN MCCARTHY: No.  
15 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
16 McFadden?  
17 COMMISSIONER ADRIENNE MCFADDEN: Yes.  
18 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?  
19 COMMISSIONER MICHAEL NARDONE: Yes.  
20 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?  
21 COMMISSIONER JAMI SNYDER: Yes.  
22 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

1 CHAIR VERLON JOHNSON: Yes.

2 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 15 in  
3 favor, 2 against.

4 Okay. We're going to move to children and youth  
5 with special health care needs.

6 AVA WILLIAMS: Hello. Recommendation 5.1 reads:  
7 The Secretary of the U.S. Department of Health  
8 and Human Services should direct the Centers for Medicare &  
9 Medicaid Services to amend 42 CFR 435.919(b)(6) to require  
10 states to send a notice, 60 days in advance of children and  
11 youth with special health care needs, CYSHCN, aging out of  
12 Medicaid eligibility, to inform them that the renewal  
13 process has been initiated. Children and youth with  
14 special health care needs include, but are not limited to,  
15 children who are enrolled in Medicaid through Supplemental  
16 Security Income, or SSI, related eligibility pathways, who  
17 are not eligible for SSI as adults, and are transitioning  
18 to non-SSI-related pathways when they reach age 19, the  
19 Katie Beckett pathway for children with disabilities, those  
20 eligible for Medicaid under the Tax Equity and Fiscal  
21 Responsibility Act, and children who qualify to receive an  
22 institutional level of care.

1 EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Ava. We  
2 are voting on Recommendation 5.1 Heidi Allen?  
3 COMMISSIONER HEIDI ALLEN: Yes.  
4 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?  
5 COMMISSIONER SONJA BJORK: Yes.  
6 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?  
7 COMMISSIONER DOUG BROWN: Yes.  
8 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?  
9 VICE CHAIR ROBERT DUNCAN: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
11 Gerstorff?  
12 COMMISSIONER JENNIFER GERSTORFF: Yes.  
13 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
14 COMMISSIONER ANGELO GIARDINO: Yes.  
15 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
16 COMMISSIONER APRIL HARTMAN: Yes.  
17 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
18 COMMISSIONER DENNIS HEAPHY: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
20 COMMISSIONER TIMOTHY HILL: Yes.  
21 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
22 COMMISSIONER CAROLYN INGRAM: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?

2 COMMISSIONER ANNE KARL: Yes.

3 EXECUTIVE DIRECTOR KATE MASSEY: Patti

4 Killingsworth?

5 COMMISSIONER PATTI KILLINGSWORTH: Yes.

6 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

7 COMMISSIONER JOHN MCCARTHY: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne

9 McFadden?

10 COMMISSIONER ADRIENNE MCFADDEN: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

12 COMMISSIONER MICHAEL NARDONE: Yes.

13 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

14 COMMISSIONER JAMI SNYDER: Yes.

15 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

16 CHAIR VERLON JOHNSON: Yes.

17 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 17 in

18 favor.

19 AVA WILLIAMS: Recommendation 5.2 reads:

20 State Medicaid agencies should provide children

21 and youth with special health care needs who are aging out

22 of child Medicaid eligibility with a minimum of 30 days to

1 respond to request for information to complete Medicaid  
2 redeterminations, and in accordance with 42 CFR  
3 435.919(c) (1). Children and youth with special health care  
4 needs include, but are not limited to, children who are  
5 enrolled in Medicaid through Supplemental Security Income,  
6 or SSI, related eligibility pathways, who are not eligible  
7 for SSI as adults, and are transitioning to non-SSI-related  
8 pathways when they reach age 19, the Katie Beckett pathway  
9 for children with disabilities, those eligible for Medicaid  
10 under the Tax Equity and Fiscal Responsibility Act, and  
11 children who qualify to receive an institutional level of  
12 care.

13 EXECUTIVE DIRECTOR KATE MASSEY: Okay. 5.2

14 Heidi Allen?

15 COMMISSIONER HEIDI ALLEN: Yes.

16 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

17 COMMISSIONER SONJA BJORK: Yes.

18 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

19 COMMISSIONER DOUG BROWN: Yes.

20 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

21 VICE CHAIR ROBERT DUNCAN: Yes.

22 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer

1 Gerstorff?

2 COMMISSIONER JENNIFER GERSTORFF: Yes.

3 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

4 COMMISSIONER ANGELO GIARDINO: Yes.

5 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

6 COMMISSIONER APRIL HARTMAN: Yes.

7 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

8 COMMISSIONER DENNIS HEAPHY: Yes.

9 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?

