



PUBLIC MEETING

Horizon Ballroom
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Washington, D.C. 20004

Thursday, September 24, 2026
10:30 a.m.

COMMISSIONERS PRESENT:

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1 administrative burden for beneficiaries and states.

2 Our staff today will walk us through the key
3 provisions of the interim final rule. They will provide
4 some updates as to relief and MACPAC's framework for
5 monitoring its implementation. And then a discussion will
6 be followed by an expert panel.

7 So, with that I will turn it over to Linn and
8 Janice to lead us through this topic. Linn and Janice?

9 **### COMMUNITY ENGAGEMENT (CE) REQUIREMENTS IN**
10 **MEDICAID: INTERIM FINAL RULE AND MONITORING**
11 **FRAMEWORK**

12 * JANICE LLANOS-VELAZQUEZ: Thanks, Verlon, and good
13 morning, Commissioners. Today Linn and I will provide an
14 overview of the interim final rule on implementing
15 community engagement, or CE, requirements in Medicaid. The
16 rule was issued by the Centers for Medicare & Medicaid
17 Services, or CMS, this past June.

18 As Verlon just mentioned, to give you a reminder
19 of our work on this topic, last year we engaged in analytic
20 work to identify considerations for implementing CE
21 requirements in Medicaid. This work resulted in a chapter
22 in the June 2026 Report to Congress, with a recommendation

1 directing CMS to monitor and evaluate CE.

2 This past July we commented on CMS's interim
3 final rule with comment, or IFC, drawing on prior MACPAC
4 work related to key IFC provisions. In the letter we
5 acknowledged and appreciated CMS's establishment of state
6 reporting requirements to monitor CE and encouraged CMS to
7 adopt all of the elements of our recommendation by making
8 these monitoring data publicly available in a timely
9 manner, and to develop a transparent plan for evaluating
10 the effect of CE requirements.

11 Given Commissioner interest in this new policy we
12 plan to monitor implementation activities and report on
13 early results to the extent possible. Linn will speak more
14 about MACPAC's monitoring framework later in this
15 presentation.

16 Given that context, let's turn now to an overview
17 of today's presentation, where we will summarize key
18 provisions of the IFC, then highlight a few updates since
19 the release of the IFC, including additional CMS resources
20 for states and ongoing litigation. Next, we will discuss
21 MACPAC's monitoring framework, and then we will conclude
22 with next steps.

1 The 2025 Budget Reconciliation Act established CE
2 requirements in Medicaid for certain individuals. The
3 statute required CMS to issue an interim final rule to set
4 standards and procedures for implementing CE. We will
5 summarize several key provisions from the IFC.

6 We will start with applicable individuals and how
7 to demonstrate compliance with CE. Applicable individuals
8 are those who are required to comply with CE, which are
9 individuals eligible for or enrolled in the new adult group
10 and those who are not pregnant, not dually eligible for
11 Medicare, and are age 19 through 64, eligible for or
12 eligible for or enrolled in a Section 1115 demonstration,
13 providing minimum essential coverage.

14 To be considered compliant with CE, these
15 individuals must demonstrate a monthly income of at least
16 \$580, which is the federal minimum wage multiplied by 80,
17 or they must participate in a minimum of 80 hours of work
18 or a work program, educational program with at least half-
19 time enrollment, community service, or a combination
20 thereof.

21 The IFC provides more details on the definition
22 of each of the qualifying activities. For example, the

1 rule explains how caregiving hours can count toward work
2 hours. It also establishes criteria for calculating hours
3 for education and seasonal work, which we won't go into in
4 detail here but noting for context.

5 The statute established individuals mandatorily
6 excepted from CE requirement, and the IFC describes how
7 states should deem compliance for these individuals.
8 Mandatory exceptions are individuals who are younger than
9 age 19, dually eligible for Medicare, enrolled via a
10 mandatory eligibility pathway, incarcerated at any point in
11 the three months prior to the application month, or a
12 specified excluded individual. Individuals who meet the
13 criteria for a mandatory exception are deemed compliant for
14 the month or months in which they meet the criteria, except
15 for individuals who are incarcerated. They are deemed
16 compliant for the three-month period prior to the
17 application month.

18 The law identifies nine population groups who are
19 considered specified excluded individuals, and the IFC
20 detailed the criteria for each of these groups. Unlike
21 mandatory exceptions who are subject to CE and deemed
22 compliant, specified excluded individuals are not subject

1 to CE. The nine categories of specified excluded
2 individuals are listed on this slide, but for the sake of
3 time I won't list them all. However, I will spend some
4 time discussing individuals who are medically frail or
5 otherwise have special needs in the next couple of slides.

6 In statute, medical frailty is defined as
7 individuals with a physical, mental, or behavioral health
8 condition. The IFC expands on this definition by requiring
9 the individual's condition to significantly impair their
10 ability to comply with CE. To qualify for this exclusion,
11 individuals need to meet the criteria for only one of the
12 conditions included in the medical frailty definition,
13 which are individuals who are blind or disabled, have a
14 substance use disorder and are not in stable recovery,
15 which means they have been in recovery for less than five
16 years, a disabling mental disorder, having a disability
17 that significantly impairs their ability to perform one or
18 more activities of daily living, or they have a serious or
19 complex medical condition.

20 To identify individuals who are medically frail,
21 CMS expects states to develop lists of diseases, diagnoses,
22 disorders, or other health conditions using several

1 resources such as International Classifications of
2 Diseases, or ICD-10 codes, and the Diagnosis and
3 Statistical Manual of Mental Disorders, or the DSM-5. The
4 IFC notes that these lists must be auditable and shared
5 with CMS for oversight and monitoring purposes.

6 The presence of the condition alone does not
7 satisfy the IFC's definition of medical frailty, and states
8 should use other information such as utilization or acuity
9 to assess whether the condition significantly impairs their
10 ability to comply with CE.

11 After the IFC was issued, CMS published a slide
12 deck on identifying medical frailty using a tiered
13 approach. CMS clarifies in the slide deck that the tiered
14 approach is a suggested method and states can choose to
15 adopt it as they operationalize medical frailty. They also
16 provide several clinical vignettes, illustrating the
17 application of this approach.

18 CMS's suggested approach categorizes conditions
19 into three tiers. Tier 1 conditions are those that the
20 state can confirm impair the individual's ability to comply
21 with CE, based on the diagnosis alone. CMS includes
22 pancreatic cancer and end-stage renal disease as examples

1 of Tier 1 conditions.

2 Tier 2 conditions are those that may indicate
3 medical frailty, but the state requires additional
4 information to assess whether the condition significantly
5 impairs the individual's ability to comply. CMS specifies
6 that additional information can come from additional
7 diagnosis information, for example, comorbidities, or
8 utilization information from claims or encounter data.
9 Tier 2 could include individuals with multiple chronic
10 conditions and who have high service utilization.

11 Tier 3 are cases where there is insufficient
12 information and it triggers a manual review by the state
13 where they may ask for documentation to support an
14 individual's status as medically frail.

15 While statute requires states to implement
16 mandatory exceptions and specified excluded individuals,
17 which we just covered, it gives the states the option to
18 provide short-term hardship exceptions and deem individuals
19 compliant in certain circumstances, such as receiving
20 hospital or nursing facility care or living in a county
21 with high unemployment.

22 The IFC provides more details on the criteria for

1 each of these circumstances, and it notes that states
2 electing to provide short-term hardship exceptions must
3 provide all of them and cannot pick and choose.

4 The IFC explains the difference between an
5 exclusion or specified excluded individual and an
6 exception. This distinction has important implications for
7 the time period that the state reviews to verify an
8 individual's status. As mentioned earlier, individuals who
9 meet the criteria for one of the specified excluded
10 populations are not applicable individuals and are not
11 subject to CE. This means that they do not need to
12 demonstrate compliance and the state may not apply a look-
13 back period to assess their compliance.

14 Individuals who meet the criteria for mandatory
15 or optional short-term hardship exception are considered
16 applicable individuals. This means that they need to
17 demonstrate compliance with CE. States will assess CE
18 compliance for these individuals during the appropriate
19 look-back period, which we will cover in the next slide.
20 In the months in which they meet the criteria, the state
21 must deem the individual as compliant.

22 There are cases in which there is overlap of an

1 exclusion and an exception, and that is for individuals who
2 do not meet the criteria for an exclusion during the
3 application months but meet the criteria for an exclusion
4 during the look-back period. Then they are deemed
5 compliant for the month in which they meet the criteria. I
6 know it is confusing. I will go through this in the next
7 slide, using an example.

8 This figure shows the appropriate look-back
9 period based on information I just covered. On the right-
10 hand side we have the gray box, which is the application or
11 renewal month. Upon receiving the application, the state
12 determines if the individual meets the criteria for an
13 exclusion in that month. If they meet the criteria for an
14 exclusion, then the state will not assess compliance and no
15 look-back period is applied. If the individual does not
16 meet the criteria for an exclusion or the state cannot
17 verify an individual's exclusion status, then the state
18 applies the appropriate look-back period to assess
19 compliance.

20 If it is a new applicant, then the state assesses
21 compliance for at least one month immediately preceding the
22 application month, and the state has the option to require

1 up to two additional months of compliance, for a total of
2 three consecutive months.

3 If it is a renewal, then the state assesses
4 compliance for at least one month immediately preceding the
5 renewal month, and the state has the option to require up
6 to five additional months of compliance, for a total of six
7 months. States that choose fewer than six months of
8 compliance must assess compliance for the total number of
9 months, and they cannot pick and choose which month they
10 determine compliance for.

11 Because redeterminations for this population must
12 occur every six months, states choosing a six-month
13 verification period will need to assess compliance for all
14 six months. I will try to illustrate this using an example
15 of the overlap of an exclusion and exception that I
16 mentioned earlier, so bear with me.

17 An individual submits their application in July
18 in a state that has a three-month compliance period. The
19 individual is a new applicant, and the state determines
20 that the applicant does not meet the criteria for an
21 exclusion during the month of July, which means the state
22 must assess compliance during the three months prior to the

1 application. So, in this case, the look-back period is
2 April, May, and June. In the month of May, the applicant's
3 child turned 14. This means that in April and May the
4 applicant qualified as a specified excluded individual, as
5 a parent of child younger than age 14. In this case, the
6 state will deem the individual compliant with CE for April
7 and May, and assess CE compliance for the month of June.

8 To reiterate the example of an exclusion using
9 this same applicant, if their child was 13 years old in
10 July then they would meet the criteria as a specified
11 excluded individual and the state would not apply a look-
12 back period.

13 I hope you are sufficiently confused, and with
14 that I will turn it over to Linn.

15 * LINN JENNINGS: Thanks, Janice. States are
16 required to first attempt to verify compliance exception or
17 exclusion status without requiring individuals to submit
18 additional information, known as ex parte. For new
19 applications, renewals, and verification, the state must
20 first attempt to confirm whether the individual is a
21 specified excluded individual, using reliable information
22 available to the state. If the individual is excluded then

1 they are not subject to CE requirements, and the state
2 should not evaluate them for compliance with CE. If a
3 state verifies an individual does not meet exclusion
4 criteria, the state can then check other reliable
5 information such as payroll or education, to verify
6 compliance with CE.

7 Additionally, if reliable information about an
8 individual is insufficient for determining exclusion status
9 and they are able to verify compliance with CE, the state
10 must first enroll the individual based on CE compliance to
11 ensure a timely redetermination, and then later should
12 verify additional information post enrollment about whether
13 the individual is excepted or excluded from CE.

14 The IFC describes reliable sources of information
15 that states should use for verifying compliance with CE,
16 mandatory exceptions, and specified excluded individuals,
17 and requires that states use a variety of reliable sources
18 that are listed on this slide and the electronic data
19 sources established by the Secretary, including the Federal
20 Data Services Hub, which states can use to access
21 information needed to verify Medicaid eligibility. CMS
22 recently added two new data sources to hub, education data

1 from the National Student Clearinghouse and data from the
2 U.S. Department of Veteran Affairs, for verification of
3 these exclusion statuses.

4 CMS will continue to incorporate additional
5 sources needed for CE verification into the hub and once
6 those data are added states must use those data sources or
7 another federal service unless CMS approves an alternative
8 mechanism.

9 The IFC requires states to verify the presence of
10 the condition that qualifies the individual for medical
11 frailty exclusion and that that condition significantly
12 impairs the individual from complying with CE. To verify
13 medical frailty, states must first attempt to do this on an
14 ex parte basis, using reliable information, and these
15 reliable data can include adjudicated claims or encounter
16 data from the preceding 12 months that are related to the
17 individual's condition, and the IFC suggests states develop
18 a list of qualifying diagnosis codes combined with a
19 variety of other types of data, including utilization and
20 severity of condition, to determine the medical frailty.

21 As Janice also mentioned earlier, CMS recently
22 published their slide deck that expands on the IFC by

1 providing examples of how states could verify medical
2 frailty using this tiered framework, that uses reliable
3 information primarily from claims and encounter data.

4 Additionally, states may accept provider
5 documentation, and if states allow this type of
6 documentation states must be able to share a list of
7 qualified practitioners to CMS.

8 Unlike other CE verification processes,
9 reverification for medical frailty specified excluded
10 status is only required once every 12 months, but states
11 may choose to reverify more frequently.

12 In addition to state verification of reliable
13 information, the statute also allows for self-attestation.
14 The IFC clarifies that when reliable sources of
15 documentation are not available, the state can either have
16 the individual first submit documentation or they can allow
17 for self-attestation in the absence of available
18 information to the state. And this is allowed before
19 January 1, 2028.

20 Starting on January 1, 2028, the state no longer
21 has the option to accept self-attestation in place of the
22 individual submitting documentation. Instead, the state

1 must first require the individual to submit documentation,
2 when it is reasonably available, and if no documentation is
3 reasonably available the state must have a process in place
4 to accept other types of information.

5 When verifying medical frailty the state may only
6 accept self-attestation one time during the individual's
7 period of continuous enrollment, whereas for other
8 populations states are not limited in the number of times
9 they can accept self-attestation when there is no other
10 reliable form of documentation.

11 Moving on to the noncompliance procedures, the
12 IFC establishes standards for notifying individuals whose
13 compliance with CE requirements can't be verified. States
14 are required to provide beneficiaries with 30 calendar days
15 from the date that the individual receives the notice to
16 respond to a notice of noncompliance, which the IFC defines
17 as five days following the send date, unless the applicant
18 or beneficiary can show that they did not receive the
19 notice within this time frame.

20 If states are unable to verify compliance,
21 mandatory exception, or specified exclusion status at
22 application or renewal, then states have two options. They

1 can first send the notice of noncompliance concurrently
2 with a request for information, which includes a
3 prepopulated form, or they can choose to send the request
4 for information first to the beneficiary and only if the
5 information provided is insufficient or the beneficiary
6 does not respond the state then sends a notice of
7 noncompliance.

8 The IFC also clarifies that existing reenrollment
9 and reconsideration period regulations apply to this
10 population, and describes how noncompliance may affect the
11 eligibility for financial assistance with marketplace
12 coverage. So, if an individual is determined eligible for
13 minimum essential coverage but is not compliant with CE,
14 they are not eligible for premium tax credits for the month
15 of application or renewal.

16 States are required to send periodic outreach
17 through at least two modalities to inform individuals
18 of CE requirements, and they are permitted to use managed
19 care plans to assist with some outreach activities. States
20 are required to send initial outreach in advance of state
21 implementation to all enrolled individuals in the new adult
22 group and those in applicable Section 1115 demonstrations.

1 This outreach must be sent out at least three months prior
2 to the start of the compliance review period immediately
3 preceding the state's implementation date. So, for states
4 implementing on January 1st, they are required to send
5 initial outreach by September 30th.

6 The initial outreach notice must include
7 information about these new CE requirements, including
8 information on how applicable individuals are defined, how
9 the beneficiary can demonstrate compliance, and definitions
10 for mandatory exceptions and excluded populations.

11 Following this initial outreach, states are
12 required to conduct outreach on a periodic basis related to
13 circumstances that may affect their eligibility. And CMS
14 also may require additional state outreach based on state
15 reported monitoring metrics.

16 The IFC establishes new reporting requirements,
17 as was recommended by the Commission in the June 2026
18 Report to Congress. And CMS requires states to report
19 timely and high quality data related to CE requirements,
20 which includes information on enrollment, applications and
21 renewals, individuals subject to CE requirements, and any
22 other information the agency may specify.

1 States can leverage existing data collection
2 efforts, but they also will need to create 11 new data
3 elements, 6 of which were added to the performance
4 indicator, or PI, data, 5 of which were added to the
5 Medicaid and CHIP eligibility processing, or EP, data.
6 Additional updates may also be made to the transformed
7 Medicaid Statistical Information System, or T-MSIS.

8 The IFC also specifies that CMS will develop a
9 CE-specific report, but does not specify whether these data
10 will be made public.

11 On this slide you can see the new data elements
12 that states will be required to report. They include
13 measures on the number of individuals that applications
14 determined eligible and ineligible, including whether they
15 were determined ineligible due to procedural reasons, the
16 number of renewed and retained coverage, and the number of
17 renewed and determined ineligible.

18 In MACPAC's chapter in the June 2026 Report to
19 Congress the Commission recommended CMS develop a
20 transparent plan for monitoring and evaluating community
21 engagement requirements in Medicaid, and in the chapter we
22 outlined specific metrics that CMS may consider for state

1 reporting, many of which are already collected as part of
2 state reporting for PI, EP, and T-MSIS data.

3 So we have included a table in your appendix, in
4 your materials, as well as a reference that crosswalks
5 these new CE-related data elements to those that were
6 included in the chapter as potential measures. Many of the
7 new data elements do align with those that the Commission
8 identified, but there are some that are still not included
9 in the state-required reporting metrics, including measures
10 related to individuals who are identified as compliant,
11 excluded, or excepted on an ex parte basis.

12 States must implement CE requirements by January
13 1, 2027, and are permitted to implement CE requirements
14 earlier, under the state plan or a Section 1115
15 demonstration. For states who have chosen to implement
16 earlier, Nebraska implemented on May 1st, Montana on July
17 1st, and Iowa is implementing on December 1st. Arkansas
18 has also soft launched CE requirements, which started on
19 July 1st, but won't disenroll individuals for noncompliance
20 until January 1, 2027.

21 Applicable individuals who apply on or after the
22 implementation date are required to demonstrate compliance

1 or be deemed compliant. For enrolled beneficiaries, states
2 must verify compliance with CE requirements upon the
3 beneficiary's first renewal initiated on or after the
4 implementation date.

5 CMS can grant a time-limited good faith effort
6 exemption to states for up to six months, to those who can
7 demonstrate they are making a good faith effort to
8 implement CE but cannot meet compliance by January 1st.
9 For states who receive this exemption, they cannot be
10 extended or renewed beyond December 31, 2028. The statute
11 outlines criteria for CMS to use when determining whether a
12 state has demonstrated a good faith effort, and CMS will
13 issue a template for good faith effort exemption requests.

14 The IFC estimates that about 10 states will
15 submit one of these exemption requests, but notes that
16 approvals will be limited to states that demonstrate
17 meaningful efforts towards implementation and experience
18 extraordinary, severe, or unexpected issues that hinder
19 their progress.

20 Now moving on to updates since the release of the
21 IFC, and I will start with additional resources that CMS
22 has published.

1 As part of our ongoing monitoring, we have been
2 tracking CMS publications and resources that are supporting
3 states with CE implementation. In July, CMS published
4 outreach materials and templates to support development of
5 state-specific outreach notices, which are available in
6 English and Spanish. These resources include a fact sheet,
7 social media toolkit and graphics, fillable flyer, and a
8 qualitative research communication summary from focus
9 groups that were conducted from four states in early
10 April.

11 In September, CMS published a slide deck, which
12 we have mentioned in our earlier slides, on approaches that
13 states can use to identify individuals who meet medical
14 frailty.

15 Additionally, the IFC noted several areas where
16 additional guidance or resources will be released to
17 support state implementation, which include but are not
18 limited to coordination with exchanges, submitting a
19 request for a good faith effort exemption, and on the
20 intersection with 42 CFR Part 2 and the community
21 engagement requirement.

22 Additionally, we have been tracking two lawsuits

1 that are challenging certain provisions in the IFC.
2 Commonwealth of Massachusetts v. Oz, et al. was filed on
3 July 29, 2026, by 25 states and the District of Columbia,
4 challenging aspects of the IFC's interpretation of the 2025
5 Budget Reconciliation Act's CE requirements, including the
6 interpretation of the medical frailty exclusion definition.

7 On July 29, 2026, the court denied the plaintiff
8 states' motion for a preliminary injunction during the
9 preliminary hearing, and the court's decision set an
10 expedited schedule for a full briefing of merits before the
11 implementation deadline on January 1st. And the hearing
12 for the motion for summary judgment is set for October
13 20th.

14 The second lawsuit challenging the IFC is Taylor,
15 et al. v. Kennedy Jr., et al. and was filed on Friday,
16 September 18th by five Medicaid beneficiaries, six provider
17 organizations, and the City of Columbus. This lawsuit
18 challenges specific provisions in the IFC related to
19 medical frailty exclusion definition, the limitation on
20 self-attestation, prohibition on using claims data older
21 than 12 months to identify medical frailty, and the stable
22 recovery definition for beneficiaries with a substance use

1 disorder.

2 We will continue to track updates on both of
3 these lawsuits.

4 Next I will go over monitoring framework for this
5 analytic cycle. We will be monitoring implementation of CE
6 requirements and specifically four areas related to state
7 implementation and ongoing operationalization of these
8 requirements that are informed by the Commission's work on
9 CE requirements to date and key themes that we identified
10 in the IFC comment letters.

11 These areas are state readiness for
12 implementation, which includes IT system updates and
13 programmatic and operational changes; medical frailty,
14 including state approaches to identifying individuals who
15 meet this criteria; beneficiary outreach and awareness
16 around these new requirements; and monitoring of federal
17 and state reporting requirements.

18 We will also be tracking publicly available
19 information from reliable sources, including issued by
20 federal agencies, state Medicaid agencies, and national
21 research and policy organizations engaged in researching CE
22 requirements. Additionally, we will engage with

1 stakeholders on a regular basis to stay up-to-date on state
2 implementation.

3 Next we'll continue with an expert panel, and you
4 will have the opportunity to ask them policy-related
5 questions on the IFC. And we will be returning in October
6 to provide an update on CE implementation, including our
7 findings from ongoing stakeholder interview, and we will
8 facilitate a state panel.

9 Now I will pass it on to Janice to introduce our
10 panelists.

11 **### CE REQUIREMENTS IN MEDICAID: EXPERT PANEL**

12 * JANICE LLANOS-VELAZQUEZ: Thanks, Linn.

13 Can I get the panel slides? Okay. There you go.

14 As we just discussed, the interim final rule
15 provided states with -- sorry about that -- with needed
16 guidance for implementing CE requirements. To provide
17 insight into how states are using the IFC and where further
18 guidance might be needed, we're excited to have two expert
19 panelists joining us today.

20 Today we have Jack -- with us, we have Jack
21 Rollins, the Director of Federal Policy with the National
22 Association of Medicaid Directors, and Lora Saunders, the

1 Associate Principal with Health Management and Associates.

2 There they are.

3 Commissioners received their bios in your meeting
4 materials, and thank you both so much for joining us today.
5 I will pass it to Linn to moderate the questions.

6 * LINN JENNINGS: Thanks, Janice. Thank you both
7 for being here.

8 So the first question is, the IFC provided
9 guidance CE implementation, including demonstrating
10 compliance, definitions for certain specified excluded
11 individuals, and verification processes. In addition, CMS
12 released a slide deck on identifying medical frailty. How
13 are states using this information to implement CE
14 requirements?

15 And, Jack, can you kick us off?

16 * JACK ROLLINS: Great. Thank you, Linn, and thank
17 you to the Commission for the opportunity to come here and
18 represent some of the perspectives of Medicaid agencies
19 that are implementing these requirements.

20 So CMS has provided states with an array of
21 resources, including the publicly available resources that
22 were just reviewed.

1 I'll start with medical frailty. The medical
2 frailty slide deck is a very helpful resource for states to
3 better appreciate the types of frameworks that can align
4 with CMS policy on the verification of medical frailty
5 determinations. I think it is worth emphasizing, as CMS
6 did in the deck and in their discussions with states on the
7 deck, that this is one option. It is not a requirement for
8 states to replicate this type of framework or the
9 methodology in it, but it is intended to be an illustrative
10 example of how states could operationalize.

11 I think some elements that are really valuable in
12 there include the centrality of ex parte as part of the
13 medical frailty process, as the statute and regulation does
14 envision states maximizing the use of automated data
15 sources as much as possible throughout the verification of
16 medical frailty and CE writ large.

17 The discussion of the types of data sources that
18 can support those ex parte processes is also very valuable,
19 including claims data, pharmacy data, health information
20 exchange data, and other types of information, as well as
21 the overall discussion around frequency of verification and
22 advice regarding the sequencing of medical frailty compared

1 to other types of exclusions to minimize the potential need
2 for seeking additional documentation to kind of streamline
3 the overall operations of this.

4 I think stated in a different way, just medical
5 frailty being one of the last elements the state might look
6 to, as there are other exclusions in the statute that might
7 be more readily verified. So that's, I think, from a
8 sequencing standpoint, really helpful for states.

9 We do anticipate that states will be utilizing
10 this information, particularly some of those clinical
11 examples around how different circumstances can manifest in
12 this type of framework, to inform their own approaches.
13 But we also expect that, like overall implementation of
14 community engagement, medical frailty will be an area that
15 will be iterated on throughout 2027, continuing to be a
16 dynamic process.

17 In addition to the medical frailty information,
18 CMS has also provided states with a lot of information on
19 other important aspects of implementation, such as overall
20 process flows and sequences and verification hierarchies,
21 particularly as states work through identifying individuals
22 who are specified excluded individuals versus applicable

1 individuals and the order of operations from a policy and
2 workflow perspective to sequence those determinations.

3 CMS has also provided states with information
4 around how managed care organizations can assist with
5 overall CE implementation, mindful of some of the statutory
6 requirements around that, and there's information provided
7 to states around how to really overall assess systems
8 readiness and functionality. That has been a central area
9 of focus in frequent engagements between CMS's data and
10 systems group and state chief information officers and
11 overall systems leads.

12 Additionally, and also in that kind of systems
13 bucket, CMS has provided states with an array of technical
14 information and technical assistance on data that will be
15 incorporated into the Federal Data Services Hub, which will
16 be an important touchpoint and amplifier for those ex parte
17 processes and by facilitating access to data that states
18 might otherwise be challenged to negotiate and secure on
19 their own. We expect that that will also be an additional
20 layering feature as more types of data get incorporated
21 into the Federal Data Services Hub, which in turn imparts a
22 12-month timeline for states to access that data, either

1 directly through the hub or through other mechanisms.

2 But stepping away from those specific examples, I
3 think broadly speaking, these resources are really
4 supporting states continuing their overall work around
5 iterating and refining their policy and operations for
6 successful implementation.

7 I really want to underscore the dynamism of this
8 process, and we do look forward to continuing collaboration
9 with CMS throughout 2027 and applying additional learnings.

10 LINN JENNINGS: Thank you.

11 And Lora?

12 * LORA SAUNDERS: Yes. Thank you.

13 I would agree with everything that Jack said, and
14 really I think in terms of how states are using the
15 information that's been provided so far, that we're already
16 seeing at least a couple of states actually adopting that
17 three-tier approach that CMS did provide in its most recent
18 guidance in that PowerPoint presentation, so just seeing
19 them kind of automatically look at how they might be able
20 to consume that information and really make it practical
21 based on their existing resources, processes, policies, and
22 those sorts of things.

1 States are still having to make some degree of
2 educated guesses around where there's not an exact process
3 going forward, so seeing that they are really looking to
4 the policies, systems, and process changes that need to be
5 ready and kind of working within the structures that they
6 have in place to try to kind of retrofit some of those
7 policies that have been put forward, both in H.R. 1 and the
8 subsequent IFR.

9 We are seeing states leveraging those existing
10 resources, processes, algorithms, as well so that states
11 are identifying the types of data that they need, the
12 sources that they have access to already in order to put
13 together a system that is going to be compliant come
14 January 1st.

15 And then, particularly for the medically frail
16 conditions, we're seeing states that are leveraging
17 existing medically frail processes, those alternative
18 benefit plan, medically frail designations and conditions
19 that already existed. And they're looking to other states
20 that might have those processes in place to also help
21 identify how they might be able to practically move
22 forward.

1 We're also seeing states really relying very
2 heavily on self-attestation and manual processes for 2027.
3 So kind of using that as a temporary workaround for the
4 lack of time going into this policy and process change to
5 try to just sort of make sure that they are compliant with
6 the federal law come January 1st, while also trying to
7 minimize some of the burden or work around some of the kind
8 of in-development types of system changes that need to
9 occur for long-term sustainability.

10 LINN JENNINGS: Thank you.

11 So, in addition to CE, states are implementing
12 other eligibility-related changes, including the six-month
13 redetermination requirement for the new adult group. Can
14 you discuss how these overlapping policies affect CE
15 implementation?

16 And, Lora, do you want to start?

17 LORA SAUNDERS: Sure. So, really, for starters,
18 it does increase the complexity to both explain the policy
19 changes and administer them.

20 So communication challenges are probably top of
21 mind for me in the type of work that I do. So in the midst
22 of trying to explain the basics around the new community

1 engagement requirements, who they impact, how they work,
2 who it applies to, they are also having to communicate that
3 the verification process is going to happen more often. So
4 it's just an extra layer of complexity for people, and then
5 that leads into the actual administrative challenges that
6 are coming.

7 So you've got the impact on state staff and
8 vendors, including managed care organizations, that are
9 dealing with what will likely be a more manual eligibility
10 verification process more frequently. So that is going to
11 increase the day-to-day burden for, like, the case managers
12 who are handling the eligibility and enrollment processes
13 within the state.

14 In addition to the six-month, you have other
15 competing priorities, like SNAP error rates. So, on top of
16 implementing an entirely new eligibility criteria, you also
17 have states and many of those same workers who are doing
18 Medicaid eligibility also having to work on things like
19 SNAP error rates because of the financial implications for
20 upcoming penalties related to the SNAP error rate. So it's
21 kind of a double and triple whammy for the same eligibility
22 workers to make sure that they are entirely ready to go

1 with all of these new policies, processes, that they can
2 explain it, that they can implement them. And so the
3 eligibility workers are kind of being pulled in different
4 directions on this.

5 And then, the ex parte rates, which Jack was
6 talking about in the previous question, are also going to
7 be incredibly important. So, to the extent that states can
8 leverage the available electronic data and verify
9 compliance instead of having to manually touch each case,
10 that will be critically important to reducing some of the
11 new potential administrative burden on states.

12 And we are seeing that even in some states,
13 they're using the electronic information to help verify
14 eligibility, but then they are still requiring that
15 eligibility worker to do kind of the final touch to say,
16 yes, in fact, this person is eligible. So that still is
17 kind of creating that additional bit of friction and
18 additional burden. So, to the extent states can truly
19 fully rely on the available information as reliable and
20 reduce some of that administrative burden, that will be
21 critically important just from both the community
22 engagement and the more frequent verifications perspective.

1 Then you've got the beneficiaries perspective.
2 So they're going to be getting more frequent notices, more
3 requests for information, and then greater potential for
4 them to lose coverage because of both the community
5 engagement and the more frequent checks. So it's likely
6 going to result in more procedural terminations. Longer
7 application processing times could be a major challenge.

8 We are seeing some states that are hiring
9 additional staff to help support these functions, and it
10 will remain to be seen just in terms of how -- whether or
11 not that increase in staff is truly sufficient to meet the
12 new need, given potential questions and concerns and need
13 for additional processing.

14 LINN JENNINGS: Thank you.

15 Jack?

16 JACK ROLLINS: Thank you.

17 So I'd like to start with just kind of an
18 inventory of the different eligibility policy changes, so
19 kind of in some ways, reiterating the framing of the
20 question and some of the things that Lora covered.

21 But, in addition to the six-month renewals, we
22 are also seeing some changes to retroactive coverage

1 periods in both expansion populations for Medicaid, non-
2 expansion populations in Medicaid as well as options in
3 CHIP, and, also, nearer term, coming up actually at the end
4 of this month, starting on October 1st, some changes to
5 federal match availability for certain immigrant
6 populations, which will also have effects on eligibility
7 for those populations.

8 So the way that we have been conceptualizing all
9 of this is that it's best understood as kind of a layering
10 effect across different parts of Medicaid policy,
11 operations, and communications. And I think it's worth
12 emphasizing that when we talk about layering effect within
13 those domains, they are very much interrelated, and we at
14 NAMD along with CMS have really been working to ensure that
15 these things are tackled together in a disciplinary
16 approach and mitigating the potential for silos or
17 miscommunication across different functional areas. And
18 I'll talk a little more about that in a future question.

19 But in terms of the policy areas, the big piece
20 that we're navigating is overall understanding and
21 clarification of each individual policy area, so community
22 engagement, six-month renewals, and other changes, and the

1 identification of the interrelated effects of those
2 policies and how one might affect the other.

3 I think the most obvious example, of course, here
4 is the community engagement requirement and the six-month
5 renewal requirement generally applying to the same
6 population. This has been an ongoing area of conversation
7 and collaboration with CMS, probably one of the earliest
8 things that we were navigating with them.

9 There's also been discussion around communication
10 engagement as it applies to retroactive coverage periods.
11 So that's another area of focus and attention.

12 But, as we think about this from kind of policy
13 clarification directly informing state operational
14 decisions and systems needs, again, close coordination
15 between policy and systems leaders within the states, as
16 well as for many states, their vendor partners. Not every
17 state operates their E&E system through a vendor, but most
18 do.

19 I would also include in there, to the point that
20 Lora was making, the training and communications for
21 frontline eligibility workers, just applying these array of
22 different eligibility policy changes. And in E&E, we have

1 been paying close attention to how states have structured
2 their eligibility function, whether it is embedded in the
3 Medicaid agency, a sister state agency, whether it is in an
4 integrated eligibility system environment, so the same
5 caseworker handling other health and human services
6 programs, to Lora's point around SNAP, or as well as states
7 that have eligibility at the county level, so different
8 permutations with different challenges to account for in
9 each of those. And we're kind of paying close attention to
10 each of those pieces.

11 And then to wrap up on the communications front,
12 states are really applying a lot of the lessons that were
13 learned in the unwinding efforts from a few years ago
14 around what is most effective in terms of communications
15 modalities and the messengers that can be most effective
16 for reaching Medicaid members and communities.

17 We're seeing a lot of creative approaches here,
18 both kind of taking things that worked well in unwinding.
19 One example is there's a state that has actually hired a
20 well-known state kind of TV personality to be part of their
21 trusted messaging framework. Several states adopt a road
22 show approach where state Medicaid leaders really travel

1 throughout the state, county to county, to create a direct
2 person-to-person accessibility to talk about these changes
3 and what they mean.

4 I also want to emphasize that some of the things
5 that we navigated on unwinding, particularly around the use
6 of text messaging as an acceptable modality which required
7 some engagement between CMS and the Federal Communications
8 Commission, remains in place. We don't need to solve for
9 some of those federal pieces, and states can really take up
10 that communications modality and incorporate it directly
11 into their communications campaigns.

12 So we expect there's going to continue to be a
13 lot of iteration around this as well as we continue to
14 identify those trusted messengers working with managed care
15 plans and the messaging that they can provide to their
16 enrollees and just many other pieces and particularly as we
17 see how CMS continues to evolve its own communications
18 toolkit.

19 We expect that this layering approach of policy
20 systems and operations and communications is just going to
21 continue to be something that is overall iterated on
22 throughout 2027. I think that you'll probably hear me say

1 this many times throughout the course of our conversation
2 today, but none of this is static. All of this is dynamic.
3 And I think our members are approaching this from a method
4 of learning and updating implementation plans based on what
5 we see.

6 LINN JENNINGS: Thank you.

7 So what are areas where states need further
8 clarification to implement by January 1st?

9 Jack, can we start with you?

10 JACK ROLLINS: Sure. This is a great question.

11 So I would say CMS is -- again, I want to start
12 with saying that CMS has been providing a lot of good
13 information to our members, but as we look ahead to
14 additional things that our members would find really
15 helpful as they head towards the January 1, 2027,
16 implementation date, first, looking for final state plan
17 amendment templates for effectuating the community
18 engagement requirement. CMS did make state plan templates
19 available through the Paperwork Reduction Act portal. So
20 that work is underway, just awaiting, essentially, the
21 crossing of the T's and the dotting of the I's for the
22 information. States will need to apply through their SPAS.

1 We also are looking forward to additional
2 information on the good faith effort extension process for
3 states that might be interested in utilizing that process.
4 The IFC does describe some of the kinds of parameters that
5 CMS would consider there. I think that there's a lot of
6 linkage here, particularly around systems functionality to
7 this, but I think getting a little more granular on what
8 that can look like would be valuable for our members.

9 Similar to the SPA issue, we're also just looking
10 for the final data reporting elements and templates.
11 Similarly, CMS made those available through the Paperwork
12 Reduction Act process and portals. The states have been
13 able to see what CMS is proposing on that front. Again, as
14 MACPAC staff covered, the IFC does have some detail around
15 what those measurements are going to look like. So I
16 would, again, characterize that as more just waiting for
17 finalization, but not necessarily expecting a lot of change
18 on that front.

19 I think our members would really benefit from
20 additional information on some of the short-term hardship
21 exception processes, particularly around the noticing
22 requirements, because there's an array of noticing

1 requirements specific to those short-term hardship
2 exceptions, particularly two of the four which require the
3 member or the individual to take a proactive action, so
4 just thinking about what that will look like and embedding
5 into existing noticing systems, as well as the way to make
6 that clearly understandable so members are aware of the
7 options that are available to them and how they can take
8 action.

9 We are also just directly following from the
10 question previously to this one, the continued attention to
11 those overlapping eligibility changes and just making sure
12 that state subject-matter experts and CMS are really having
13 robust and detailed conversation around those policy
14 interactions and associated operational interactions to
15 implement them.

16 The last thing that I would say, which is a
17 little more forward-looking than January 1, but our members
18 are very focused on the future audit environment and
19 expectations for audit processes going forward,
20 particularly how the community engagement implementation
21 will play out in the payment error rate measure, or PERM
22 process.

1 We are mindful that in FY 2030, under the
2 statute, there will be some changes to the eligibility
3 component of PERM processes, and with community engagement
4 being a significant eligibility change, I think our members
5 are really looking to CMS for more information on how the
6 CMS Office of Financial Management that conducts the PERM
7 process will be thinking about the incorporation of CE into
8 some of the sampling for that PERM process.

9 But PERM is not the only audit process. We are
10 also thinking about CMS's own audits that might be
11 eligibility audits, for example, as well as other
12 priorities from the Center for Program Integrity, HHS
13 Office of the Inspector General, and other federal
14 oversight entities.

15 LINN JENNINGS: Thank you.

16 Lora?

17 LORA SAUNDERS: Certainly, the concept of kind of
18 that good faith effort and long-term auditing was top of my
19 mind as well. So just thinking that, you know, medically
20 frail remains probably one of the biggest and most complex
21 challenges that states are facing right now. So I think
22 they are having to move forward with the information that

1 they have. So I don't know that a lot of additional
2 clarification is necessarily going to be helpful at this
3 point in terms of if it's shifting the direction that
4 states are already going.

5 So I think to the extent there are additional
6 models that CMS can provide to states to give them
7 additional ideas on how they can use and leverage existing
8 policies and processes and concepts that they already have
9 going as an option, that that makes sense, and to the
10 extent there can be some reassurance from CMS that the
11 direction that states are going is not going to be putting
12 them on the hook for future auditing or jeopardizing future
13 federal funding, I think is important. So just kind of
14 those additional flexibilities for states, additional
15 assurances that they're not going to be penalized, I think
16 would be helpful kind of for the remaining time.

17 LINN JENNINGS: Thank you.

18 So, Jack, there's limited publicly available sub-
19 regulatory guidance on implementation. How are states
20 receiving information on areas where they do need this
21 additional clarification?

22 JACK ROLLINS: Great. Thank you for the

1 question.

2 And this is where some of the models that NAMD
3 and CMS developed early in the COVID-19 public health
4 emergency that continued through unwinding are really
5 serving us well. And the one that I would point to as a
6 central mechanism is what are now weekly meetings that NAMD
7 is convening between Medicaid agency staff and CMS every
8 Friday afternoon, regularly seeing an average attendance of
9 over 300 staff, so very fulsome conversations, highly
10 collaborative, highly engaged discussion.

11 This has been very effective for us. Again, it
12 started during -- early in the COVID-19 public health
13 emergency, and we've been pleased to be able to replicate
14 that. It is a place where that has been effective both for
15 developing the working relationship and familiarity between
16 state subject-matter experts and CMS. We have a really, I
17 would say, very collegial and informal vibe on that call,
18 if you will. But it's also been a great place for
19 collective issue spotting and problem solving, so an array
20 of eligibility scenarios and complexities that have been
21 worked through, thought through, and really helped states
22 get clarity at a much more granular level than what CMS

1 might be able to necessarily turn around in a more public
2 sub-regulatory guidance with its associated timelines for
3 development.

4 CMS has also been sharing information directly
5 with state Medicaid agencies and Medicaid leaders. I made
6 some reference to some of those earlier, including some
7 slide decks and technical information around verification
8 and systems readiness supplements.

9 But another thing that I would emphasize here is
10 that in addition to that CMS workgroup, NAMD maintains what
11 we call our "affinity group model," which brings together
12 functional leaders across Medicaid. So we bring it
13 together for financing and CFO leaders, IT and chief
14 information officers, eligibility leaders, and
15 communicators. Those are mechanisms that we use internally
16 at NAMD to build peer learning across those Medicaid
17 functions.

18 But we also don't approach that from a siloed
19 perspective. So, as I was talking about earlier, the
20 interdisciplinary frameworks that are so important for
21 successful implementation of Medicaid policy change, we aim
22 to engineer through those affinity groups.

1 We actually brought those groups together in
2 person earlier this year in March. That really amplified a
3 lot of that interdisciplinary approach.

4 We've also used those groups to bring in CMS
5 subject-matter experts. So, for example, leaders from the
6 CMS financial management group come to speak to the CFOs,
7 or we have leaders from CMS's digital services group come
8 to speak to our CIOs. So there are additional mechanisms
9 that bring really a matching of subject-matter expertise at
10 the state and federal level to get really into the weeds on
11 all things that are necessary for effective implementation
12 of CE.

13 We are really appreciative of how this
14 collaboration has worked with CMS thus far. It's, in our
15 view, produced really actionable dividends.

16 LINN JENNINGS: Thank you.

17 Lora, we reviewed our monitoring framework with
18 the Commissioners, and one of the areas we're focusing on
19 is beneficiary outreach, which states must send by
20 September 30th if they're implementing on January 1st. Are
21 there requirements related to beneficiary compliance,
22 exclusion, or exceptions that are particularly important to

1 communicate to beneficiaries to start building awareness?

2 LORA SAUNDERS: So I definitely think that all of
3 the requirements, the compliance, the exclusion, the
4 exception, are critical to communicate to beneficiaries to
5 start building awareness.