10 COMMISSIONER TIMOTHY HILL: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?

12 COMMISSIONER CAROLYN INGRAM: Yes.

13 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?

14 COMMISSIONER ANNE KARL: Yes.

15 EXECUTIVE DIRECTOR KATE MASSEY: Patti

16 Killingsworth?

17 COMMISSIONER PATTI KILLINGSWORTH: Yes.

18 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

19 COMMISSIONER JOHN MCCARTHY: Yes.

20 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne

21 McFadden?

22 COMMISSIONER ADRIENNE MCFADDEN: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

2 COMMISSIONER MICHAEL NARDONE: Yes.

3 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

4 COMMISSIONER JAMI SNYDER: Yes.

5 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

6 CHAIR VERLON JOHNSON: Yes.

7 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 17 in  
8 favor.

9 AVA WILLIAMS: Draft Recommendation 5.3 reads:

10 To ensure the accuracy of information provided by  
11 the Social Security Administration (SSA) to Medicaid  
12 beneficiaries enrolled in Supplemental Security Income  
13 (SSI)-related eligibility pathways who are being notified  
14 that they are losing eligibility for SSI, the Secretary of  
15 the U.S. Department of Health and Human Services, through  
16 the Centers for Medicare & Medicaid Services, should  
17 coordinate with SSA to review and update model notice  
18 language pertaining to Medicaid in SSA's Program Operations  
19 Manual System manual paragraphs. The model language should  
20 clearly indicate that the individual may retain their  
21 Medicaid coverage while the state Medicaid agency takes  
22 steps to redetermine the individual on a new basis of

1 eligibility. Additionally, the model language should  
2 describe, in general terms, the steps the individual needs  
3 to follow to complete the Medicaid redetermination that are  
4 specific to 1634, SSI criteria, and 209(b) states.

5 EXECUTIVE DIRECTOR KATE MASSEY: Okay. Heidi  
6 Allen?

7 COMMISSIONER HEIDI ALLEN: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

9 COMMISSIONER SONJA BJORK: Yes.

10 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

11 COMMISSIONER DOUG BROWN: Yes.

12 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

13 VICE CHAIR ROBERT DUNCAN: Yes.

14 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer

15 Gerstorff?

16 COMMISSIONER JENNIFER GERSTORFF: Yes.

17 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

18 COMMISSIONER ANGELO GIARDINO: Yes.

19 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?

20 COMMISSIONER APRIL HARTMAN: Yes.

21 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?

22 COMMISSIONER DENNIS HEAPHY: Yes.

1 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
2 COMMISSIONER TIMOTHY HILL: Yes.  
3 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
4 COMMISSIONER CAROLYN INGRAM: Yes.  
5 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
6 COMMISSIONER ANNE KARL: Yes.  
7 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
8 Killingsworth?  
9 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?  
11 COMMISSIONER JOHN MCCARTHY: Yes.  
12 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
13 McFadden?  
14 COMMISSIONER ADRIENNE MCFADDEN: Yes.  
15 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?  
16 COMMISSIONER MICHAEL NARDONE: Yes.  
17 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?  
18 COMMISSIONER JAMI SNYDER: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.  
20 CHAIR VERLON JOHNSON: Yes.  
21 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 17 in  
22 favor.

1           AVA WILLIAMS: Draft Recommendation 5.4 reads:  
2           State Medicaid agencies should implement optional  
3 Medicaid eligibility for children and youth with special  
4 health care needs (CYSHCN) up to age 21 who are not  
5 otherwise eligible for and enrolled in mandatory coverage  
6 or optional full Medicaid coverage under the state plan (42  
7 CFR 435.222 and 42 CFR 435.223). Children and youth with  
8 special health care needs include, but are not limited to,  
9 children who are enrolled in Medicaid through Supplemental  
10 Security Income (SSI)-related eligibility pathways who are  
11 not eligible for SSI as adults and are transitioning to  
12 non-SSI related pathways when they reach age 19, the Katie  
13 Beckett pathway for children with disabilities, those  
14 eligible for Medicaid under the Tax Equity and Fiscal  
15 Responsibility Act, and children who qualify to receive an  
16 institutional level of care.