6 I think the nuances of exclusion versus exception
7 are probably a little bit in the weeds for beneficiaries,
8 just letting them know, you know, are these requirements
9 potentially going to impact you, like, are you in the
10 Medicaid expansion population is a critical piece of
11 information that they're going to need to know, and then
12 are they going to need to meet that hours or income
13 requirement or not is kind of the other big piece.

14 So what we've been seeing is states have launched
15 community engagement-focused webpages, and a fairly
16 significant handful of states have also put out preliminary
17 screening tools to kind of help people walk through some of
18 the different criteria to identify whether it may or may
19 not apply to them or, perhaps, you know, if they would be
20 eligible for an exception or an exemption. So I think that
21 those are kind of the building blocks for some of that, the
22 building awareness and outreach.

1 I think states are generally encouraging anyone
2 who is visiting those websites to sign up for alternative
3 communication methods. Jack had mentioned a couple of
4 those. I think text and email are some of the most common
5 so that it's not fully reliant on those paper notices.

6 And then also encouraging people to create an
7 online account. So if they don't have one already, it is
8 encouraging them to, you know, create a portal, create some
9 other electronic way for the state to communicate with
10 them. So, again, it's not 100 percent reliant on USPS mail
11 getting into that person's hands opened timely and read and
12 understood, and then that could help give the state
13 additional avenues to engage with beneficiaries.

14 I think there are potential challenges with
15 reliance on those things, just in that the beneficiaries or
16 potential beneficiaries need to know that those websites
17 exist. So I think that just kind of pushing people to
18 those websites is an initial challenge, and then having
19 people savvy enough to search and find them, if they're not
20 already being directed there by some other social media
21 post or notice or something like that. So they're not
22 necessarily always intuitive or easy to find. So the

1 information that's there is kind of giving the basics, but
2 as of right now, it is still a little bit early from a
3 beneficiary perspective. It's not necessarily giving kind
4 of that process information that people are really going to
5 need to have in order to get from kind of a basic, "Okay, I
6 understand that maybe it does apply to me. Now, what do I
7 need to actually do? What proof do I need to have?"

8 And states have been taking some different
9 approaches in terms of kind of preliminarily what level of
10 detail they are providing people. Ohio was probably first
11 out of the gate with information around these are the
12 documents that we would accept as proofs to just kind of
13 give people an idea of what they might need to have ready
14 and in hand.

15 But I think kind of coming back to Jack's point
16 too about the lessons learned from unwinding, but this is
17 even more challenging, is just the very basic concept of
18 having somebody understand, one, that they're on Medicaid,
19 because I think a lot of the time there are challenges
20 around somebody has their Molina, their Aetna, their
21 Elevance card, and so, you know, as far as they're
22 concerned, that is their coverage. They're not necessarily

1 connecting it with Medicaid. Even if they are, if the
2 state is telling them, you have Medicaid, they don't
3 necessarily know that they're in the expansion adult
4 population.

5 We have seen a couple of states, I think, kind of
6 building off of some of those lessons learned from
7 unwinding. We are seeing some states that are trying to
8 put some designation factors on their individual member
9 cards or the envelopes to help people understand this does
10 apply to you, there is something special going on here. So
11 that can be a help.

12 I think some of the model notices I've seen, it's
13 been a little bit of a mix in terms of just how specific it
14 is. So a lot of the model notices I've seen are a lot more
15 general of, like, this may apply to you if under these
16 conditions. And so it's still relying on the person to try
17 to figure out does that apply to them without necessarily
18 giving a specific.

19 So I think moving some of that language away from
20 you may be to you are subject to this and then kind of
21 trying to help walk them through exemptions or options for
22 compliance is really going to be critical. So I think

1 first step is getting them to understand who, the very
2 direct, immediate individual who is an applicable
3 individual here.

4 Other than that, I think it's critical that we
5 not forget to engage managed care organizations and
6 providers. So I think there is some engagement with
7 managed care organizations. It sounds like providers still
8 are not quite sure what to do, how to engage, and this is
9 particularly important related to medically frail and
10 particularly for 2028 and beyond.

11 So going back to the idea of a lot of states
12 relying on self-attestation for that first year, they don't
13 necessarily need the providers to be as engaged in a
14 medically frail designation for that first year because
15 people can generally attest to that, but then going
16 forward, needing to make sure that providers are very on
17 top of, what are the conditions that can kind of help
18 somebody become medically frail, can you identify somebody
19 as medically frail if they don't know that they are
20 themselves kind of thing, and just how do you work that
21 into your process when providers already have so many items
22 that they need to get through during that visit, and then

1 this is one more thing, so just kind of figuring out how do
2 you communicate it to a provider in a way that is not going
3 to further increase the administrative burden on their end.

4 And so I think it is needing states -- or states
5 need beneficiaries to understand the rules. They also need
6 the providers to understand what their role can be within
7 the communication process and awareness process.

8 LINN JENNINGS: Great. Thank you so much.

9 Now I'm going to turn it back to Verlon.

10 CHAIR VERLON JOHNSON: Thank you so much, Jack
11 and Lora. This was very, very helpful to hear on-the-
12 ground information from the folks that you are interacting
13 with at the states, for sure.

14 So I've been seeing fellow Commissioners writing
15 a lot of notes. So I know we have lots and lots of
16 questions.

17 But I'd just like to start with, I love idea,
18 particularly Jack, of what you talked about with the NAMD
19 meeting with CMS, making sure that you all are very much
20 aligned with what the issues may be and how to address
21 that.

22 I also love, Lora, what you said about making

1 sure the providers are very much into it as well.

2 I would also argue, though, that vendors who are
3 actually helping with so many systems should be very much
4 engaged, and very good to hear, too, that CMS has really
5 reached out to them as well. So all these different
6 entities really make up the Medicaid ecosystem. It's
7 important to make sure we're all lockstep and all that for
8 sure.

9 So, with that, let me first turn to Angelo. It
10 looks like he has his hand up.

11 COMMISSIONER ANGELO GIARDINO: Thank you, Verlon.

12 And thanks to the panel. This was really
13 informative.

14 I come to this work from experience with quality
15 improvement, where we use words like "iterate" and
16 "dynamic" a lot. Sometimes we use "chaos," too, because
17 that's what that sometimes means.

18 But, in that environment, there's kind of a just
19 culture or there's a spirit of collegiality where we're
20 going to realize that people might do something but get it
21 wrong, but in good faith do it, and then just make a
22 correction. So then when I hear the word "auditing" is

1 coming, I worry about regulators. I worry about providers
2 and clinicians. I worry about other stakeholders, because
3 I watch all the networks, and I see a lot of talk about
4 waste, fraud, and abuse.

5 So, in this iterating, dynamic world where people
6 are really trying to get it right, but there isn't a firm
7 stance on this or that, so you have to kind of make the
8 best choice, make a judgment, what are the protections or
9 what have the discussions been around the protections for
10 folks in this 2027 iterating year? And will folks in good
11 faith make decisions and then providers will find out that
12 they can't get reimbursed or regulators will find out that
13 now they're accused of waste or abuse? So what have been
14 those discussions? If you could just give me your
15 thoughts.

16 JACK ROLLINS: I'm happy to start from kind of
17 the state Medicaid agency perspective, and I appreciate the
18 question because I did note -- I think my remarks initially
19 surfaced on the audit pieces.

20 I think we do recognize that across different
21 domains of community engagement, implementation, there are
22 still areas where policies are continuing to be iterated,

1 and operational decisions may, particularly from a system
2 standpoint, need to be made prior to having complete
3 clarity on the policy. That is a dynamic that our members
4 are working through with CMS, and I think in all parties
5 involved in those conversations are well aware of those
6 dynamics and what they entail.

7 So what I anticipate we will be seeing is states,
8 particularly those that are operating or making those
9 decisions that kind of pre-configure the full policy
10 environment or understanding, just documenting those
11 decisions and maintaining that documentation and just
12 having that, whether it is correspondence with CMS that can
13 then be made available to an auditor in a future period or
14 internal process manuals, things of that nature, is where I
15 think that states are going to be putting a lot of their
16 focus and attention.

17 We could see, particularly as we see maybe a good
18 faith effort process roll out or other processes like
19 additional more formal correspondence from CMS, but we're
20 not quite there yet. I think that we are still currently
21 in very much the heads down, let's focus on what is
22 necessary to implement, and just make sure that we have a

1 good documentation of point in time, this is our
2 understanding of the policy, this is our intentions for
3 implementing that policy as of a date certain.

4 COMMISSIONER ANGELO GIARDINO: Thanks.

5 Lora, did you have any thoughts?

6 LORA SAUNDERS: So I think I agreed 100 percent
7 with what Jack said, and I think just to kind of add to
8 that, the stipulation that with the self-attestations, it
9 is being done under penalty of perjury, so just kind of
10 trying to add that extra layer of assurance that somebody
11 can't just say whatever, that it does need to be a truthful
12 statement on the beneficiary's behalf as well.

13 COMMISSIONER ANGELO GIARDINO: Thank you.

14 CHAIR VERLON JOHNSON: All right. Thank you.

15 So Jami, Heidi, and then April.

16 COMMISSIONER JAMI SNYDER: Jack, Lora, thanks so
17 much for joining us today. This has been a great
18 discussion. I have six questions.

19 CHAIR VERLON JOHNSON: One at a time. One at a
20 time.

21 COMMISSIONER JAMI SNYDER: Okay. One at a time.
22 Most of them are focused on states' approach, given some of

1 the flexibilities that are offered under the CE framework.

2 So the first question -- and I'll open all of
3 them up to both of you -- is are all states electing to
4 provide the hardship exceptions that are detailed in the
5 rule?

6 JACK ROLLINS: No.

7 COMMISSIONER JAMI SNYDER: Do you have a sense of
8 the number or percentage of states that are?

9 JACK ROLLINS: We don't have a great line of
10 sight at the NAMD level, but I think that the factor that
11 is affecting that decision is the requirement in the IFC
12 that all of the short-term hardship exceptions need to be
13 adopted or not. I think that is one of the factors that's
14 kind of influencing that decision point.

15 COMMISSIONER JAMI SNYDER: That makes sense.
16 That makes sense.

17 LORA SAUNDERS: And from --

18 COMMISSIONER JAMI SNYDER: Oh, go ahead, Lora.

19 LORA SAUNDERS: Oh, sorry. I was going to say,
20 just from the tracking perspective, it does look like the
21 bulk of states that I've seen so far are adopting all of
22 the short-term exceptions, but we do have a handful,

1 probably about three or four so far, that look like they're
2 not.

3 COMMISSIONER JAMI SNYDER: Okay. That's really
4 helpful. Thank you.

5 And then I'm curious, too, to know whether you
6 have a sense of the number of states that are choosing a
7 longer look-back period, both at initial eligibility and
8 redetermination.

9 LORA SAUNDERS: That is also a much smaller
10 number. So fewer states are choosing a longer look-back on
11 initial application. There are a couple more states that
12 are doing a longer look-back for redeterminations.

13 COMMISSIONER JAMI SNYDER: Okay.

14 LORA SAUNDERS: And so far, I have not seen
15 anything over three months' look-back, but like Indiana is
16 doing a three-month look-back with a quarterly check.

17 COMMISSIONER JAMI SNYDER: Okay.

18 LORA SAUNDERS: So theirs is effectively every
19 month, but I think theirs is the most frequent.

20 JACK ROLLINS: And I think it is worth
21 emphasizing for that look-back at renewal that those don't
22 need to be continuous months. If your look-back is two

1 months, for example, it can be two months but not adjacent
2 months in that six-month period.

3 COMMISSIONER JAMI SNYDER: That's a great point.
4 Great point. Thank you for that.

5 Number three. So I know CMS is estimating that
6 10 states are going to take advantage of the extension, the
7 good faith extension option. Do you have a clearer sense
8 of what that might look like? And I'm asking because,
9 clearly, if they're going live on January 1, those notices
10 need to go out by the end of this month.

11 JACK ROLLINS: So we are not hearing of a great
12 number of states that are at this point intending to seek
13 good faith effort extensions. I think it continues to be a
14 live topic of conversation, that I think that the majority
15 of our members are really focused and operating on the
16 assumption that January 1 is going to be their effective
17 go-live date.

18 COMMISSIONER JAMI SNYDER: Okay.

19 Lora, I think your --

20 LORA SAUNDERS: Yeah. I have not heard of any
21 states that are actively pursuing it. and I think, like
22 Jack said, that all that I've heard of are assuming January

1 1, 2027.

2 COMMISSIONER JAMI SNYDER: And this kind of ties
3 to that question. So are you feeling like states are ready
4 from a systems perspective at this point?

5 JACK ROLLINS: I think that we will likely see
6 some elements of systems that need to continue to have more
7 manual processes while we see that 2027 kind of iterative
8 framework.

9 And to Lora's point throughout these
10 conversations, I think that's where particularly the use of
11 self-attestation will be a mechanism to allow for that
12 ongoing evolution iteration is going to be something that
13 many states will be reliant on.

14 COMMISSIONER JAMI SNYDER: That makes sense.

15 And then I'm just curious to know more about what
16 you're hearing from states in terms of how they're
17 verifying educational enrollment and community service,
18 because I know, you know, since we've started talking about
19 this, that's always been a topic of discussion, how you're
20 going to verify those two elements for compliance.

21 JACK ROLLINS: Lora, do you want to jump in
22 first?

1 LORA SAUNDERS: So my understanding is that for
2 education, there's an anticipation that the school itself
3 is going to be able to provide some sort of written
4 verification of whether the person is halftime or not.

5 For the volunteering piece, that still seems like
6 a very manual process from what I've been seeing. I think
7 there is one state that is working on kind of creating
8 basically a statewide type of a database that multiple
9 volunteer organizations that are eligible under the IFC
10 could kind of tap into and help with reporting. But that
11 one, to me, still seems kind of very manual, very
12 individualized, unfortunately.

13 JACK ROLLINS: I would concur with the assessment
14 around kind of the community service and volunteer
15 activities, and that is probably one of the more complex
16 areas for gathering data.

17 To build on the educational piece, CMS is likely
18 going to be incorporating into the Federal Data Services
19 Hub, the information from the National Student
20 Clearinghouse, which I think will be an effective
21 mechanism.

22 There are a couple of things to navigate on kind

1 of the role of individual consent for that information.
2 There's different federal statutes of, I believe, FERPA. I
3 can't say -- don't recall what the acronym stands for, but
4 that is the governing statute that does have more stringent
5 consent requirements than other data that states might be
6 leveraging. But that is going to be a mechanism that we
7 expect will be available.

8 COMMISSIONER JAMI SNYDER: Yeah. And I would
9 imagine on the community service side; we're going to see
10 some progress over the course of 2027 in terms of how
11 states are able to work with vendors to document that type
12 of compliance activity.

13 And my final question, I promise, and to both of
14 you, what would be most helpful -- and this is a question
15 we always like to ask when we have these discussions. What
16 would be most helpful in terms of work that MACPAC could
17 do, given that we're so close to go live? How can MACPAC
18 support states as states approach that January 1 date?

19 JACK ROLLINS: I really appreciate that question.

20 I would maybe kind of pick up the piece around
21 data and data sources to help enhance the use of ex parte.
22 That, to my mind, is something that states would really

1 benefit from, particularly if there are federal data
2 sources or other data that could be incorporated into the
3 Federal Data Services Hub to make a more streamlined
4 process for states to access that data and mitigate the
5 need for states to negotiate individualized arrangements or
6 otherwise identify things.

7 And I think it might be helpful as well to just
8 have a scan -- to the extent that this feels feasible for
9 MACPAC, scans of the types of data that might commonly be
10 available at the state level that states could also
11 consider. But that, to my mind, would be extremely
12 valuable.

13 COMMISSIONER JAMI SNYDER: Super helpful. Thank
14 you, Jack.

15 Lora, anything on your end?

16 LORA SAUNDERS: I definitely think anything that
17 can help ex parte processes would be critical. And then I
18 think just to the extent that there could perhaps be
19 additional sharing between states around medically frail
20 and the different algorithms that they are using, kind of
21 what the preliminary results might be, just in terms of how
22 effective they are. You know, to the extent that you can

1 help identify some particularly effective algorithms and
2 help other states perhaps adopt them, if not right away
3 then as a part of that iterative process, what has been
4 most effective, what can kind of hold up to the validation,
5 the verification, the potential audits down the road I
6 think would be very helpful, as well.

7 COMMISSIONER JAMI SNYDER: Great. And that
8 concludes my question. Thank you so much.

9 CHAIR VERLON JOHNSON: For now it does, right?
10 Just real quick, though, are you hearing anything from the
11 early adopters yet, or is it too early to hear anything for
12 the states who are doing it before?

13 JACK ROLLINS: I don't think we are in a good
14 position to offer a lot of specific insights there.

15 CHAIR VERLON JOHNSON: Yeah, that makes sense.
16 We will look forward to hearing it when you do, so that
17 would be great.

18 All right. Next up we have Heidi.

19 COMMISSIONER HEIDI ALLEN: Thank you so much for
20 being here today. It has really been helpful listening to
21 you. I have a couple questions too. One, I had a
22 wonderful experience when I was director of the Medicaid

1 Advisory Committee in Oregon, back in my youth, where I
2 spent a couple of days with enrollment workers, and that
3 was quite an education.

4 And I'm curious if, in the affinity groups, that
5 there is any representation from people who would be at
6 enrollment offices, if they have been able to be part of
7 this conversation and talk about their workforce and
8 morale, readiness, et cetera.

9 JACK ROLLINS: Yes. The short answer is yes.
10 The workforce training and overall like hiring strategies
11 and retention strategies have been a perennial topic, and
12 also one that has been revisited.

13 COMMISSIONER HEIDI ALLEN: Great. The other
14 question that I have, it's kind of a question and a
15 concern, which is about this ex parte adjudicated claims,
16 encounter data, and algorithms. I'm a health services
17 researcher who has worked with federal data before, and the
18 first thing, if you were to ask me to give an adjective for
19 that I would say often messy. And I'm curious how clean
20 this data is, how it is going to be verified to make sure
21 that it is high quality data that could be used to
22 determine whether somebody was eligible for medical

1 frailty, specifically. And just thinking about this idea
2 of before the system is in place, manual engagement. Are
3 we thinking enrollment workers would do manual engagement
4 with utilization data? What kind of expertise would they
5 be provided to determine what kind of claims would meet the
6 criteria of medical frailty? Or are we just assuming that
7 on January 1st that for all claims and utilization data,
8 that will entirely be automated?

9 JACK ROLLINS: I'll start but with a caveat that
10 I am definitely not a data expert, so I would love to hear
11 Lora's thoughts on the questions around the data quality
12 pieces.

13 But I think we are continuing to have a lot of
14 conversations, to the point earlier that Lora made, around
15 sharing effective practices on medical frailty. We are
16 doing that, as well, at NAMD. And part of this has been
17 having some states that have been able to present to our
18 own members how they are approaching this from kind of a
19 coding perspective. There are examples that really look to
20 streamline that process, to make it much more of a yes-no
21 flag, from a data automation standpoint, rather than
22 expecting a case worker to have some kind of understanding

1 of navigating clinical data.

2 I think that is what we will likely be seeing
3 here. So yes, definitely this is where the automation
4 element comes in. And this is probably more applicable for
5 renewal or someone already known to the Medicaid program.
6 For a new applicant we are likely going to be seeing things
7 that rely more on screeners that then activate a different
8 type of process.

9 So long story short, automation in ex parte is
10 going to be the starting point, and trying to capture as
11 much as possible there, before we then potentially have to
12 get into more of that looking for other data sources, or at
13 the last step, potential documentation providers, which
14 opens up the pieces around minimizing provider burden and
15 reducing provider operation, which is also very much a part
16 of our conversations.

17 COMMISSIONER HEIDI ALLEN: Lora, do you have
18 anything to add?

19 LORA SAUNDERS: I would say for the states that
20 we have seen so far who have released their conditions
21 lists, three out of the four states have opted for giving
22 very specific diagnostic codes as a part of that medically

1 frail conditions list. So I think, to Jack's point about
2 automate as much as possible, reduce the need for somebody
3 who is not clinical to make clinical decisions, by putting
4 the diagnostic codes on there it really kind of helps take
5 that need for additional assessment out of the hands of
6 somebody who might not be comfortable or trained to do so.
7 I think Montana is the only one who has just kind of done
8 buckets of conditions and not necessarily at least
9 publicized what those exact conditions codes are.

10 So I think, yes, to the extent we can kind of
11 just do a yes/no, you have a condition that is on this
12 list, it does help simplify that process and reduces some
13 of the need for the manual review. And then it comes down
14 to what is the provider doing.

15 CMS, in the IFC, also did give some parameters
16 around what they consider to be reliable, verifiable
17 information. So there are some existing parameters for
18 states to use on what they can reasonably consider to be
19 reliable information and data sources.

20 COMMISSIONER HEIDI ALLEN: Great. And I should
21 probably know the answer to this question, but do you know
22 how all of this intersects with presumptive eligibility?

1 JACK ROLLINS: This is one of the conversations
2 that we have had in that workgroup that I mentioned, and
3 essentially presumptive eligibility is a self-attested
4 process, and that will include self-attestation for CE.
5 That's essentially what that is going to look like. It is
6 going to require updated training materials and ensuring
7 that all the providers that are providing presumptive
8 eligibility activities are aware of what they need to
9 assess for CE.

10 COMMISSIONER HEIDI ALLEN: For pregnancy, for
11 example, that would mean that the provider who is
12 documenting pregnancy would also need to know how to
13 document CE?

14 JACK ROLLINS: Well, in that example --

15 COMMISSIONER HEIDI ALLEN: Or no, they wouldn't?

16 JACK ROLLINS: That would make the individual
17 specified excluded individual.

18 COMMISSIONER HEIDI ALLEN: That would put them in
19 that category. So it would have to be some other category
20 that the doctor would have to be also aware that they meet
21 or don't meet CE requirements.

22 JACK ROLLINS: Most likely. But I think that's

1 something that is being iterated on, as well.

2 COMMISSIONER HEIDI ALLEN: Gotcha. Thank you so
3 much.

4 CHAIR VERLON JOHNSON: Lora and Jack, we have a
5 number of Commissioners that have questions. Can you stay
6 a little bit longer? Is that possible?

7 JACK ROLLINS: I am able to, yes.

8 CHAIR VERLON JOHNSON: Okay. All right.
9 Perfect. With that I want to turn it over to April, and
10 then Carolyn.

11 COMMISSIONER APRIL HARTMAN: April Hartman. I'm
12 from Augusta, Georgia, a practicing pediatrician. And as I
13 hear you talk about this I'm cringing, thinking about the
14 amount of documentation that I am going to have to do to
15 help some of my patients. And it is not as simple and
16 straightforward as just having a diagnosis. I can have a
17 child with cerebral palsy who will be fine to work and
18 carry on, and another with the same diagnosis that it is
19 not. Or it might be a list of multiple diagnoses, none of
20 which are individually severe enough, but because of the
21 combination now they need this coverage and it is going to
22 be important for them.

1 And as they age out of traditional Medicaid and
2 they are looking to apply for this, just making sure that I
3 am documenting everything appropriately for them is going
4 to be a lot. And I just wonder how much conversation there
5 is around some of the complexity around this. I kind of
6 flash back to doing disability exams for the state, and,
7 you know, it was complicated. And I just wonder how much
8 conversation has been around that. I know it is very
9 complex and something we will have to work on.

10 And then the other thing I wanted to ask, and you
11 can just answer real quick, is it sounds like you guys have
12 a really good multidisciplinary group, multiagency group,
13 and you guys are really sharing information with CMS,
14 great, meeting weekly. It sounds like you guys are taking
15 this and shaping policy on the go, kind of doing things as
16 you go, and I just wonder how agencies like ours, like
17 MACPAC is being included in these policy and data sharing
18 things, so that the recommendations we give, so that we are
19 part of this. And I just wonder how that data is being
20 shared with people who are doing a lot of the analysis,
21 such as MACPAC.

22 JACK ROLLINS: Thank you for both of those

1 questions. I will start with your first piece around
2 thinking about the level of documentation that might be
3 necessary. This is something that our members are working
4 through together, and there is very much an awareness that
5 providers do have a lot of existing obligations. We have
6 thought about this in the context of some of the data and
7 quality reporting elements over the years, and certainly
8 thinking about it here.

9 The goal that we have seen from our members is to
10 try and streamline and simplify the process as much as
11 possible. We are seeing states that are beginning to
12 develop one form, a streamlined form that a provider might
13 be able to fill out, that would support any documentation
14 the state might need.

15 But I would also emphasize that step would only
16 be necessary if the states' use of ex parte and other known
17 data sources are not sufficient to verify medical frailty
18 determination. So I think that documentation and
19 requesting for documentation is kind of the last step here.
20 So that is why that emphasis on data, accessible data
21 sources and ongoing dialogue around what is working most
22 effectively from the ex parte standpoint is, in our view,

1 quite important to narrow the universe of individuals that
2 would be expected to have their provider provide that kind
3 of documentation.

4 COMMISSIONER APRIL HARTMAN: Can I just ask, with
5 the speed of how this is happening, do you think that the
6 IT, the technology of the states is going to be such that
7 that can happen? I mean, I guess to me I just see it as
8 it's going to take a while to get there, where we can
9 actively use all these ex parte ways of doing things, and
10 that for the next few years a lot of it is going to have to
11 be manual.

12 JACK ROLLINS: This is where I would emphasize
13 that for 2027, the majority of our members will be
14 utilizing that self-attestation process. That will
15 mitigate the need for that level of documentation requests,
16 which will allow for additional time to help to solve for
17 some of those data access and IT issues. That's where I
18 think the majority of our members are going to be around
19 this, so that come 2028, when self-attestation can only be
20 utilized in the absence of recently available
21 documentation, we are on stronger footing to, again,
22 minimize the burden associated with seeking that

1 documentation.

2 And then quickly to your second point around how
3 is MACPAC engaged. We actually have had the opportunity at
4 NAMD to talk with MACPAC staff about these implementation
5 issues, and we intend to do so ongoing. So that's where we
6 will hopefully be able to provide information to MACPAC
7 staff so that they can keep the Commission well informed.

8 CHAIR VERLON JOHNSON: All right. Thank you.
9 Carolyn and then Michael.

10 COMMISSIONER CAROLYN INGRAM: Thank you so much
11 for hanging in there with us today. My questions really
12 are about how things will affect providers, community
13 organizations like FQHCs, and other nonprofits.

14 One of the questions I had are how are states
15 starting to work with hospitals, FQHCs, other community
16 organizations that did presumptive eligibility, and how are
17 these changes affecting those groups and organizations?
18 Are they still doing those actions? Are they focused on
19 outreach? Do you have any of that information yet, or is
20 it too early to tell? And I have a couple more questions
21 after that, I should say, but that's the first one.

22 JACK ROLLINS: Lora, I know I've been jumping in

1 first. I want to give you the opportunity.

2 LORA SAUNDERS: No, you're fine. I have not seen
3 a whole lot of specifics. It sounds to me like this is an
4 area for opportunity really. It seems like a lot of the
5 time, where I am, the presumptive eligibility is kind of a
6 secondary or back burner conversation. I am also in a very
7 different spot than Jack is in terms of the conversation
8 being had with the states. PE has not really been top of
9 my mind for the type of work that I've been doing.

10 But I think there is the concern from those
11 providers in terms of how they can be engaged specifically.
12 It doesn't seem like there's been as much broader
13 engagement of the provider groups so far. That said, we
14 have seen a couple of localized entities, cities and towns
15 types of entities, who are doing a lot more of that
16 provider engagement, and even community-based
17 organizations, foundations, advocacy group type of
18 engagement, recognizing that oftentimes a lot of their kind
19 of localized economy is very much going to be impacted by
20 the success or failure of Medicaid enrollment and
21 retention. So they are seeing this as kind of like an
22 intentional, personal need to push greater engagement,

1 awareness, those sorts of things. So they are doing more
2 of that provider engagement, just to make sure there is at
3 least a basic understanding of what is coming.

4 JACK ROLLINS: I think wrapping around that I
5 would just go back to some of the conversation and remarks
6 earlier that states are really prioritizing the larger
7 scale policy clarification and operational and systems
8 changes to accompany that. Presumptive eligibility, I
9 think, is a part of that, and there has been some
10 discussion around the PE process and the role of self-
11 attestation in some of those workgroup conversations that I
12 mentioned.

13 But I would generally concur with Lora, that it
14 is probably not the central area of focus for states at the
15 moment. But as we continue to iterate and develop that
16 bigger clarity around overall process and procedure, then I
17 think the capacity and the bandwidth will be opened up to
18 turn attention to those important provider partners and the
19 PE process.

20 COMMISSIONER CAROLYN INGRAM: Thank you for that.
21 And then my next question has to do with how states are
22 sharing back with some of those providers that have the

1 contact the most with the members. So managed care
2 companies, FQHCs again, community health centers, are they
3 sharing redetermination dates back with those organizations
4 so that they can help with education, or how is that being
5 managed? Do you know?

6 JACK ROLLINS: That is a lever that we saw states
7 pull in unwinding, and we do anticipate states will utilize
8 that kind of playbook again, particularly with managed care
9 partners being able to share upcoming renewal information
10 so that plans, in particular, can conduct their own
11 outreach to their enrollees that may be due for a renewal
12 process.

13 I have less line of sight into how states are
14 utilizing those from kind of a provider standpoint, so I
15 can't offer as much on that part of the question.

16 LORA SAUNDERS: Same, likewise. And I think we
17 have heard of at least one state that is not necessarily
18 sharing the redetermination date with providers
19 specifically, but I think by and large we are seeing that
20 data sharing as a strategy for helping vendors understand
21 where they can kind of get involved and help with retention
22 and awareness.

1 COMMISSIONER CAROLYN INGRAM: And then my last
2 question, and I'll go fast, has to do with payment. We
3 know that as people go back to work what the Medicaid
4 program is going to be left with are people with higher
5 acuity, which is the goal. We want people working in the
6 community. But more high risk, more expensive. What are
7 states doing to look at rates that they are paying to
8 providers, to safety net hospitals, to care for these
9 populations if they are asking and expecting more, to
10 managed care companies? Have you all heard anything, any
11 discussion about that yet?

12 JACK ROLLINS: We have had several rounds of
13 conversations, particularly with our chief financial
14 officer affinity group around budget forecasting and
15 enrollment forecasting and expected acuity levels. I think
16 this is going to also be one of those conversations that is
17 ongoing and iterative, and I think that our folks are
18 certainly thinking about how, particularly, 2027 will look
19 compared to 2028, particularly for that piece around self-
20 attestation, and just how indicative the underlying data
21 will be for future rate-setting processes.

22 So I can't necessarily go into a whole lot more

1 detail than that. It's a very broad conversation and topic,
2 as we are also mindful of other fiscal changes around
3 health care-related taxes, state-directed payments, and
4 other things that are more broadly affecting the Medicaid
5 budget, alongside the potential changes to acuity. This is
6 just a very large and interconnected set of issues to
7 navigate.

8 COMMISSIONER CAROLYN INGRAM: Thank you.

9 CHAIR VERLON JOHNSON: Thank you. So we're going
10 to go to Mike, then Sonja, and then we will finish with
11 Doug.

12 COMMISSIONER MICHAEL NARDONE: Hi, Jack and Lora.
13 Thanks for hanging with us here. I just had a couple of
14 questions, and first I just want to start by saying, like
15 what Verlon said, I think it's great that it sounds like
16 you are working very closely with CMS around these many
17 complex issues.

18 I was wondering, on the medical frailty questions
19 and the various algorithms, and maybe this is difficult for
20 you to respond to, but has there been a state that it's
21 been identified that their medical frailty framework is
22 approvable or is kind of in line with CMS's thinking? I

1 just noted yesterday, I think it was in the HMA newsletter,
2 Lora, about Nebraska receiving a letter around the need to
3 change some of their algorithms around medical frailty.

4 And I am just wondering, where are we at in that process?
5 Do we anticipate having some sort of, like here are two or
6 three models that states are using, and these seem to be in
7 line with what CMS is seeking in terms of medical frailty?

8 JACK ROLLINS: So yes, great question. I would
9 say first that it is our understanding that while CMS is
10 seeking additional information from states around their
11 medical frailty frameworks and their plans for
12 operationalizing, that's for general oversight and
13 monitoring purposes and not necessarily for CMS explicitly
14 approving the state's medical frailty framework. That's
15 one element.

16 That being said, I think that there is a state
17 that CMS has been in close dialogue with that generally the
18 state's approach is broadly aligned with CMS's policy
19 affectations. Louisiana is the example that I think CMS
20 has indicated that their approach is workable and aligned
21 with the IFC.

22 COMMISSIONER MICHAEL NARDONE: Would it have to

1 be included in SPA, medical frailty?

2 JACK ROLLINS: I am not sure. I can't, off the
3 top of my head, recall what was in that PRA piece.

4 COMMISSIONER MICHAEL NARDONE: Lora, are you
5 hearing anything?

6 LORA SAUNDERS: Anything different? No. I have
7 been hearing the same. I would have assumed that states
8 would need to be submitting a SPA related to their medical
9 frailty, but I heard the same thing Jack heard in terms of
10 not necessarily needing a formal approval. That was not
11 what I was expecting, but I think, to the point of needing
12 to give states perhaps a little bit more flexibility as
13 they get rolling and then attempting to be compliant
14 January 1st, it makes sense. So yes, I'd also heard
15 Louisiana was kind of the one to watch, and it looks like
16 there are a few other states that are kind of working with
17 Louisiana to potentially adopt that same algorithm.

18 COMMISSIONER MICHAEL NARDONE: Great. Thanks.
19 On a different topic, different exclusion category, I was
20 wondering, I think one of the things that was in the MACPAC
21 letter related to the privacy of SUD data and the use in
22 terms of CE requirements. And I just wanted to ask, I know

1 that was an area that I think CMS was going to provide
2 additional technical assistance on. And I was wondering
3 where those conversations are, or if you've had additional
4 discussions around the use of that data in terms of some of
5 the exclusion categories.

6 JACK ROLLINS: So our understanding is that we
7 will be seeing guidance or information originating from the
8 HHS Office of Civil Rights, rather than CMS, on this, and
9 we're tracking that there will be a notice. I believe it's
10 been filed in the Unified Regulatory Agenda.

11 We're not quite sure exactly what the approach is
12 going to be there. It hasn't been the part of our
13 conversations that's been of the most central focus. But I
14 think we are aware of the historic -- I would say the
15 different parameters for states to access SUD data and the
16 role of an individual kind of agreeing to that data
17 compared to sharing that data compared to kind of the HIPAA
18 process. And that's something that NAMD over the years
19 advocated congressionally for better alignment between
20 those two data exchange frameworks.

21 Other than that, I don't think I have a lot more
22 to offer at this point.

1 COMMISSIONER MICHAEL NARDONE: Great. All right.
2 Thank you.

3 CHAIR VERLON JOHNSON: Thanks.

4 Sonja?

5 COMMISSIONER SONJA BJORK: Thank you.

6 Last year, we had a panel that included an
7 experienced application assister from Georgia, because they
8 had done work requirements, of course, and she pointed out
9 some things that had gone awry with document submission and
10 some other aspects like that. So I was wondering if you'd
11 heard from states that they might be also increasing their
12 staffing related to ombudsman or administrative hearing
13 staff so that there's not such an enormous backlog when
14 things may or may not go awry upon launch. So I just
15 didn't know if that was a topic yet.

16 And my other questions already got answered due
17 to the excellent questions asked by the other
18 Commissioners. So thank you.

19 JACK ROLLINS: So, I appreciate that question.

20 And, yes, this has been a part of our overall
21 preparatory conversations, particularly centered within our
22 Eligibility Leader Affinity Group, kind of thinking ahead

1 to what is the appeals process going to look like and the
2 preparatory steps that states can take to manage a
3 potential increase in volume there.

4 So I would say I don't, to mind, have specific
5 examples that I can offer in terms of how states are
6 configuring that staffing model. But it is part of the
7 overall landscape of things that our leaders that are most
8 attuned to these issues are thinking about.

9 I would also note that some states are also
10 looking to leverage their MAC and BAC processes, just to
11 the point around kind of like the application assistance
12 lens, kind of using those mechanisms, those structures to
13 kind of get some of the perspectives of beneficiaries and
14 beneficiary advocates to inform some of these so that the
15 communication is clearer and the confusion is minimized for
16 an individual or their family.

17 LORA SAUNDERS: And I would agree. The staffing
18 additions that I've seen so far have really been focused
19 primarily on kind of the eligibility enrollment and
20 customer service call lines or call centers and less around
21 kind of the back-end piece. It's possible that they could
22 still be hiring people to fill those roles, but it has not

1 been nearly as publicized as those states that are saying
2 we're building in a lot more staff on the front end.

3 CHAIR VERLON JOHNSON: All right. Thank you.

4 Anne?

5 COMMISSIONER ANNE KARL: So my question sort of
6 builds on Mike's question before about medical frailty.
7 So, Laura, in your comments earlier, you had said that
8 there were states that were looking to build on their
9 existing medical frailty processes related to the
10 Alternative Benefit Plan. And my understanding was that
11 the medical -- I think that was what people had hoped and
12 thought would be the definition of medical frailty. And
13 then the CMS guidance and then the IFC kind of went in a
14 different direction to have, I think, a more rigid and
15 tacking specifically to your ability to work, which is
16 somewhat different than what states were doing for the
17 ABPs.

18 So I guess my question is, are states really able
19 to leverage there? I get that they would say, we're going
20 to use this as a starting point, but is that basically just
21 like, you know, that gives you a half-step head start as
22 opposed to really something that you could be leveraging

1 more fully?

2 LORA SAUNDERS: I think it is kind of that half-
3 step head start, that they're not able to just pick it up
4 and use it exactly as it is, but that the states that have
5 those already in place at least have some degree of, like,
6 formed process where they are consuming that type of
7 information, they have some sort of a process already in
8 place to, you know, absorb what it means. And so it's
9 going to be needing to put new parameters around what is
10 acceptable, but at least they kind of have at least a lot
11 of the groundwork and framework already in place that they
12 can use where other states would be really starting more
13 from scratch on a process, a systems, a people kind of a
14 standpoint.

15 COMMISSIONER ANNE KARL: That's helpful.

16 JACK ROLLINS: And I would just very quickly add
17 to that, that the distinctions between the ABP, Medical
18 Frailty Framework, and the statutory language for medical
19 frailty and community engagement were things that CMS was
20 pointing to very early. So I don't think that it was a
21 surprise for states that the ABP and CE medical frailty
22 processes were not going to be one-to-one.

1 CHAIR VERLON JOHNSON: All right. Thank you.

2 And now our final question goes to Doug.

3 COMMISSIONER DOUG BROWN: Thank you.

4 I appreciate you all being with us today, sharing
5 your background and your knowledge here. It's very helpful
6 for us as we contemplate our next steps here.

7 We're going to see procedural denials as part of
8 the renewal process. What percentage do you expect we're
9 going to see kind of average across states? And at what
10 point do you begin to hit the panic button that we're
11 denying coverage for those folks who otherwise qualify for
12 Medicaid but just can't navigate the systems?

13 LORA SAUNDERS: So I think it's really going to
14 vary a lot state to state in terms of those procedural
15 disenrollments, and I think a lot of it does go back to how
16 effectively and efficiently is a state using ex parte to
17 process as much as possible and minimize friction. And so
18 I think states that are more effective at that are going to
19 see a lot lower procedural terminations. So I can't even
20 hazard a guess. I don't think what we would see is kind of
21 a national average.

22 And then -- I'm sorry. I just blanked on the

1 second part of your question.

2 COMMISSIONER DOUG BROWN: When do you hit the
3 panic button and say this isn't working, or you really got
4 to get back and take another swing at how the system is
5 designed and what those obstacles are in particular states?

6 LORA SAUNDERS: I mean, I think that Nebraska
7 should at least kind of help us get a little bit of a
8 preliminary. You know, they have a very robust self-
9 attestation process. They have a very robust list of
10 conditions that should qualify people as medically frail.
11 So things are kind of lining up to they should be a fairly
12 flexible and permissive type of a state, and if we see them
13 losing a lot of coverage or seeing a lot of procedural
14 terminations at the end, we should hopefully be able to use
15 them even before January 1st as a little bit of a case
16 study to kind of see like what's going on when they have
17 all of these other permissions.

18 They also have a smaller population. So they
19 theoretically should be able to do more of that outreach
20 and engagement and awareness. So I think they could be the
21 canary in the coal mine in terms of pulling the plug.

22 I don't know if pulling the plug is even really a

1 true option, but just in terms of saying that there is a
2 big problem -- I mean, I think we saw New Hampshire
3 basically going right up to the point at which they were
4 about to disenroll a bunch of people before they said, "You
5 know what? We've got to stop this community engagement
6 waiver back" -- you know, I think it was 2018, 2019.

7 So I think we're going to see a lot of variation
8 is kind of the short answer.

9 JACK ROLLINS: And I would just, again, to
10 reemphasize, the statute and the regulation both really
11 make the ex parte process a central area of focus here, and
12 that is why that kind of -- to the question earlier around
13 how MACPAC could really support states, I wanted to point
14 to the additional data to round out the ex parte process,
15 because that is the first line of defense against
16 procedural disenrollment. And it is both helpful from an
17 administrative and -- administrative efficiency standpoint
18 from the state perspective as well.

19 So I think that is where we will continue to see
20 our members focusing as it is both the statutory and
21 regulatory requirement, as well as something that from a
22 beneficiary coverage retention and appropriate coverage

1 outcomes perspective is also a useful tool.

2 COMMISSIONER DOUG BROWN: Thank you.

3 CHAIR VERLON JOHNSON: All right. Thank you.

4 That's a great way to end too in terms of how we can
5 continue to help.

6 So thank you both again for coming on and staying
7 a little bit longer as well. I think that a lot of your
8 comments are very helpful. You can see our Commissioners
9 are very thankful in terms of the information delivered,
10 and we had a good dialogue around it, so appreciate it.

11 I also want to say that this will not be the last
12 time you see us. I'm sure that we'll be reaching out again
13 as we continue down this process of implementation. So,
14 again, thank you all so much. We appreciate it.

15 All right. So now we are going to move into
16 public comments. We do invite people in the audience to
17 raise their hand if you'd like to offer a comment. Please
18 make sure you introduce yourself and the organization that
19 you represent, and we also ask that you keep your comments
20 to three minutes or less.

21 **### PUBLIC COMMENT**

22 * [Pause.]

1 CHAIR VERLON JOHNSON: All right. It looks like
2 we have no comments currently. So just remember that if
3 you do have a comment later, you can definitely provide
4 that through our MACPAC websites.

5 With that, we will now break for lunch and
6 reconvene at 1:30 p.m.

7 * [Whereupon, at 12:21 p.m., the meeting was
8 recessed, to reconvene at 1:30 p.m. this same day.]

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1 AFTERNOON SESSION

2 [1:30 p.m.]

3 CHAIR VERLON JOHNSON: Welcome back, everyone.

4 Hope you all had a great lunch.

5 So our next session will provide an overview of
6 our two CMS-proposed rules involving state-directed
7 payments and health care taxes, health care-related taxes,
8 and I'm going to turn it over to Chris and Chris to walk us
9 through.

10 **### STATE DIRECTED PAYMENTS (SDPs) AND HEALTH CARE-**
11 **RELATED TAXES: SUMMARY OF PROPOSED RULES**

12 * CHRIS PARK: Thank you, Verlon.