17           EXECUTIVE DIRECTOR KATE MASSEY: Okay. Heidi  
18 Allen?

19           COMMISSIONER HEIDI ALLEN: Yes.

20           EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

21           COMMISSIONER SONJA BJORK: Yes.

22           EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

1 COMMISSIONER DOUG BROWN: Yes.  
2 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?  
3 VICE CHAIR ROBERT DUNCAN: Yes.  
4 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
5 Gerstorff?  
6 COMMISSIONER JENNIFER GERSTORFF: Yes.  
7 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
8 COMMISSIONER ANGELO GIARDINO: Yes.  
9 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
10 COMMISSIONER APRIL HARTMAN: Yes.  
11 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
12 COMMISSIONER DENNIS HEAPHY: Yes.  
13 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
14 COMMISSIONER TIMOTHY HILL: Yes.  
15 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
16 COMMISSIONER CAROLYN INGRAM: Yes.  
17 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
18 COMMISSIONER ANNE KARL: Yes.  
19 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
20 Killingsworth?  
21 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
22 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?

1 COMMISSIONER JOHN MCCARTHY: No.

2 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne

3 McFadden?

4 COMMISSIONER ADRIENNE MCFADDEN: Yes.

5 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

6 COMMISSIONER MICHAEL NARDONE: Yes.

7 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

8 COMMISSIONER JAMI SNYDER: Yes.

9 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

10 CHAIR VERLON JOHNSON: Yes.

11 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 16 in

12 favor, 1 against.

13 AVA WILLIAMS: Recommendation 5.5 reads:

14 To ensure children and youth with special health

15 care needs receive a full 12-month continuous eligibility

16 period in their final year of child Medicaid eligibility,

17 Congress should amend § 1902(e)(12) of the Social Security

18 Act to require states to provide children and youth with

19 special health care needs with a 12-month continuous

20 eligibility period that lasts a full 12 months from the

21 date of the eligibility determination, even if during the

22 continuous eligibility period an individual reaches the

1 upper age limit for the eligibility pathway by which they  
2 are eligible for Medicaid. This 12-month continuous  
3 eligibility period should apply to all children and youth  
4 with special health care needs who receive coverage from a  
5 mandatory or optional child eligibility pathway, including  
6 optional pathways covering youth above age 18. Children  
7 and youth with special health care needs include, but are  
8 not limited to, children who are enrolled in Medicaid  
9 through Supplemental Security Income (SSI)-related  
10 eligibility pathways who are not eligible for SSI as adults  
11 and are transitioning to non-SSI related pathways when they  
12 reach age 19, the Katie Beckett pathway for children with  
13 disabilities, those eligible for Medicaid under the Tax  
14 Equity and Fiscal Responsibility Act, and children who  
15 qualify to receive an institutional level of care.

16 EXECUTIVE DIRECTOR KATE MASSEY: Thanks, Ava.  
17 Heidi Allen?

18 COMMISSIONER HEIDI ALLEN: Yes.

19 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

20 COMMISSIONER SONJA BJORK: Yes.

21 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

22 COMMISSIONER DOUG BROWN: No.

1 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?  
2 VICE CHAIR ROBERT DUNCAN: Yes.  
3 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
4 Gerstorff?  
5 COMMISSIONER JENNIFER GERSTORFF: Yes.  
6 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?  
7 COMMISSIONER ANGELO GIARDINO: Yes.  
8 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
9 COMMISSIONER APRIL HARTMAN: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
11 COMMISSIONER DENNIS HEAPHY: Yes.  
12 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
13 COMMISSIONER TIMOTHY HILL: Yes.  
14 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
15 COMMISSIONER CAROLYN INGRAM: Yes.  
16 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
17 COMMISSIONER ANNE KARL: No.  
18 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
19 Killingsworth?  
20 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
21 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?  
22 COMMISSIONER JOHN MCCARTHY: No.

1 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
2 McFadden?

3 COMMISSIONER ADRIENNE MCFADDEN: Yes.

4 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?

5 COMMISSIONER MICHAEL NARDONE: Yes.

6 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

7 COMMISSIONER JAMI SNYDER: Yes.

8 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

9 CHAIR VERLON JOHNSON: Yes.

10 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 14 in  
11 favor, 3 against.