13 So today we'll be summarizing the provisions of
14 two proposed rules CMS released over the summer, the state-
15 directed payment, or SDP-proposed rule, released May 22nd,
16 and the health care-related taxes, or provider tax proposed
17 rule, released on July 23rd.

18 We'll start with the state-directed payment rule,
19 which also includes new provisions to limit targeted
20 provider payments in fee-for-service, and then we'll
21 transition to the provider tax rule.

22 So, just as a little bit of a background, both

1 rules implement provisions on state-directed payments and
2 provider taxes that were put into place by the 2025 Budget
3 Reconciliation Act. The Budget Reconciliation Act reduces
4 the payment limits for state-directed payments that require
5 prior written approval to Medicare-based rates, which
6 differ for expansion and non-expansion states. So it's 100
7 percent of Medicare in expansion states and 110 percent of
8 Medicare in non-expansion states.

9 Current arrangements are grandfathered in at the
10 existing dollar amount for a couple of years before phasing
11 down to the Medicare-based limits.

12 And then for provider taxes, the legislation
13 also amends the indirect hold harmless threshold, also
14 called the safe harbor threshold. It freezes existing tax
15 arrangements at the current tax rate and essentially
16 prohibits increases and implementation of new provider
17 taxes in the future. It also institutes a phase-down of
18 the safe harbor threshold in expansion states starting
19 fiscal year 2028.

20 To help provide context for the proposed changes
21 to both supplemental payments and state-directed payments,
22 we'll start with a quick refresher.

1 Under fee-for-service, states may pay
2 supplemental payments in addition to base payments. The
3 total payment to many providers is subject to upper payment
4 limits, or what's known as a UPL. For institutional
5 providers, the UPL is defined as a reasonable estimate of
6 what would have been paid under Medicare payment
7 principles, and this limit is applied in the aggregate and
8 not at the individual claim or provider level.

9 For physician services, CMS has not established a
10 UPL in regulations but has used the standard of average
11 commercial rates, or ACR, when assessing state payment
12 policies.

13 Under managed care, states pay managed care plans
14 capitation rates, and the plan pays providers based on
15 their own negotiated payment rates. The state can only
16 direct plans pay specific provider rates or use specific
17 payment methods under state-directed payments that meet
18 regulatory standards. The 2024 managed care rule
19 formalized average commercial rate as the limit on state-
20 directed payments for four services, inpatient and
21 outpatient hospitals, nursing facility, and qualified
22 practitioners at academic medical centers.

1 The proposed rule implements new Medicare-based
2 limits for the 50 states and D.C. for rating periods
3 beginning on or after July 4th, 2025. These limits apply
4 to state-directed payments requiring prior written approval
5 for the four services I just mentioned that were included
6 in the 2024 managed care rule.

7 The proposed rule defines the total published
8 Medicare rate as the amount calculated as payment for the
9 specific service under Medicare's Part A and B. So this
10 means the limit is applied at the service and provider
11 level, in contrast to the aggregate limit that applies on
12 fee-for-service UPL payments. If there is not a Medicare
13 payment rate for that service, the limit is the Medicaid
14 state plan rate.

15 The rule also goes beyond what was specified in
16 legislation to apply the Medicare-based limits to all
17 state-directed payment arrangements starting January 1st,
18 2029. So this includes any arrangements that don't require
19 prior written approval, all services, not just the four
20 specified in legislation, and the territories.

21 There's a transition period for current state-
22 directed payment arrangements. In order to be

1 grandfathered in, the arrangement must require prior
2 written approval applied to the four services specified in
3 legislation and apply to rating periods that were 180 days
4 within the implementation date of the Budget Reconciliation
5 Act, which means October 11th, 2024, to July 3rd, 2025, or
6 July 5th, 2025, to March 27th, 2026.

7 To be grandfathered in, the state must have
8 submitted a completed state-directed preprint for the
9 arrangement prior to July 4th, 2025. The proposed rule
10 defines the total grandfathered dollar amount as the
11 estimated total dollar amount listed in the relevant
12 preprint, and at no point can the total payment rate exceed
13 average commercial rate.

14 The grandfathered total dollar amount is phased
15 down 10 percentage points each year beginning January 1,
16 2028, until the Medicare-based limit is reached. To help
17 states operationalize these limits, CMS will still allow
18 the use of separate payment terms during the grandfathered
19 period, but once the Medicare-based limit is reached,
20 separate payment terms will be prohibited.

21 Starting January 1, 2028, CMS proposes to only
22 allow certain types of arrangements and eliminate the

1 option to use uniform dollar or percentage increases for
2 new state-directed payments or renewals of non-
3 grandfathered SDPs.

4 In the preamble, CMS also stated that it would
5 consider situations in which the state directs actuaries to
6 develop capitation rates assuming higher provider payment
7 rates to be implicitly directing plan payments and would be
8 considered SDPs subject to the regulatory requirements such
9 as the Medicare-based limits.

10 CMS also proposes state reporting requirements to
11 monitor compliance with the new limits. For grandfathered
12 SDPs, states will need to continue to demonstrate
13 compliance with the average commercial rate limit until
14 2029. To help establish and monitor the phase-down
15 process, states will need to report the grandfathered total
16 dollar amount as a percentage of the amount that would have
17 been paid under Medicare rates, starting in 2027 and until
18 the phase-down is complete.

19 For all state-directed payments, states will need
20 to submit a variety of information, including a list of
21 eligible providers and their national provider identifier,
22 the total published Medicare rate for each service, and a

1 description of how the state will ensure compliance with
2 service-level limits, including under value-based payment
3 initiatives.

4 CMS also commits to providing guidance on an as-
5 needed basis regarding the requirements and standards,
6 documentation, and any other considerations for applying
7 the limits and monitoring and oversight.

8 Next, we'll move on to the new requirements that
9 CMS is proposing on fee-for-service-targeted practitioner
10 payments.

11 So the proposed rule includes provisions to add
12 limits on certain fee-for-service practitioner payments
13 that are targeted to a subset of providers within the state
14 or geographic area. CMS proposes to apply the same
15 Medicare-based limits that apply to state-directed payments
16 to these targeted practitioner payments. So that would be
17 100 percent of Medicare in expansion states and 110 percent
18 of Medicare in non-expansion states.

19 Similar to the state-directed payments, CMS
20 proposes to apply the limits at the service and provider
21 level instead of the aggregate level used for other fee-
22 for-service UPLs. And then these limits will go into

1 effect for the first state fiscal year beginning on or
2 after January 1, 2029, as I mentioned before, this was not
3 part of the Budget Reconciliation Act.

4 This new limit is focused on payments that target
5 a subset of providers. So the Medicare-based limit does
6 not apply if payment rates are uniform for all eligible
7 providers furnishing the applicable service within the
8 state or region.

9 CMS also prioritizes existing statutory
10 regulatory requirements. So this new limit doesn't apply
11 in such cases such as payment methodologies for federally
12 qualified health centers or existing fee-for-service UPLs.

13 Furthermore, CMS exempts services that do not
14 have a reasonably comparable Medicare-equivalent service or
15 payments that are reconciled to a practitioner's actual
16 cost incurred.

17 The Commission did submit a comment letter
18 regarding this proposed rule, and we commented in a few
19 areas. First, we expressed concern that the application of
20 the Medicare-based limits at the service and provider level
21 do limit state's flexibility to use payment as a tool to
22 achieve policy goals such as access or implement innovative

1 payment models.

2 Medicare payment rates are developed to promote
3 specific Medicare goals which would not prioritize certain
4 populations and services that are important to Medicaid,
5 such as children or pregnant women.

6 Also, the administration and oversight of
7 service-level limits will be administratively complex and
8 burdensome to implement.

9 The letter also asks CMS for additional guidance
10 on what actuarial assumptions could be included in the rate
11 setting without being considered implicit SDP arrangements.

12 And, finally, we also ask for additional
13 clarification on how the limits would apply to providers
14 who have not been paid by Medicare, such as children's
15 hospitals, but could be paid under a Medicare-based
16 methodology.

17 And now I'll pass it over to the other Chris to
18 review the provider tax rule.

19 * CHRIS THOMPSON: Thank you, Chris.

20 Now let's turn to the provider tax rule, which as
21 mentioned earlier implements changes made in the 2025
22 Budget Reconciliation Act. It also proposes additional

1 changes that were not in the legislation.

2 We will start off with a little background on
3 provider taxes. In general, a provider tax is a tax for
4 which at least 85 percent of the tax burden falls on the
5 health care providers in the class. To be a permissible
6 source of funding for the Medicaid program, the tax must be
7 assessed against a permissible class of health services or
8 providers. It must be broad-based, meaning applied to all
9 providers within the class, and the tax must also be
10 uniformly applied to all providers in the same manner.

11 The state cannot include a direct or indirect
12 hold harmless guarantee that the taxpayer will receive all
13 or some portion of their tax costs back through Medicaid
14 and other state payments.

15 To allow states to make some Medicaid payments to
16 taxpayers, statute and regulations have established a two-
17 pronged test to determine if a tax is permissible under the
18 indirect guarantee requirement. If a tax is less than or
19 equal to 6 percent of the net patient revenue from the
20 providers within the class to be taxed, then the tax is
21 deemed to be permissible. This 6 percent threshold is
22 known as the indirect hold harmless or safe harbor

1 threshold.

2 If the tax exceeds the 6 percent threshold, then
3 the tax could still be determined to be permissible so long
4 as the 75 percent or more of the tax providers do not
5 receive 75 percent or more of the tax costs back from
6 Medicaid or other state payments. This is also known as a
7 75/75 test.

8 This proposed rule implements changes to the safe
9 harbor threshold as prescribed in the 2025 Budget
10 Reconciliation Act. Beginning October 1, 2026, a new safe
11 harbor threshold replaces the 6 percent and essentially
12 freezes provider taxes at existing tax rates. This new
13 threshold will be based on taxes that were enacted and
14 imposed as of July 4, 2025. The threshold for taxes that
15 were enacted or imposed after July 4, 2025, will be zero,
16 effectively eliminating any new provider taxes after that
17 date.

18 The safe harbor threshold in non-expansion states
19 will be based on the new safe harbor threshold. In
20 expansion states and with the exception of taxes on nursing
21 facilities and intermediate care facilities for individuals
22 with intellectual disabilities, the safe harbor threshold

1 will be subject to a potential phase down each year.

2 Starting in fiscal year 2028, the threshold will
3 be based on the lower of the new safe harbor threshold of
4 5.5 percent, and this additional limit gets further reduced
5 by 0.5 percentage points each subsequent year until it
6 reaches 3.5 percent in federal fiscal year 2032.

7 Tax programs for nursing facilities and
8 intermediate care facilities in expansion states will be
9 treated the same as tax programs in non-expansion states.
10 As proposed by this rule, these new thresholds will be
11 applied on a federal fiscal year basis.

12 Now let's talk about how CMS will calculate these
13 new state- and class-specific thresholds.

14 CMS will calculate both an interim and a final
15 threshold. The thresholds will be based on data from the
16 state fiscal year that includes July 4, 2025. These
17 calculations will include all tax collection amounts by tax
18 program and permissible class. This must include all tax
19 payment offsets, delinquent tax payments, and penalties.
20 These calculations will also include all net patient
21 revenue from all providers in the class, regardless of
22 whether the provider was assessed the tax. To facilitate

1 calculation of the final threshold, states will be required
2 to submit actual tax collection and net patient revenue by
3 June 30, 2028. However, tax programs will first be subject
4 to interim thresholds from October 1, 2026, through
5 September 30, 2028.

6 To prepare for calculation of the interim
7 thresholds, CMS requires the submission of various tax
8 program information. By December 31, 2026, states must
9 submit the data shown on this slide which includes the best
10 available data on tax collections, information on a
11 Medicaid payment supported by the tax, and other
12 documentation to ensure that the tax was enacted and
13 imposed by July 4, 2025, and is permissible.

14 As some of this information is new information
15 that states did not previously submit to CMS, states may
16 need to revise and update current reporting mechanisms and
17 validation processes to facilitate reporting of this
18 information.

19 As far as the calculation of the final threshold,
20 it should be highlighted that while the interim threshold
21 can be based on the best available data concerning tax
22 collections and net patient revenue, the final threshold

1 calculation must be based on actual tax collections and net
2 patient revenue amounts. States must submit final tax
3 collection and net patient revenue data by June 30, 2028,
4 and CMS will announce final thresholds and phase-down
5 schedules by September 30, 2028.

6 This rule also adds a new provider class for
7 services of health insurers that can be taxed. This new
8 class of health insurers does not include managed care
9 organizations that are already a permissible class. The
10 preamble stated that it may include limited benefit plans
11 like catastrophic plans or dental and vision insurers. It
12 may also include premiums from private fee-for-service
13 Medicare Advantage plans and premium assistance plans to
14 purchase coverage through the exchanges as part of a
15 Medicaid 1115 demonstration waiver.

16 It's worth noting that CMS proposed to apply the
17 new safe harbor thresholds to this new class, although this
18 new class was not described in regulations in effect on May
19 1, 2025, and the addition of this new class was not
20 included in the 2025 Budget Reconciliation Act.

21 CMS is also proposing to remove the longstanding
22 75/75 test. CMS proposes eliminating this test as of

1 October 1, 2026. From there, only taxes below the new safe
2 harbor threshold will be permissible. CMS notes that only
3 one tax ever utilized this test. Similar to the addition
4 of the new permissible class, the proposal to eliminate
5 this test was not included in the 2025 Budget
6 Reconciliation Act.

7 And, lastly, CMS adds new reporting requirements
8 to provide better monitoring and oversight of provider
9 taxes. In addition to the one-time reporting requirements
10 for the calculation of the interim and final thresholds,
11 states will be required to submit quarterly information via
12 the CMS-64 for all taxes. This information will include
13 tax collections and net patient revenue and what each tax
14 on each permissible class is used to fund.

15 For purposes of CMS-64 reporting, it's important
16 to note that states must report actual tax collections and
17 net patient revenue with no estimates allowed, and states
18 must furnish complete and accurate data with full
19 disclosure of all tax programs and expenditures.

20 We will close with MACPAC's comments regarding
21 this proposed rule.

22 In the comment letter the Commission submitted on

1 September 21, 2026, it expressed its support of ongoing
2 reporting of provider tax information that aligned with
3 prior MACPAC recommendations. However, the Commission
4 asked CMS to consider collecting and reporting these data
5 at the provider level to enable analysis of net payments
6 for specific providers. Provider-level analyses will be
7 important to understand how the new provider tax limits
8 affect payment rates to specific providers and subsequent
9 outcomes, such as access.

10 The comment letter expressed concern over the
11 effect that the elimination of the 75/75 test could have on
12 states' flexibility to raise revenue. It also highlighted
13 the need for clarification regarding the new class of
14 health insurers and the operational and compliance
15 challenges states may face due to timing differences
16 between the state fiscal year upon which taxes may be based
17 versus the application of safe harbor thresholds on a
18 federal fiscal year.

19 As far as a discussion, we welcome Commissioner
20 feedback on areas where MACPAC should focus future analysis
21 concerning the impact of both of these rules. Thank you.

22 CHAIR VERLON JOHNSON: Thank you both. That was

1 very, very helpful and really good background given our
2 upcoming conversations, as well. I will turn to my
3 Commissioners to see if they have any comments or
4 questions. Tim, and then we will have Mike. Thank you.

5 COMMISSIONER TIMOTHY HILL: I'll start. A couple
6 of random thoughts. Do you have any sense about where they
7 were going with this new class for health insurance? I ask
8 just because there are lots of folks out there in the world
9 who wish they would have had a class; I think particular to
10 providers that are not added. Any sense about where they
11 are going with this and why it was added?

12 CHRIS PARK: No direct insight. In the rule, CMS
13 did mention that they were aware of a few states that have
14 taxes on certain health insurers that would potentially be
15 considered impermissible because they are not a specified
16 class with the regs right now. So that was part of the
17 reasoning, I think. Part of the reasoning is also that
18 they want to kind of limit provider taxes in general. They
19 want to have them subject to the new safe harbor thresholds
20 and not be able to shift taxes to another area.

21 COMMISSIONER TIMOTHY HILL: So it's sort of
22 preemptive. Like we are going to put you on the --

1 CHRIS PARK: Some of that. Yes. This was all
2 kind of what they discussed in the preamble of the proposed
3 rule.

4 COMMISSIONER TIMOTHY HILL: I don't know, I had a
5 second question on what to do about it. But if I remember,
6 looking at the scoring of the regs versus the scoring of
7 the One Big Beautiful Bill, there was huge differential.
8 It's an order of magnitude difference. And I don't think
9 it's completely accounted for by the fact that there has
10 been an increase in SDPs, and this is on the SDP rule, in
11 particular, since enactment.

12 I guess it's a question for us to consider, like
13 taking that much more money out of the system that what
14 folks was going to be taken out of the system is going to
15 have an impact on access. I think this goes to Sonja's
16 point earlier. We're taking all this money out and it just
17 feels, I don't know, bigger in a way that anybody thought.
18 And I'm not sure how to deal with that as a Commission and
19 whether we want to talk about it, or if there's a place to
20 talk about it. It feels much more significant than what
21 was done last summer.

22 And then the last piece, sort of akin to some of

1 the conversations we've had here over the last couple of
2 years. This going to be a bear for CMS to administer. I'm
3 looking at Chris, like we've been in those rooms. It would
4 be good to hear from CMS about what's their plan. Like
5 they're going to impose a huge burden on states, in new
6 reporting and different reporting in states and providers,
7 as well. And it would be a shame if it ends up just
8 sitting on somebody's desk and not being used and not being
9 used in a way that we thought it would be. So I think it
10 would be helpful to hear from CMS about what's their plan.
11 This is a significant new workload for them that they're
12 imposing on their partners, to hear from them about what
13 they're going to do with all this information and how
14 they're going to use it.

15 CHAIR VERLON JOHNSON: All right. Thanks, Tim.
16 Mike and then Sonja.

17 COMMISSIONER MICHAEL NARDONE: Yeah, thanks.
18 Thanks for this presentation. My issues are kind of
19 following in on Tim's, because I think we were going in a
20 similar direction. I was wondering, for this new class I'm
21 trying to understand who's in this new class. Because am I
22 right in that -- I mean, most states have a premium tax on

1 insurers. I think it's like over 40. I mean, to me that
2 would mean that basically if any of the money went back to
3 Medicaid that you couldn't raise that, that states couldn't
4 raise that tax. Am I understanding that right, or am I not
5 understanding the class of providers that's kind of brought
6 into this. I'm trying to still get my head around that, I
7 guess.

8 CHRIS PARK: Yeah. There was not a definitive
9 list of exactly who would be in the new class of health
10 insurers versus the existing class of managed care
11 organizations. So that was part of our comments is for
12 additional clarification.

13 I think some of the examples provided were
14 limited benefit plans, like vision or dental, certain
15 catastrophic plans that may not meet the definition of
16 comprehensive coverage that would be required to be like a
17 managed care organization. But there was not a hard and
18 fast rule, and CMS did mention that there would be some
19 overlap, potentially, between plans who would be already
20 covered under the existing managed care organization class.

21 So it's hard for us to know exactly what this
22 effect might have. I think a lot of the existing taxes on

1 insurance premiums may already be included in the managed
2 care organization class already, by definition, if they
3 meet that comprehensive coverage requirement. But it's not
4 immediately clear to us exactly what that delineation would
5 be.

6 COMMISSIONER MICHAEL NARDONE: It is potentially
7 possible that those premium taxes would be kind of brought
8 into this equation?

9 CHRIS PARK: Yeah. Certainly we have seen some
10 articles about how states have a premium tax that they use
11 to help fund operations of their state-based exchange. So
12 it is a question as to whether taxes may have already been
13 included as permissible taxes under managed care
14 organizations or if they would be picked up under this new
15 class. And if so, what does that mean in terms of their
16 ability to alter those taxes in the future.

17 COMMISSIONER MICHAEL NARDONE: And just to kind
18 of follow up on Tim's point, I agree, Tim, that's what I
19 was thinking too, around the increase in the savings from
20 this new rule and what is that attributable to, kind of
21 understanding that.

22 I was wondering, is there any discussion in the

1 proposal about the burden that it puts on states to
2 actually implement these new requirements? Because trying
3 to do this at the service level you're going to have a
4 presentation on the hospital payment index coming up with
5 some of the requirements, and some of the assumptions that
6 you had to build into that to get to information. And it
7 seems to me that states are going to have a significant
8 burden to come up with these service-level baseline to make
9 a determination around how much it is over at the service
10 level.

11 I'm wondering, do you have any sense of, and
12 maybe as you're looking at MS-DRGs for your hospital index,
13 how many of the service-level codes would be not have or
14 comparable service code at the Medicare level? The letter
15 highlights maternity. I assume there are a lot of other
16 areas like children's, behavioral health that maybe don't
17 have comparable codes.

18 CHRIS PARK: Yeah, the MS-DRG grouper does
19 include information to group deliveries and newborn
20 services. It's just they're not necessarily presently
21 used, actually delivered in Medicare. But the ability is
22 there to kind of price the information under Medicare

1 payment policies, because you would be able to run the
2 claim through in the MS-DRG grouper and spit out the code,
3 and then with that relative weight you would be able to
4 apply that to the base rate to estimate what Medicare would
5 have actually paid for a delivery.

6 It does require some additional efforts in terms
7 of either purchasing the MS-DRG grouper or knowing how to
8 run it, making sure all the claim information is sufficient
9 to run it through that system. So yeah, there definitely
10 could be a significant administrative burden, particularly
11 on the oversight part of it, to ensure that payment did not
12 go over Medicare on a claim basis.