12 AVA WILLIAMS: And lastly, Recommendation 5.6:

13 The Secretary of the U.S. Department of Health  
14 and Human Services should direct the Centers for Medicare &  
15 Medicaid Services to issue guidance to states on existing  
16 authorities for supporting children and youth with special  
17 health care needs with Medicaid redetermination and  
18 transitioning to adult Medicaid coverage. The guidance  
19 should address authorities to cover case management,  
20 transition planning for child-only Section 1915(c) and home  
21 and community-based service waivers, and the state optional  
22 pathway to cover children up to age 21. Children and youth

1 with special health care needs include, but are not limited  
2 to, children who are enrolled in Medicaid through  
3 Supplemental Security Income (SSI)-related eligibility  
4 pathways who are not eligible for SSI as adults and are  
5 transitioning to non-SSI related pathways when they reach  
6 age 19, the Katie Beckett pathway for children with  
7 disabilities, those eligible for Medicaid under the Tax  
8 Equity and Fiscal Responsibility Act, and children who  
9 qualify to receive an institutional level of care.

10 EXECUTIVE DIRECTOR KATE MASSEY: Thank you, Ava.  
11 Heidi Allen?

12 COMMISSIONER HEIDI ALLEN: Yes.

13 EXECUTIVE DIRECTOR KATE MASSEY: Sonja Bjork?

14 COMMISSIONER SONJA BJORK: Yes.

15 EXECUTIVE DIRECTOR KATE MASSEY: Doug Brown?

16 COMMISSIONER DOUG BROWN: Yes.

17 EXECUTIVE DIRECTOR KATE MASSEY: Bob Duncan?

18 VICE CHAIR ROBERT DUNCAN: Yes.

19 EXECUTIVE DIRECTOR KATE MASSEY: Jennifer  
20 Gerstorff?

21 COMMISSIONER JENNIFER GERSTORFF: Yes.

22 EXECUTIVE DIRECTOR KATE MASSEY: Angelo Giardino?

1 COMMISSIONER ANGELO GIARDINO: Yes.  
2 EXECUTIVE DIRECTOR KATE MASSEY: April Hartman?  
3 COMMISSIONER APRIL HARTMAN: Yes.  
4 EXECUTIVE DIRECTOR KATE MASSEY: Dennis Heaphy?  
5 COMMISSIONER DENNIS HEAPHY: Yes.  
6 EXECUTIVE DIRECTOR KATE MASSEY: Tim Hill?  
7 COMMISSIONER TIMOTHY HILL: Yes.  
8 EXECUTIVE DIRECTOR KATE MASSEY: Carolyn Ingram?  
9 COMMISSIONER CAROLYN INGRAM: Yes.  
10 EXECUTIVE DIRECTOR KATE MASSEY: Anne Karl?  
11 COMMISSIONER ANNE KARL: Yes.  
12 EXECUTIVE DIRECTOR KATE MASSEY: Patti  
13 Killingsworth?  
14 COMMISSIONER PATTI KILLINGSWORTH: Yes.  
15 EXECUTIVE DIRECTOR KATE MASSEY: John McCarthy?  
16 COMMISSIONER JOHN MCCARTHY: Yes.  
17 EXECUTIVE DIRECTOR KATE MASSEY: Adrienne  
18 McFadden?  
19 COMMISSIONER ADRIENNE MCFADDEN: Yes.  
20 EXECUTIVE DIRECTOR KATE MASSEY: Mike Nardone?  
21 COMMISSIONER MICHAEL NARDONE: Yes.  
22 EXECUTIVE DIRECTOR KATE MASSEY: Jami Snyder?

1 COMMISSIONER JAMI SNYDER: Yes.

2 EXECUTIVE DIRECTOR KATE MASSEY: Verlon Johnson.

3 CHAIR VERLON JOHNSON: Yes.

4 EXECUTIVE DIRECTOR KATE MASSEY: Okay, 17 in  
5 favor. I turn it back to the Chair.

6 CHAIR VERLON JOHNSON: All right. Thank you so  
7 much. And with that, we wrap up our final meeting for the  
8 2025-2026 cycle. I want to thank all of you all for your  
9 engagement and your thoughtfulness and all the support you  
10 bring to this work. It really makes a difference. And  
11 just so you are aware, mark your calendars. Our next  
12 meeting will kick off 2026-2027 cycle, and is scheduled for  
13 September 24th and 25th.

14 In the meantime, I hope you all have a wonderful  
15 summer. And for those of you who have graduating students  
16 like me, congratulations. It is a special milestone for  
17 them, and definitely for all of us, as well, their family  
18 and friends.

19 So thank you all, and have a wonderful, wonderful  
20 summer, and we are adjourned.

21 \* [Whereupon, at 5:12 p.m., the meeting was  
22 adjourned.]