13 COMMISSIONER MICHAEL NARDONE: Thanks for that.

14 This is helpful in trying to get my head around the reg.

15 One question around the provider tax. I want to
16 make sure I understand this. The threshold is determined
17 by the percentage of the tax compared to net patient
18 revenues versus the total amount of tax collection in the
19 fiscal year of 2026, whenever July 4th is. So the actual
20 amount that a state collects could potentially increase,
21 but the rate would stay the same. I just want to make sure
22 I understand that.

1 CHRIS PARK: Right. The safe harbor is a
2 percentage or ratio. So changes in either the tax
3 collections or net patient revenue could still be allowed,
4 so long as that ratio doesn't go above whatever the safe
5 harbor threshold is.

6 COMMISSIONER MICHAEL NARDONE: And it doesn't
7 necessarily tie into what percentage rate might be built
8 into actually state legislation. I mean, presumably it
9 would have to be the same.

10 CHRIS PARK: It's generally the same, but CMS
11 did, in the proposed rule, identify certain situations
12 where it may not be exactly the same, in the sense that the
13 tax was only applied to a subset of providers. So for
14 example, certainly governmental providers don't have to be
15 included in the tax for it to be considered broad-based.
16 So if certain hospitals had been excluded from the tax,
17 they wouldn't be there for the tax revenue number, but
18 their net patient revenue should be included in the
19 denominator, because they are a provider within that
20 permissible class.

21 So if there are some hospitals that were excluded
22 from the tax, and say the tax rate is 5 percent, but you

1 include that revenue in the denominator, then that
2 calculation might actually come out to be like 4.8 percent,
3 or something like it.

4 COMMISSIONER MICHAEL NARDONE: So what drives it
5 in that case? Is it the actual?

6 CHRIS PARK: It would be 4.8 percent. It would
7 be based on the actual tax collections and actual revenue.

8 COMMISSIONER MICHAEL NARDONE: Okay. Thank you.

9 CHAIR VERLON JOHNSON: All right, thanks. Sonja,
10 Carolyn, and then John.

11 COMMISSIONER SONJA BJORK: Our comment letter on
12 the proposed rule was really strong, and I appreciate
13 highlighting that we all care very much about
14 accountability and oversight of Medicare payments. But I
15 also appreciated the highlighting of some potential
16 unintended consequences. And the one that I always like to
17 raise is about access, especially in rural communities. We
18 have got such a fragile health care delivery system in
19 rural areas that the focus on using Medicare as a proxy for
20 analyzing whether the payments are enough to sustain our
21 rural health care delivery system, it may need some more
22 look or some more developing in that area.

1 Because I'm very concerned that we wait until
2 after this goes into effect and then everybody feels bad
3 about hospitals closing, going into bankruptcy, eliminating
4 certain services, like maternity care, et cetera. All of
5 those things are so hard to start up again. So I'd like
6 attention on that before we get there.

7 I also want to make sure that one of the
8 consequences isn't that we inadvertently constrain some of
9 the approaches, like value-based payment arrangements and
10 other innovative models that are being tried these days.
11 We don't want to cut off the ability to innovate and work
12 on changing the cost curve in different ways.

13 So I also wanted to mention, which is kind of
14 dove-tailing on the other Commissioners, that the
15 administrative burden by looking at service level, it's
16 millions of claims that a state is going to have to
17 reprocess. So millions of managed care claims.

18 So it seems that a better approach would be
19 looking at some kind of summary-level data, and if
20 something is identified, then taking the next step and
21 focusing and going deep on the service level analysis that
22 would be needed. But to reprocess every single claim at

1 different service levels will be burdensome for CMS, as you
2 mentioned, for the state Medicaid program, and even for the
3 managed care plans as we all try to comply and make sure
4 that we're having a good approach to these state-directed
5 payments.

6 Thank you, Chris and Chris, for taking very
7 complex concepts and really narrowing it down so that we
8 can focus on what the Commission has always cared about,
9 and that is payment and access. And I think you're doing a
10 really good job. I just want to keep that spotlight on
11 those issues. So thanks.

12 CHAIR VERLON JOHNSON: Thank you, Sonja.
13 Carolyn, and then John, and then Jami.

14 COMMISSIONER CAROLYN INGRAM: Yeah, I have a
15 couple of questions and then some comments. First, I want
16 to go back to some of the questions that Commissioner
17 Nardone was asking, to make sure I understand this piece
18 about service level issues.

19 You mentioned, Chris, that I guess there are some
20 Medicare equivalents for OB/GYN service delivery,
21 behavioral health, SNF level, and children's care, that
22 could be utilized. Could you talk just a little bit more

1 and try to explain to us how that works, but then also how
2 often they are updated, and if we know what is envisioned
3 at all. Are states going to hire a vendor to figure this
4 out? It seems quite complicated. But anyway, if you could
5 just cover that a little bit more, that would be helpful in
6 terms of the first question, and then I have a couple more.

7 CHRIS PARK: Sure. There are a few states, at
8 least historically, who have used the MS-DRG grouper as the
9 basis of payment. The grouper does have the ability to
10 read in a claim and assign it to a DRG that is specific to,
11 like, vaginal delivery, Cesarean section, newborn. So
12 there is at least that ability to group that appropriately
13 into a particular service.

14 There won't necessarily be actual Medicare claims
15 per se, to say that this is exactly what Medicare would
16 have paid for that in a situation, but CMS has a Web Pricer
17 tool on their website where you can put in the hospital,
18 you can put in the DRG code, length of stay, some other
19 things, where it can spit out an estimate of what Medicare
20 would pay. That was one thing that CMS had mentioned in
21 the proposed rule, as a tool that states could use to help
22 them reprice the claims.

1 You know, it certainly will be an administrative
2 challenge. Like there might be ways, like partners could
3 help in terms of vendors that the state is using may also
4 have experience using the MS-DRG groupers. Hospitals may
5 be able to also submit claims with both the APR-DRG and the
6 MS-DRG assigned to them. Many health plans operate both in
7 Medicare and Medicaid areas, so they may already have the
8 groupers available where they could assign the MS-DRG
9 grouper.

10 And I'm using the hospital scenario right now,
11 but on the physician side it might be a little bit easier
12 because a lot of the payments are based on CPT codes, and
13 those are pretty universal.

14 But there will be situations where, for like home
15 and community-based services, where Medicare does not have
16 a comparable service. And in those situations, what the
17 rule states is that the state plan rate would be the basis
18 for comparison and the limit.

19 COMMISSIONER CAROLYN INGRAM: Okay. Thank you.
20 I sometimes wonder if we sit in rooms and think how
21 complicated can we make our health care system? It's
22 already pretty complicated in the U.S. Let's just make it

1 more complicated. So I hope that gets revisited.

2 But I guess for the purposes of the Commission,
3 looking at access to care and what that's going to end up
4 doing to access to care is our drive, so I hope that's
5 taken into consideration as states are trying to figure out
6 how to implement this.

7 One of the other areas in the rule, my
8 understanding is that the rule requires that when the
9 state-directed payments are put into capitation rates for
10 managed care companies that they be at risk. Do you know
11 if that was required in the law anywhere?

12 CHRIS PARK: The 2024 Managed Care Rule got rid
13 of the separate payment terms, which would mean that the
14 dollar amount of the state-directed payment would have to
15 be built into the per member, per month capitation rate.
16 CMS is still saying that applies to new state-directed
17 payments or any state-directed payment that was not
18 grandfathered in. For grandfathered state-directed payment
19 arrangements they will still allow separate payment terms
20 during the phasedown until they reach the new limits, and
21 at that point the separate payment terms would go away.

22 And also, I should say a lot of times the

1 separate payment terms were used for these uniform rate
2 increases, and CMS is proposing to get rid of that type of
3 arrangement. So all the arrangements going forward will
4 have to be minimum fee schedules or value-based payment
5 arrangements. That also maybe helps a little bit in terms
6 of building it into the cap rate, because everything will
7 kind of be claims-based at that point.

8 COMMISSIONER CAROLYN INGRAM: So states have an
9 opportunity to wait until things are finally implemented to
10 make that change, or do they have to actually start every
11 year with part of the phasedown?

12 CHRIS PARK: If the grandfathered state-directed
13 payment arrangement was already using a separate payment
14 term they are allowed to keep using the separate payment
15 term until they reach that Medicare base limit. So if it
16 takes five years to reach that limit, they would still be
17 able to use a separate payment term for those five years.
18 But once they reach the limit and it is no longer
19 considered grandfathered, then they would have to stop
20 using the separate payment term and build it into the cap
21 rate.

22 COMMISSIONER CAROLYN INGRAM: Okay. Thank you.

1 And I think my comment is a little bit similar to some of
2 the other Commissioners, but just that I hope as a
3 Commission we continue to look at what is going to happen
4 to access to care when all of these changes start
5 occurring, along with the changes that we just talked about
6 in our previous session. Because specifically, hospitals
7 that serve rural communities, providers that work in rural
8 communities, especially some of our tribal communities, I
9 think are going to find a really difficult time.

10 As both of these things hit at kind of the same
11 time for folks we are going to have people not eligible
12 maybe because they've missed their work requirements
13 redetermination. We're going to have rate pressures as the
14 rates start to get phased down in some of these rural
15 communities that were built up with these mechanisms in
16 order to increase access to care. And we are going to see
17 those entities really suffer. And I don't know how we're
18 going to keep access to care, frankly, in rural
19 communities. It really worries me. And coming from a
20 rural state, especially with so many tribal communities
21 where it's difficult as it is right now for people to
22 access care.

1 So I think we just have to keep our eye on what
2 all of these changes do to that and what adjustments can be
3 made to make sure that we aren't losing access in those
4 communities. And then just how we can make things, maybe
5 in terms of recommendations under the law, simpler for
6 states to implement.

7 I appreciate this idea they have that there is
8 going to be a way to use these MS-DRG groupers and those
9 types of things. But states, as it is right now, their
10 systems are complicated. It seems to me that this is kind
11 of creating a way for a vendor to make a lot of money
12 helping states do this. So I guess if those vendors are
13 out there listening I guess they should start thinking on
14 that. But I don't see how states are going to be able to
15 do all of these processes.

16 Again, if our focus is on trying to get quality
17 outcomes of care and increasing access, I think some of
18 these things are really just going to harm that. So
19 hopefully we can keep our eye on that and ask for reporting
20 from CMS about how states are going to manage doing this
21 and get the quality outcomes and the access to care at the
22 same time. Maybe some of these will be revisited. Thank

1 you.

2 CHAIR VERLON JOHNSON: Thanks, Carolyn. Let's
3 see, John.

4 COMMISSIONER JOHN MCCARTHY: Chris, one of the
5 things we didn't comment on was the phase-down period,
6 right, in our letter?

7 CHRIS PARK: That's right.

8 COMMISSIONER JOHN MCCARTHY: Because CMS had a
9 couple of different choices of how they could do the
10 phasedown, and they chose one path over another. Correct?
11 It's a little bit quicker.

12 CHRIS PARK: That's right. It's probably quicker
13 but also may be more administratively simple in that you've
14 got the total dollar amount and you're just going to reduce
15 it 10 percent each time. So that might be a little bit
16 easier to calculate and administer.

17 COMMISSIONER JOHN MCCARTHY: I think for us, as
18 the Commission, there is a bigger policy piece within this,
19 and should states be allowed to use taxes or not, we could
20 talk about. I think one of the thing we don't address is
21 the fact that if it's an expansion state you have to go
22 down to these new safe harbor thresholds, but if you're a

1 non-expansion state you get to keep your tax. It has to be
2 a no new taxes, but you get to keep your tax. So that's
3 one area of policy we could definitely comment going
4 forward.

5 Then the other one is, back to what was brought
6 up about access, I agree that it's something that we need
7 to be keeping a close eye on, but between this and state-
8 directed payments, both of those were policy decisions that
9 were made, they were then changed, so we need to keep an
10 eye on what does this look like, are there different areas
11 that get impacted differently. And that we will have kind
12 of the experiment where it's like here are states that
13 aren't subject to the safe harbor. Everyone is subject to
14 safe harbor, but it's the higher one versus the lower one,
15 so we'll be able to see between those two if access changes
16 dramatically between those two types of states. Thank you.

17 CHAIR VERLON JOHNSON: Thanks, John. Jami and
18 then Mike.

19 COMMISSIONER JAMI SNYDER: Thanks so much for
20 your work on this. I am just really interested in hearing
21 from states on this and the implications for states and
22 hearing from them what's happening on the ground, and in

1 particular on the provider tax side of things for expansion
2 states. I'd love to hear more directly on the options or
3 levers that states are considering, given that reduced
4 reliance on provider taxes for the non-federal share. I
5 think it's important to sort of get a real-world view of
6 what this means for states, and in particular, like I said,
7 on the provider tax side of things for expansion states.

8 CHAIR VERLON JOHNSON: Thank you for that
9 reminder. Mike.

10 COMMISSIONER MICHAEL NARDONE: I just wanted to
11 reinforce what Sonja said earlier. I just want to commend
12 you guys for the letters that you did on those two issues.
13 They're very complicated, and I thought you really
14 highlighted some of the really critical issues.

15 And one of the things that I'm particular
16 concerned about is the impact on value-based purchasing
17 arrangements that basically are geared to increased access
18 in certain areas. I think the letter highlights some of
19 the potential impact on maternal provider payments to OBs
20 and GYNs. I would also highlight an area that I know
21 Medicaid programs have struggled with, which is dental
22 services.

1 And so what this regulation potentially says is
2 that if you're trying to make some sort of value-based
3 purchasing arrangements around that you're kind of set at
4 that upper level, that Medicare level. And there might be
5 instances where you actually want to go above that, and I
6 would think that in rural areas that is almost another
7 reason to be able to do that, to kind of build on the
8 points that Commissioner Ingram and Sonja raised.

9 So thank you for this letter, and I hope that we
10 would continue to look at what this means with respect to
11 value-based purchasing arrangements.

12 CHAIR VERLON JOHNSON: Thank you, Mike. All
13 right. Heidi, I'm sorry.

14 COMMISSIONER HEIDI ALLEN: I was a late joiner.
15 Thank you for all the Commissioners for bringing up these
16 concerns and also thank you to the Chrises.

17 This has been such an important lever for states
18 to try to address area where Medicaid enrollees have been
19 underserved, and several Commissioners brought those up. I
20 think behavioral health is also a good example of an area
21 where it's been hard to find enough participants.

22 So it makes me think that as we are dealing with

1 the repercussions of that, that something we might want to
2 consider is what other barriers to participation providers
3 maybe experience, so that we could think about trying to
4 make the provider experience better, especially if payment
5 leverages are no longer as much of an option. I know that
6 the delay in Medicaid payment, the bureaucracy, some of the
7 documentation requirements, some of these other things are
8 also important reasons why providers opt to not participate
9 in Medicaid.

10 So if this seems to be the scenario that we can
11 no longer try to say, "Hey, we're going to give you a
12 little bit of extra money to participate," if we could be
13 thinking of other ways to incentivize providers, then I
14 think we should.

15 CHAIR VERLON JOHNSON: Thank you for those
16 comments.

17 All right. Well, clearly this was a great
18 conversation. I appreciate your work on this. And we still
19 get you for the next session. So I'll turn it over to you
20 to talk about the Inpatient Hospital Payment Index.

21 [Pause.]

22 **### INPATIENT HOSPITAL PAYMENT INDEX: COMPARISON**

1 **ACROSS STATES**

2 * CHRIS PARK: Okay. So the prior session tees up
3 this session pretty well because we will be talking a lot
4 about state-directed payments and provider taxes as well.

5 So today we'll be presenting our analysis to
6 compare Medicaid payment for inpatient hospital services
7 across states. This work is an update to our prior MACPAC
8 analysis published in 2017. We will walk through the data
9 and assumptions made to calculate the inpatient hospital
10 payment index, present state payment levels relative to
11 national average, and discuss some of the limitations of
12 this analysis.

13 We are focusing on hospital spending right now
14 because Medicaid is a large payer of hospital services,
15 accounting for about 20 percent of hospital spending
16 nationally, and hospital spending is also one of the
17 largest components of Medicaid spending, making up about a
18 third of Medicaid benefit spending.

19 Comparing Medicaid payment levels across states
20 can be difficult because of state variability in terms of
21 differences in enrollment mix, service intensity, local
22 price factors such as wages, and differences in payment

1 policies and objectives.

2 MACPAC developed an inpatient hospital payment
3 index in 2017 to provide a more comparable measure of fee-
4 for-service hospital payments across states, and this work
5 is an update to that.

6 Calculating hospital payment is particularly
7 challenging because states can make payments through
8 several different mechanisms. The first are base payments,
9 which are made for individual services delivered and are
10 typically paid through claims. Supplemental payments are
11 additional fee-for-service payments on top of the base
12 payments and are frequently paid on a lump-sum basis and
13 not tied to a specific beneficiary or service.

14 There are several types of supplemental payments
15 that may be used for different purposes such as
16 disproportionate share hospital, or DSH payments, upper
17 payment limit, UPL payments, graduate medical education,
18 and payments authorized under Section 1115 demonstration
19 waivers.

20 As discussed in a prior session, state-directed
21 payments, or SDPs, allow states to require managed care
22 plans to pay providers specific rates or methods. Many

1 states use SDPs to make large uniform rate increases that
2 are paid on a lump-sum basis and not included in any
3 claims-based payments, similar to supplemental payments.

4 The 2017 analysis that we did used 2010 fee-for-
5 service claims and did not include managed care spending,
6 because those data were not available at the time. Since
7 the 2010 data used in the prior work, the payment landscape
8 has changed. The majority of hospital spending is now
9 through managed care, and the use of state-directed
10 payments has allowed states to pay up to average commercial
11 rates in managed care, which is higher than the Medicare
12 limit that applies to fee-for-service UPL payments.

13 Additionally, new data sources allow us to update
14 the analysis to a more recent time period and to
15 incorporate managed care into the comparison.

16 The Transformed Medicaid Statistical Information
17 System, or T-MSIS, data includes managed care claims and
18 payment amounts. There's also a new fee-for-service
19 supplemental payment report called the Supplemental Payment
20 Validation report, or SPV, that captures non-DSH
21 supplemental payments at the provider level. And for
22 state-directed payments, the preprints include projections

1 of total payment under the relevant arrangement.

2 I should note that the 2025 Budget Reconciliation
3 Act, as we just talked about, does impose new limits on
4 state-directed payments in the future, and so we'll talk a
5 little bit about this in the limitations of the analysis.

6 Because there is not a comprehensive source of
7 all Medicaid hospital payments, we had to combine data from
8 several different sources shown here. We'll talk a little
9 bit more about these data as we go through the various
10 adjustments made to build up total payment.

11 Our analysis focused on acute care hospital stays
12 for full-benefit enrollees under age 65 who are not dually
13 eligible for Medicaid and Medicare. We excluded dually
14 eligible beneficiaries because Medicare is the primary
15 payer for hospital services. We excluded beneficiaries
16 over 65 because of small sample size once the dually
17 eligibles were removed. And then we excluded limited-
18 benefit enrollees because they would not always have full
19 coverage of hospital services, and what was covered may not
20 be representative of the broader Medicaid population.

21 We also excluded four states -- Alabama, Oregon,
22 South Carolina, and Utah -- due to data quality issues.

1 Overall, the analysis included more than 6.8 million stays
2 across 46 states and the District of Columbia.

3 As mentioned earlier, state payment rates may
4 reflect different economic conditions that are reflected in
5 the cost of services, such as wages. To reflect these
6 localized differences in cost, we used wage costs as a
7 proxy to adjust and normalize state payments. We used wage
8 index data from the Medicare Inpatient Perspective Payment
9 System to assign a relative wage index to each hospital
10 using provider county and zip code, and that was used to
11 adjust payment amounts back toward a national average.

12 Total hospital spending can also reflect
13 differences in the acuity of the population and mix in
14 intensity of services provided. To adjust for those
15 differences in case mix, we grouped each claim using the
16 All Patient Refined Diagnosis Related Group, or APR-DRG,
17 classification system so that all claims and services were
18 classified similarly, regardless of how the service was
19 actually billed and paid.

20 We used the default APR-DRG weights in the system
21 as a proxy for case mix complexity and resource intensity.
22 We summed up the DRG weights and divided that by the total

1 stays to calculate an average weighted case mix value
2 within each state and nationally. Each state's average
3 case mix value was divided by the national case mix value
4 to create a state-level adjustment factor, and then the
5 average payment per state in each state was divided by that
6 factor to normalize states back toward the national average
7 usage level.

8 The T-MSIS data that we used for the claims-based
9 payments do not include the lump-sum supplemental payments.
10 We made adjustments to add-in DSH, non-DSH supplemental
11 payments, and state-directed payments. For DSH payments,
12 we used the aggregate amount of DSH payments reported on
13 the fiscal year 2022 CMS-64 Net Financial Management
14 report.

15 Because DSH can be used both for inpatient and
16 outpatient services, as well as uncompensated care for the
17 uninsured, we included only a portion of the DSH
18 expenditures.

19 We used the distribution of base payment spending
20 between inpatient and outpatient services from the T-MSIS
21 data to allocate a portion of spending to inpatient
22 services. We then used the ratio of Medicaid shortfall to

1 total uncompensated care reported on the 2019 DSH audit
2 report as a way to further allocate a portion of DSH
3 spending to Medicaid shortfall. For non-DSH supplemental
4 payments, we were able to use the new SPV report that
5 includes information on supplemental payments by provider.

6 We included spending reported as inpatient
7 hospital supplemental payments, graduate medical education
8 payments, and critical access hospital inpatient
9 supplemental payments. We aggregated non-DSH supplemental
10 inpatient hospital payments from the SPV at the state level
11 and then added it to the base and DSH supplemental
12 payments.

13 In the state-directed payment preprint, states
14 are required to report the estimated total dollar amount
15 for each arrangement. So building on MACPAC's prior work
16 on SDPs, we used the payment amounts reported on preprints
17 approved of as of August 1, 2024.

18 State-directed payments may be paid to providers
19 in different ways. For example, minimum or maximum fee
20 schedules are likely to be reflected in the amount paid
21 through service claims. However, uniform rate increases in
22 value-based payments may be paid on a lump-sum basis

1 similar to fee-for-service supplemental payments.

2 To minimize the potential double counting of
3 state-directed expenditures that may have already been
4 included in claims payments, we focused on those
5 arrangements that were made through separate payment terms,
6 as these were more likely to be paid on a lump-sum basis.

7 Additionally, we only included arrangements that
8 were associated with hospital services. For SDPs
9 associated exclusively with inpatient hospital services, we
10 allocated a full amount to inpatient hospital services.
11 For arrangements that applied to both inpatient and
12 outpatient hospital services, we estimated inpatient share
13 using the ratio of inpatient to outpatient base payments
14 derived from the claims data.

15 States often rely on providers to finance a
16 portion of the non-federal share, particularly for
17 supplemental payments and state-directed payments. The
18 amount providers pay in provider taxes, intergovernmental
19 transfers, and certified public expenditures can be seen as
20 an additional cost that effectively reduces the gross
21 payments. As such, the net payment that providers can use
22 to cover the cost of providing services is lower than the

1 total gross amount initially received, but it's still
2 higher than the non-federal-based payments.

3 Comprehensive data on Medicaid financing methods
4 and amounts of the non-federal share of Medicaid spending
5 derived from those specific providers are not collected and
6 reported on a regular basis. The most recent source of
7 comprehensive information comes from a 2020 Government
8 Accountability Office report that provided 2018 data on the
9 share of non-federal spending for Medicaid services.

10 We used the 2018 GAO report data to estimate the
11 amount of non-federal share financed through provider taxes
12 and local government funds for fee-for-service-base
13 payments, DSH payments, and non-DSH supplemental payments.

14 The largest state-directed payments are similar
15 to fee-for-service non-DSH supplemental payments in that
16 they are typically targeted to hospitals and financed by
17 provider taxes or IGTs paid by those providers. As such,
18 we applied an adjustment to state-directed payments based
19 on what was reported for non-DSH supplemental payments.

20 We created an index value for each state by
21 dividing each state's average inpatient hospital spending
22 per stay by the national average spending per stay. The

1 index shows the state's spending relative to the national
2 average. For example, a state with an index value of 1.1
3 had spending per stay that was 10 percent higher than the
4 national average. To help visualize the variation across
5 states in terms of their use of different payment and
6 financing methods, we calculated the index values at three
7 levels. First was base payment after the wage and case-mix
8 adjustment. Second was total gross payment, which included
9 all of the DSH, non-DSH supplemental, and state-directed
10 payments, and then net payment, which is the total gross
11 payments minus an amount associated with the provider
12 financing of the non-federal share.

13 And just to note that the index measure really
14 shows the relative differences across states, and it's not
15 in itself a measure of payment adequacy, hospital costs, or
16 sufficiency of the Medicaid payment rates.

17 And with that, I'll pass it over to Chris.

18 * CHRIS THOMPSON: Thank you, Chris.

19 We will now discuss the findings that resulted
20 from this payment comparison.

21 In this chart, we show the range of state index
22 values for hospital-based payments after wage and case-mix

1 adjustments. The national average for hospital-based
2 payments is expressed as a value of 1.00, with individual
3 state index values ranging from 0.53 to 1.73.

4 Here, 12 states displayed in white were more than
5 25 percent below the national average. Seven states
6 displayed in green were more than 25 percent above the
7 national average. Additionally, 15 states, the medium
8 shade of blue, were within plus or minus 10 percent of the
9 national average. Overall, 19 states were above the
10 national average.

11 Application of the wage and case-mix adjustments
12 have a significant impact on the index value for some
13 states. To show the effect that these adjustments can
14 have, this chart includes illustrative examples of states'
15 index values that had large shifts in their relative
16 positions after wage and case-mix adjustments.

17 For example, California had one of the highest
18 values for base payments at 1.34 before the wage and case-
19 mix adjustments, but it was below the national average at
20 0.95 afterward.

21 New Jersey was similar in that it was above the
22 national average before the adjustments and fell below the

1 national average afterward.

2 Massachusetts and Texas are examples of states
3 where the adjustments had the opposite effect. Both states
4 had index values that increased once the wage and case-mix
5 adjustments were made, with Massachusetts going from below
6 the national average to above the national average after
7 adjustments.

8 While the previous chart illustrated the state-
9 by-state comparison of hospital-based payments, this chart
10 provides a state-by-state comparison of net payments, which
11 are total payments including base, supplemental, and
12 directed payments, less the amount of non-federal share
13 financed by providers.

14 Index values show a greater range of fluctuation
15 here when supplemental payments and non-federal share
16 financing are considered. Again, the national average is
17 expressed as a value of 1.00, and here index values range
18 from 0.41 to 2.32.

19 When considering net payments, 13 states were
20 more than 25 percent below the national average, 4 states
21 were more than 25 percent above the national average, 9
22 states were within plus or minus 10 percent of the national

1 average, and overall, 12 states were above the national
2 average.

3 The findings here show that states reach their
4 final net payment index values through different
5 combinations of payment mechanisms. Some states rely
6 primarily on base payments, while others rely more heavily
7 on supplemental payments and SDPs. As a result, a state's
8 index value and relative ranking compared to other states
9 may fluctuate between base payment, total gross payment,
10 and net payment.

11 Texas and Nevada are examples of states that are
12 consistent in their index values and rankings across all
13 three measures here. Texas was consistently high, ranking
14 2 or 3 across all three measures, while Nevada had the
15 lowest index value and ranking of 47 for all three
16 measures.

17 California, Louisiana, and Florida are examples
18 of states that use supplemental payments and SDPs to a
19 greater extent than any other states. All three states
20 were moderate or low on adjusted base payment, but jumped
21 several spots in the ranking for both total gross payment
22 and net payment.

1 Maryland, Minnesota, and North Dakota are
2 examples of states that had relatively high base payments
3 but made lower-than-average supplemental payments and
4 state-directed payments.

5 Alaska here is a unique example of a state that
6 did not make any supplemental payments or state-directed
7 payments, nor financed any hospital payments through
8 provider taxes, IGTs, or CPEs. You can see that it had a
9 relatively high ranking of 7 on base payments. Because it
10 did not make any supplemental payments or state-directed
11 payments, its index value fell to 0.74 and a ranking of 30
12 on total gross payment. Finally, its index value of 0.84
13 and ranking of 22 increased on net payment because there
14 were no provider contributions removed.

15 Now we'll briefly discuss limitations.

16 While this payment analysis provides a good basis
17 for comparisons across states, there are some limitations
18 that must be highlighted. Just as the 2017 payment index
19 was a snapshot of hospital payment and financing, this
20 index is another snapshot or point-in-time analysis. It
21 does not fully reflect current payment and financing
22 policies that have been updated since 2022, nor does it

1 reflect any changes that will result from the 2025 Budget
2 Reconciliation Act.

3 Due to gaps in data on Medicaid payment and
4 financing, several assumptions and adjustments had to be
5 made to estimate total gross and net payment for inpatient
6 hospital services. One issue was the fact that data
7 sources in terms of reporting periods did not properly
8 align. For instance, DSH spending was allocated to
9 inpatient services and Medicaid shortfall using 2019 audit
10 data, which may not fully be reflective of how states
11 distribute DSH funding between inpatient and outpatient
12 services. One of the sources of data was the SDP
13 preprints. However, these preprints reported projected
14 spending rather than actual spending.

15 And, finally, the 2018 GAO financing data may not
16 fully reflect how 2022 spending was financed. For
17 instance, Virginia implemented a hospital provider tax in
18 fiscal year 2019, which was not included in the 2018 GAO
19 data and, by extension, this payment comparison.

20 As far as next steps, we are continuing our work
21 on inpatient hospital payments and are in the process of
22 comparing Medicaid payments to Medicare payment. To

1 facilitate a more apples-to-apples comparison between
2 payers, we will apply the Medicare severity DRG grouper to
3 the Medicaid claims so that we can compare Medicaid payment
4 -- I'm sorry, so that we can compare payment at a similar
5 service level. We will focus on the most frequently used
6 MS-DRG codes for which Medicare payment data are available
7 and compare that data to claims for the same service in
8 Medicaid.

9 There are some services that are prevalent in
10 Medicaid but not in Medicare. A good example here would be
11 maternity care services. We will begin to explore methods
12 for repricing these claims under Medicare payment methods
13 to supplement the findings. The full inpatient hospital
14 payment analysis will be developed into a chapter for the
15 March report, and additionally, we will begin a similar
16 analysis for outpatient hospital services.

17 As far as discussion, staff would appreciate any
18 feedback on this initial work to compare inpatient hospital
19 payment across states. We would also appreciate any
20 consideration for the ongoing comparison of Medicare and
21 the upcoming analysis of outpatient hospital services.
22 We're particularly interested in any feedback or

1 consideration regarding the potential for analysis of
2 specific classes of hospitals such as rural or urban
3 hospitals, the comparison of findings in this payment index
4 to the findings in a 2017 payment index, and how we can
5 think about this analysis within the context of the changes
6 under the 2025 Budget Reconciliation Act.

7 Thank you.

8 CHAIR VERLON JOHNSON: All right. Thank you.
9 That's very, very comprehensive and very good.

10 So there are a list of discussion items up there,
11 so I'll turn it over to the Commissioners to provide some
12 comments and questions.

13 First, we'll start with Anne. Then we'll go to
14 Angelo and then Jenny.

15 COMMISSIONER ANNE KARL: First, I just wanted to
16 say thank you so much for this. I think this is something
17 that people out in the world have really been clamoring
18 for, trying to understand exactly how Medicaid pays for
19 services and how those levels compare across states, but in
20 particular, that next step that you have on how it compares
21 to Medicare, I think will be really illuminating.

22 I also just want to acknowledge, I appreciated

1 your long list of limitations, and I really sympathize that
2 when you feel like you're making so many different
3 assumptions and just reviewing what you all have shared
4 with us today and in the briefing materials, it looks like
5 you really did a great job trying to come up with
6 reasonable assumptions, knowing that any assumption you
7 make is not going to be accurate in 100 percent of the
8 cases. There'll be some states that look a little bit
9 different in reality, but they really felt like sound
10 assumptions to be governing this, so thank you. I'm sure
11 that was a lot of really painstaking work to sort of think
12 through the options.

13 The one piece that I don't know that you would
14 reflect it necessarily in the index -- in fact, I think you
15 probably wouldn't reflect it in the index, but it may be
16 worth just acknowledging more explicitly -- has to do with
17 the net impact of the net payments. I think it is great
18 that you are including net payments because that is
19 something that everybody who works in this space knows is
20 an issue because what we actually care about in terms of
21 thinking about access, for example, is how much money is
22 coming in the door to support operations at a facility. So

1 that's sort of the critical number, and yet that isn't
2 there. And a lot of times people just kind of hand wave
3 and say, well, we know a bunch of it's financed, but we
4 don't really know how much. So the fact that you actually
5 took that step to show both gross and net, I think is
6 really, really valuable, and people will appreciate that
7 significantly.

8 I think the one piece that is missing is in the -
9 - again, I think it is broadly true that in most states, a
10 large, you know, overwhelmingly large share of the tax
11 dollars get back to the hospitals in some way or another.
12 They're used primarily to fund payments back to hospitals,
13 but that's not always the case. Particularly, there's a
14 handful of states that really rely on their provider taxes
15 to fund Medicaid expansion, for example. At least one
16 state I know of that actually just uses the tax to go into
17 its general revenue, it doesn't direct it back to Medicaid
18 at all. In those places, the hospitals are bearing a
19 bigger tax burden than maybe would be reflected here.

20 So, again, I don't think that's something that
21 you want to be trying to calculate, but I think it's just
22 worth acknowledging that there will be -- and then, you

1 know, listing a handful of states where they are using it
2 to fund non-hospital expansion costs as well.

3 But, again, just so appreciative of this work.
4 It's really great to see. I know we all wish the data
5 would be more current, but I get it. It's challenging. So
6 thank you again for the really painstaking work.

7 CHAIR VERLON JOHNSON: Thank you, Anne.
8 Angelo?

9 COMMISSIONER ANGELO GIARDINO: Again, let me add
10 my thanks. This seems like an enormous amount of work.

11 And I guess my question is, the first iteration
12 of this with all of its limitations was put out there in
13 2017. So could you just kind of give us wise counsel about
14 how this hospital payment index has been used? We have so
15 much on our plate. I'm just wondering, is it worth the
16 effort if the 2017 hospital payment index wasn't used
17 significantly by health services researchers and
18 policymakers? So could you just tell us that landscape?

19 CHRIS PARK: Sure. We've certainly seen a
20 reference to that 2017 work in a lot of areas in terms of
21 research because, before that, there wasn't really a
22 publicly available comprehensive analysis that tried to

1 compare across states but also to Medicare. So, certainly,
2 we can't say fully like how well it's been used, but
3 certainly has been one of the items from MACPAC that's been
4 linked to several times in terms of like American Hospital
5 Association and other organizations like that have referred
6 back to that work.

7 Of course, because not only was it done in --
8 released in 2017, but it was based on 2010 data. So it's
9 even older from that perspective. As I mentioned, a lot of
10 things have changed. So much more care is now in managed
11 care. The implementation of state-directed payments has
12 certainly changed the landscape as well in managed care.
13 So, certainly, being able to add in the managed care
14 experience will be a significant value to researchers in
15 terms of being able to use this, granted all the
16 limitations we've talked about, but it will provide a basis
17 for a lot of future analysis, I believe.

18 COMMISSIONER ANGELO GIARDINO: Okay. Good.
19 Thank you.

20 CHAIR VERLON JOHNSON: Thank you.
21 Jenny?

22 COMMISSIONER JENNIFER GERSTORFF: I have a few

1 technical questions that I think should be easy and then a
2 couple considerations as you work towards the chapter.

3 For the average that you're comparing against the
4 national average, is that a weighted average or a straight
5 average?

6 CHRIS PARK: It's a weighted average, so total
7 spending across the states divided by total stays.

8 COMMISSIONER JENNIFER GERSTORFF: And then were
9 there any facilities, any facility types that were excluded
10 that might bill on a DRG basis, like standalone behavioral
11 health hospitals or other specialty-type hospitals?

12 CHRIS PARK: Yeah. I'll need to go back
13 specifically into the methodology, but I'm fairly certain
14 it was mainly just the acute care hospitals. So inpatient
15 psych hospitals were not included.

16 COMMISSIONER JENNIFER GERSTORFF: Okay. And did
17 you include claims that would have had third-party
18 liability payments netted out of them?

19 CHRIS PARK: I would say that it's likely we did
20 not do anything specific to try to identify where third-
21 party liability may have been paid. So we were looking at
22 kind of the total Medicaid payment that was submitted on

1 the claim.

2 COMMISSIONER JENNIFER GERSTORFF: Perfect. Okay.

3 And then when you made the adjustments for wage
4 index and case-mix index, I noticed that that was applied
5 just to the base payments, and I'm wondering if it's
6 appropriate to apply to the gross payments and the net
7 payments.

8 CHRIS PARK: That is a very good question that we
9 contemplated, and I don't think we had a definitive reason
10 why to just apply it to base versus maybe applying it later
11 to the supplemental payments as well.

12 Part of our reasoning why we just applied it to
13 base is that it would be more likely to reflect the actual
14 case mix in terms of what services were specifically
15 provided as well as the base rate would probably be built
16 up in a way to kind of reflect what the wages were, where a
17 lot of times the supplemental payments are just like
18 percentages or built around a total dollar amount and
19 doesn't really reflect -- that dollar amount doesn't
20 necessarily change if there's more deliveries or higher
21 acuity services. It's more, you know, we're paying \$100
22 million, and each hospital gets their portion based on like

1 total days and not necessarily like really acuity adjusted,
2 and so that's kind of why we just applied it to base
3 payments.

4 But, certainly, the argument could be made like
5 we should do it as well to like the total gross payments.

6 COMMISSIONER JENNIFER GERSTORFF: Yeah. A dollar
7 in California means something different than a dollar in
8 Indiana.

9 And then when you're working on the chapter and
10 presenting different summaries, are you going to look at
11 comparing different service groups by state?

12 CHRIS PARK: Yeah. I think we can -- the way
13 we'll probably end up doing the Medicare comparison will be
14 at the service level. I think that's where we will try to
15 do a little bit more like comparison across states
16 potentially on highlighting a couple of high-use DRGs that
17 we could maybe focus on and do a state-level comparison --
18 a comparison across states along with comparison like of
19 each state to Medicare.

20 COMMISSIONER JENNIFER GERSTORFF: That's great.
21 I look forward to seeing that.

22 And then I would just suggest in the reporting,

1 if you can separate the case-mix adjustment factor the wage
2 index factor, I think that those communicate very different
3 things, and understanding them differently by state would
4 be of interest to me.

5 CHAIR VERLON JOHNSON: Thank you, Jenny.

6 Tim?

7 COMMISSIONER TIMOTHY HILL: Let me add my voice
8 to those saying great job. It's important work, and I
9 recognize the limitations that the data provides. But
10 you've done a good methodology that we can build on. I'm a
11 big believer that the more we use the data and kind of talk
12 about it, the better the data will become.

13 So, to Angelo's point, I think we want to keep
14 talking about it and keep using it.

15 The one question I have -- and this may be just --
16 - this is going to show my Medicaid age and just a little
17 bit of trauma. When I saw the maps, I immediately jumped
18 to expansion and non-expansion and thinking about is there
19 a relationship? Is there anything interesting to say about
20 the index relative to expansion and non-expansion?

21 I look at Texas and Florida in particular and
22 thinking about UC pools and kind of what was being driven

1 through there. It may be kind of old to think about, but I
2 think it's an interesting dynamic when you think about cuts
3 and how you're going to layer the data.

4 CHAIR VERLON JOHNSON: Thank you, Tim. We share
5 your trauma.

6 All right. Mike?

7 COMMISSIONER MICHAEL NARDONE: Thanks. Thanks
8 for this work, Chris and Chris.

9 I wanted to, you know, just -- I appreciate also
10 the presentation of the limitations of this work. I mean,
11 you know, we can't let the perfect get in the way of the
12 good. We have to make decisions, and, you know, I can't
13 really question -- I mean, I think the methodology seems
14 sound to me, not as a health services research, but just as
15 someone who kind of looks at the data.

16 And, you know, I do appreciate kind of making
17 sure that people understand that, you know, that there are
18 a lot of pieces here of data that we don't have. I
19 appreciate the limitation around that this is not
20 reflective of the extent to which -- well, it might be
21 reflective, but it is not how much Medicaid pays related to
22 costs, and I think that's an important caveat to be talking

1 about.

2 One of the things that strikes me as I look at
3 that map, though, is the incredible variability of the net,
4 the net payments, and I'm hoping that maybe between now and
5 we actually get to the chapter that there is some maybe
6 vetting of this with other researchers or states to kind of
7 better understand, like, what is the reason for the
8 variability? I mean, there may be factors there that we
9 might not be understanding, and I think it would be
10 important to kind of make sure that we're kind of exploring
11 those so we can put this work in the right context,
12 because, you know, I can tell you that within each of these
13 individual states, hospitals will be very interested to see
14 where they are on this chart.

15 So I think we need to, I think, do our due
16 diligence in terms of how we present this data so that it's
17 used in the right way, in an appropriate way.

18 One point, one of the questions you have is
19 around the interaction with outpatient work. My experience
20 in kind of the MCO world is that frequently when -- and,
21 you know, maybe some of my MCO colleagues can correct me on
22 this, but when you're dealing with a hospital system,

1 you're not negotiating inpatient rates in a vacuum. You're
2 negotiating inpatient rates, outpatient rates, kind of the
3 whole gamut.

4 Because outpatient rates generally, at least in
5 my state, were set based on a fee schedule for outpatient
6 that represented all providers, those rates tended to be
7 lower.

8 So one of the things that I think you would see
9 is that the inpatient rates may be a higher percentage of
10 fee-for-service than the outpatient rates, or vice versa.
11 But I think it's one of the ways that you could kind of
12 negotiate rates would have been to say, well, it's the
13 combination of those two. So, I just think when we're
14 thinking through this analysis, that that's something I
15 think we should also be thinking about.

16 Then the final thing I'm interested in is how
17 does this relate to high Medicaid critical access
18 hospitals? You know, how does this look for them?
19 Obviously, there's a big stake in terms of ensuring that
20 those providers are paid adequately, and so that would be
21 something that I hope would come out in the future work.

22 CHAIR VERLON JOHNSON: Thank you, Mike.

1 April?

2 COMMISSIONER APRIL HARTMAN: You've mentioned
3 what breakouts we'd like to see. Definitely see
4 freestanding children's hospitals be separated out, just
5 the number of enrollees served versus how much of the money
6 actually goes to the children's hospital.

7 And then you have to forgive my ignorance. Where
8 do nursing homes fit in? Are those inpatient? Outpatient?
9 Where does that go? Or is that its own category?

10 CHRIS PARK: That's its own category.

11 COMMISSIONER APRIL HARTMAN: Okay. All right.
12 So just looking at how that compares.

13 And then when you go to work on outpatient,
14 there's really not a lot to compare to what we do, what we
15 do with a well child and an adult well-check is very
16 different. So I would just be interested to see how those
17 rates are compared or how you -- what decisions are made on
18 that, just because it's very different. The emphasis, the
19 quality, everything is significantly different than how
20 it's done in the adult world. I'll just be interested to
21 see how that plays out, just a comment there.

22 CHAIR VERLON JOHNSON: All right. Thank you.

1 John?

2 COMMISSIONER JOHN MCCARTHY: Again, just
3 incredible work, Chris and Chris. I know it's super hard
4 to do. So nothing I'm saying is a criticism. It's just,
5 okay, how do we look at it going forward, that type of
6 piece.

7 Number one -- and this isn't for you all. It's
8 more for people listening to us, and that is, this data is
9 from 2022. So anybody who's looking at this data and says,
10 hey, let's make some policy decisions around this, there
11 are limitations to that, obviously, because we've seen
12 quite a bit of take-up in state-directed payments since
13 2022. So, if you looked at this data for 2025, I bet you
14 it would look very different. Even '26 would look even
15 more different than that. So I think that's one that's
16 really important.

17 I want to go back to the comment that Jenny made,
18 and that is, I agree with her. I think we should apply
19 those indexes to the total amount, because I understand,
20 Chris, why you did the way you did it. I fully understand.
21 But from running a Medicaid program, the way I'm looking at
22 it is, those hospitals are using that money to pay for

1 services. Just as Jenny said, a million dollars in
2 California is probably not going to go as far as a million
3 dollars in Louisiana. So there's probably some difference
4 there. So, to me, it's looking at applying those to gross.

5 The other piece that I would say is, I think we
6 need to be as transparent as possible in this, because I'm
7 always concerned of -- people come to us or attacking us or
8 saying that -- or saying why the data can't be used or
9 something like that. So, if we just had it all just out
10 there from the standpoint of, as Jenny said, like what are
11 those two different adjustment factors so we could see
12 that, but then also the table by state, because in that one
13 section, you talk about -- because I was thinking about
14 this when Mike was talking about the differences in the
15 two.

16 And it's like, well, when you're using an index,
17 it's not that big of a deal, because if there's -- well, I
18 know we don't have 50. But if there was 50, you know, and
19 each one was just different by one penny, you still have an
20 index that goes across, right? But then in your prose, you
21 say in there, I think Nevada was at like 7,000 and somebody
22 else was at 30 -- and Virginia was at 31,000. So there's a

1 huge difference between there. So I think seeing a table
2 that had those averages in there would be good to see also.
3 So you just could actually see how different that is across
4 there.

5 And then, lastly, back to what April was just
6 saying of, like, how do we break it out, I think if we do,
7 it would be helpful to broker it out by urban, rural, but
8 then also public versus private hospitals or teaching
9 hospitals also, because what I'm concerned about is in some
10 states, especially if you have a small number of hospitals
11 -- you know, some states that only have, like, three
12 hospital systems, you know, you could have it skewed
13 because one entity is a state entity, and they're using
14 IGTs. And they're driving the rates way, way up, and then
15 everyone else is paying very small -- you know, so you
16 could -- because we're using averages in there that -- I
17 mean, I know it's a weighted average, but it still would
18 skew those numbers quite a bit. So, if we broke it out by
19 some of those groups, you might be able to see that.

20 I know, just for instance, in Ohio, when we set
21 rates -- this was a while ago -- you know, we were looking
22 at cost coverage, just cost coverage. And when we redid

1 our rates the first time, urban hospitals were at, like,
2 somewhere around 80 percent cost coverage, and rurals were
3 at, like, 35 percent cost coverage. So we adjusted it so
4 everyone was at 80, but to get the rurals up to 80, it only
5 cost us -- I can't remember the exact number, but for sake
6 of argument, let's just say it was, like, 35 million state
7 share to get them up, because they were such a small number
8 compared to everyone else. And so that's why it's
9 important to see some of those breakouts in there for us in
10 the future to make any policy decisions around.

11 But, again, no criticisms. Just asking for stuff
12 you already have, and it's just amazing work that you did
13 to even bring this together because I know how hard it is
14 to get all that, especially on the supplemental payment
15 side.

16 CHRIS PARK: Yeah. I think we'll be able to do a
17 little bit more at for certain classes of hospitals when we
18 do the comparison to Medicare, because we'll be applying
19 some of the stuff both at the hospital and service level.

20 CHAIR VERLON JOHNSON: Thanks, John, for those
21 comments.

22 Jenny?

1 COMMISSIONER JENNIFER GERSTORFF: I wanted to add
2 just a couple of things.

3 One, I would suggest maybe breaking the hospitals
4 out further than just rural versus urban and bringing in
5 frontier as well as its own category.

6 And then coming back to outpatient hospital
7 services, I know that's on your agenda. I was wondering
8 what services will be included for that, if it's limited
9 to, like, what's in the outpatient prospective payment
10 system.

11 CHRIS PARK: Yeah. So I don't remember all of
12 the logic in terms of, like, how the -- the T-MSIS data are
13 classified, but CMS has created these federally assigned
14 service categories to kind of break out services into,
15 like, inpatient hospital, outpatient hospital. So that's
16 how we're identifying outpatient hospital services is
17 through that kind of logic using that specific FASC code
18 that was assigned by CMS.

19 So it may, like -- and depending on exactly that
20 logic, it may include certain -- some things that, you
21 know, might fall outside of the outpatient prospective
22 payment system.

1 Part of this work was informed by a technical
2 assistance panel a few years ago, and as we were vetting
3 some of this methodology with the experts, we were looking
4 at the quality of the data for, like, outpatient services
5 and inpatient services. And outpatient was certainly a
6 little bit more problematic in terms of states not
7 necessarily consistently reporting certain identifiers that
8 would be needed to run, like, an outpatient grouper.

9 So we are thinking about, like, the best way to
10 do that analysis, and we may have to kind of revert back to
11 comparing it to cost, you know, looking at cost reports and
12 trying to estimate cost as a way to benchmark the
13 outpatient payment versus doing it to Medicare.

14 COMMISSIONER JENNIFER GERSTORFF: Thanks, Chris.

15 CHAIR VERLON JOHNSON: All right. Well, thank
16 you again. And just echoing everyone else, this was just
17 great work, and we appreciate all your efforts and looking
18 forward to the next conversation around this.

19 So, for right now, we will go on to public
20 comments. We invite everyone in the audience to raise your
21 hand if you would like to offer a comment. Please make
22 sure you introduce yourself and the organization that you

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

3 And we have one. Rob. Rob Nelb.

4 **### PUBLIC COMMENT**

5 * ROB NELB: Yes.

6 CHAIR VERLON JOHNSON: Let's hear you.

7 ROB NELB: Hi there. Good afternoon.

8 Yes. Rob Nelb. I'm Director of Policy with
9 America's Essential Hospitals and appreciate the chance to
10 join you today.

11 First, I wanted to just appreciate the
12 Commission's work reviewing the SDP regulations and
13 especially the concerns that you've raised about that
14 service code-specific limit. We would share those concerns
15 as well, and we led a joint coalition letter with over 24
16 different providers, plans, and consumer groups to really
17 highlight how this new burden sublimit would limit states'
18 ability to implement value-based payment reforms.

19 I also wanted to elevate the point that some of
20 the Commissioners raised about how CMS's proposed state-
21 directed payment rule goes further than the statute and
22 would result in a much larger cut than what Congress

1 intended.

2 CBO projected that the SDP provisions would cut
3 about \$149 billion over 10 years, but in the proposed rule,
4 CMS projects \$510 billion in cuts, which is 3.4 times more
5 than what Congress intended.

6 I think these cuts are going to
7 disproportionately harm essential hospitals, which serve a
8 high share of Medicaid and uninsured patients.

9 So, as the Commission continues its work looking
10 at hospital payments, I really encourage you to look at the
11 unique effects on essential hospitals and consider all the
12 costs of care, not just for Medicaid but also for the
13 uninsured and the costs of some of the essential services
14 that our hospitals provide, which are under-reimbursed
15 across all payers.

16 As you do so, I encourage you to -- we've
17 proposed an essential health system designation that would
18 be a tool to help identify essential hospitals that builds
19 on the Commission's prior work looking at deemed DSH
20 hospitals, so point folks to that as a potential tool that
21 could be used in your analysis.

22 But really appreciate your work in this area, and

1 we hope to continue to work with you as you engage in this
2 important issue. Thanks.

3 CHAIR VERLON JOHNSON: Thank you, Rob.

4 Any other comments?

5 [No response.]

6 CHAIR VERLON JOHNSON: All right. Well, seeing
7 none, thank you again, Rob, for your comments. If there
8 are additional comments that you have later, you can
9 definitely submit those through our website.

10 So, with that, we'll go ahead and take a few
11 minutes' break. We'll be back at 3:30 p.m. to continue the
12 meeting.

13 Thank you.

14 * [Recess.]

15 CHAIR VERLON JOHNSON: All right. Welcome back.
16 Our next session examines utilization management for MOUD,
17 including prior authorization, daily dosage limits, and
18 refill thresholds. We are actually going to turn to Sheila
19 and Anu who are going to present with us some findings and
20 start us in our conversation. So I will turn it over to
21 both of you.

22 ### UTILIZATION MANAGEMENT FOR MEDICATIONS FOR OPIOID

1 **USE DISORDER (MOUD) IN MEDICAID**

2 * ANUPAMA WARRIER: Thanks, Verlon. Good
3 afternoon, Commissioners. Today Sheila and I will be
4 presenting an introduction to our work on utilization
5 management for medications for opioid use disorder, or
6 MOUD, in Medicaid. This work is a follow-up from our work
7 on access to MOUD in Medicaid, which culminated in a
8 chapter in our June 2025 Report to Congress.

9 Today we will review this project's key questions
10 and methodology, go over some background, and then Sheila
11 will review our key findings on utilization management of
12 MOUD in Medicaid. We will finish with our next steps and
13 questions for Commissioners.

14 Our key policy question for this project was
15 whether certain utilization management strategies, that is
16 prior authorization, or PA, daily dosage limits, and refill
17 thresholds enable states and managed care organizations, or
18 MCOs, to ensure appropriate and timely access to MOUD while
19 also managing costs. Our research questions centered
20 around what state and MCO policies were regarding these
21 utilization management strategies, how these policies were
22 developed, and what concerns stakeholders may have around

1 the use of these strategies for MOUD.

2 We contracted with Acumen to conduct a literature
3 review, 17 interviews, and a claims analysis to better
4 understand how states and MCOs use these utilization
5 management strategies for MOUD and the impacts on Medicaid
6 enrollees. The presentation today focuses on the
7 qualitative findings, and our October presentation will
8 focus on the quantitative findings.

9 Now we will cover some background on MOUD and
10 utilization management.

11 There are three types of FDA-approved MOUD.
12 Buprenorphine is a Schedule III controlled substance that
13 can be administered in several ways, including orally as
14 films or tablets, or subcutaneously as extended release
15 injections. The oral forms are available as either
16 buprenorphine-only monoproductions or buprenorphine/naloxone
17 combination products. Adding naloxone may reduce the risk
18 of misuse by dampening the effects of buprenorphine and
19 inducing opioid withdrawal when not taken as prescribed.

20 And then we have methadone, which is a Schedule
21 II substance, and can be dispensed for opioid use disorder
22 only at certified opioid treatment programs, or OTPs, and

1 cannot otherwise be prescribed for OUD.

2 Finally, naltrexone can be administered orally or
3 as an extended release injection, and is not a controlled
4 substance. And only the extended release injectable form
5 is FDA-approved to treat OUD.

6 The FDA has previously clarified that
7 buprenorphine treatment, or MOUD use generally, can be
8 indefinite depending on the patient's individual needs, and
9 federal guidance underscores that access to MOUD should not
10 be contingent upon receipt of other services, such as
11 counseling.

12 Past MACPAC analysis found that expanded
13 methadone coverage as a result of the MOUD benefit mandate
14 was associated with an increase in MOUD use that was nearly
15 6 percentage points higher than the increase in MOUD use in
16 states that already covered methadone, helping to narrow
17 gaps in coverage.

18 Compared to oral buprenorphine, use of the other
19 forms of MOUD, including injectable buprenorphine, was low
20 in fiscal year 2022. Factors such as limited provider
21 availability for administering these injectable
22 medications, utilization management policies intended to

1 steer patients towards the less costly oral formulation,
2 and patient preference may have restricted the use of this
3 form of MOUD.

4 Use of methadone may also be impacted by the
5 limited availability of OTPs and patients typically having
6 to travel to an OTP clinic to receive medication daily or
7 near daily.

8 States and MCOs implement utilization management
9 strategies to help ensure the delivery of appropriate care
10 and control costs while implementing the MOUD benefit
11 mandate. Common utilization management strategies include
12 PA, daily dosage limits, and refill thresholds.

13 The exact role of the entities involved in
14 setting these strategies vary by state, with Medicaid Drug
15 Utilization Review, or DUR, boards, making review
16 recommendations on the standards used in the DUR program.
17 In addition to the DUR boards, other entities such as State
18 Boards of Pharmacy, or SBOP, and Pharmaceutical and
19 Therapeutics, or P&T, committees establish utilization
20 management policies. P&T committees develop the state
21 Medicaid agencies' preferred drug list, or PDL, unless the
22 state has opted for the DUR board to do so.

1 And I will note that federal Medicaid statute
2 addresses certain aspects of these utilization management
3 strategies and their development under DUR boards and P&T
4 committees but does not govern State Boards of Pharmacy.

5 Medicaid P&T committees and DUR boards generally
6 develop Medicaid PA policies. State Medicaid agencies and
7 MCOs have flexibility to apply PA to health care services,
8 including MOUD and related treatments, but federal statute
9 and rules set some general requirements.

10 The Social Security Act requires that any PA
11 approval system used in fee-for-service Medicaid must
12 provide a response within 24 hours of a request. MCOs can
13 also apply PA and are subject to the same approval system
14 requirements as fee-for-service. State Medicaid agencies
15 and MCOs use PDLs to indicate which drugs are covered
16 without PA.

17 Daily dosage limits are generally set by P&T
18 committees and DUR boards and can vary by payer. Daily
19 dosage limits typically follow FDA labeling and clinical
20 trial findings but may fail to keep up with changes in
21 clinical practice. Dosage limits are sometimes included on
22 the PDL or in attached documentation.

1 Refill thresholds are often defined in state
2 regulations, including Medicaid or SBOP regulations. State
3 Medicaid agencies also report refill thresholds used in
4 their fee-for-service programs and by MCOs to CMS.

5 Federal regulations govern how often in a time
6 frame prescriptions for controlled substances can be
7 refilled, mandating that Schedule III controlled substances
8 cannot be refilled beyond six months after the prescription
9 date or more than five times, whichever occurs first.

10 I will now pass it to Sheila to discuss the
11 findings from the literature review and the stakeholder
12 interviews.

13 * SHEILA SHAHEED: Thanks, Anu. I will now go over
14 our key findings, starting with PA.

15 States and MCOs implement PA requirements on
16 medications to control costs while ensuring care is
17 medically necessary, safe, and cost effective, but findings
18 are mixed when it comes to these outcomes. Cost savings
19 for total cost of care expenditures are limited when PA is
20 applied to MOUD. One study on the effects of a
21 Massachusetts Medicaid policy that increased the frequency
22 of PA for higher doses of buprenorphine found that it was

1 associated with limited cost savings.

2 States can also achieve cost savings through
3 supplemental rebates by placing certain medications on
4 their PDLs and categorizing others as non-preferred and
5 requiring PA for coverage. States we spoke to did not
6 describe any changes in costs associated with the removal
7 of PA requirements but noted less provider burden and
8 increased buprenorphine utilization.

9 There is some evidence that PA can achieve its
10 goals of ensuring MOUD is prescribed appropriately, but
11 ultimately research is mixed on the effects of PA on
12 utilization of MOUD. We reviewed a study that found that
13 removing PA requirements for buprenorphine may not result
14 in marked changes in buprenorphine prescribing. However,
15 another study found that removing PA was associated with an
16 increase in buprenorphine prescribing in states with lower
17 baseline prescribing rates. The study found no change in
18 states with higher baseline prescribing rates.

19 We also found limited information about the
20 association between PA and diversion, which is when a
21 prescription medication is rerouted to someone other than
22 for whom it was intended or they are used for purposes not

1 intended by the prescriber.

2 Stakeholders had mixed perspectives on whether
3 diversion is considered in PA policy development, knowing
4 that buprenorphine has a limited diversion value. We
5 reviewed a study examining outcomes following initiation of
6 MOUD treatment among Medicaid enrollees in Pennsylvania
7 that demonstrated that enrollees in Medicaid plans with
8 high or low PA had lower rates of opioid misuse than
9 enrollees in plans with no PA.

10 Ultimately, PA can cause delays and disruptions
11 in care at multiple points during treatment, including for
12 initial prescriptions, refills, increasing or decreasing
13 dosages, or through receipt of a particular form of MOUD.
14 PA can be time consuming and can sometimes take multiple
15 days to process, particularly in smaller practices, and
16 these delays can inhibit a patient's ability to start or
17 continue MOUD.

18 There is a lack of publicly available, payer-
19 specific PA processes and clinical criteria, and the
20 Commission commented on the 2026 CMS interoperability
21 proposed rule and asked CMS to consider reporting certain
22 PA data at a more granular level to better monitor outcomes

1 for specific populations and services.

2 The DUR report provides some information on state
3 PA policies. It includes information on whether states
4 have at least one formulation of a buprenorphine/naloxone
5 combination product available without PA, but does not
6 provide details about the policies. The DUR report does
7 not include information on PA requirements for other
8 buprenorphine products, such as the oral buprenorphine
9 monoprodut or the injectable buprenorphine products.

10 The DUR report does not differentiate between
11 coverage of the FDA-approved extended release injectable
12 naltrexone or use of off-label, medically accepted
13 indication of oral naltrexone, when asking whether states
14 cover at least one formulation of naltrexone for OUD
15 without PA. And the DUR reports do not include information
16 on PA for methadone.

17 In fiscal year 2023, 47 states and the District
18 of Columbia reported having at least one
19 buprenorphine/naloxone combination product available
20 without PA, an increase from 41 states and D.C. in fiscal
21 year 2019, though PA may still be required for higher doses
22 of buprenorphine/naloxone or for early refills.

1 Several states that we interviewed indicated they
2 have flexibility in designing PA policies, and we learned
3 from the literature review and from interviews that some
4 states have removed PA for buprenorphine in their Medicaid
5 programs. We also learned that decisions over what drugs
6 are included in a state's PDL are primarily cost based and
7 depend on negotiations with manufacturers regarding
8 supplemental rebates.

9 PDL designs vary by state. For example, some
10 states have decided to use a single PDL because it allows
11 for better negotiation of supplemental rebates for some
12 drugs and improves their purchasing power. States also
13 told us that single PDLs may reduce administrative burden
14 and improve the prescribing process for providers. Two
15 state interviewees indicated that a single PDL has also
16 improved continuity of care for their Medicaid enrollees.

17 Daily dosage limits are intended to ensure that
18 prescriptions align with clinical standards but can pose
19 barriers to access to treatment. FDA regulations specify
20 the information that must be listed on drug labels, such as
21 prescribing information for health care providers,
22 including an upper limit beyond which safety and

1 effectiveness have not been established or beyond which
2 increasing the dose does not result in increasing
3 effectiveness.

4 In December 2024, the FDA, recognizing the
5 growing role of highly potent synthetic opioids and with
6 input from stakeholders asked manufacturers to update their
7 oral buprenorphine product labels to clarify that 16 or 24
8 milligrams per day should not be interpreted as maximum
9 doses, and that daily doses above 24 milligrams per day may
10 be appropriate for some patients. However, as of August
11 2025, only labels for two brand-name products have been
12 updated.

13 States generally set their limits based on
14 initial clinical trials and drug labels. As of fiscal year
15 2023, three states still have a daily dosage limit of 16
16 milligrams per day. States may be concerned about
17 budgetary considerations or the risk of diversion with
18 higher doses.

19 Additionally, some states have also implemented
20 dose-tapering policies, requiring that dose limits be
21 lowered after a specific period. But state policies
22 requiring that doses be lowered over time may also be

1 misaligned with FDA guidance clarifying that doses above 24
2 milligrams per day may be appropriate for some patients
3 with more severe needs.

4 Based on our review of CMS DUR reports, in fiscal
5 year 2023, a majority of state fee-for-service programs set
6 daily dosage limits on oral buprenorphine products in the
7 24 milligram amount, an increase of six states from fiscal
8 year 2019. Thirteen states have set daily dosage limits of
9 32 milligrams per day, or do not have such limits in place.

10 While the Drug Enforcement Agency determines
11 refill limits and time frames for Schedule III drugs as
12 part of their regulation of controlled substances, state
13 Medicaid agencies and MCOs are required to specify refill
14 thresholds for opioids, including MOUD, as part of their
15 DUR programs.

16 Refill thresholds are a prospective safety edit
17 which aims to provide information to pharmacists at the
18 point of sale before they dispense a prescription. As an
19 example of a refill threshold percentage, an enrollee in a
20 state with a refill threshold in the 90 to 94 percent
21 range, who filled their 30-day prescription on the first of
22 the month, would be unable to refill their prescription

1 until about the 28th or 29th day of the month. Higher
2 refill thresholds imposed for shorter prescriptions, like a
3 7-day fill, can mean a refill could be dispensed only one
4 day early.

5 States have the flexibility to set different
6 thresholds for controlled substances compared to non-
7 controlled substances and based on controlled substance
8 schedules, i.e., thresholds for Schedule III drugs
9 differing from those of Schedule IV drugs.

10 We heard in our interviews that pharmacies may
11 set refill threshold policies that are stricter from those
12 of Medicaid and other payers, and policies can vary within
13 and across chain pharmacies. While some of the
14 stakeholders that we spoke to noted such pharmacy
15 practices, they had differing views on how commonly the
16 practices occurred, and we found little literature on this
17 topic.

18 Four interviewed states excluded MOUD from edits
19 for opioids for pain, although most states did not describe
20 the specifics of these edits, while one state Medicaid
21 agency we spoke to confirmed that these edits for pain do
22 apply to MOUD.

1 Though the Commission's focus is on Medicaid, we
2 did want to highlight a few key differences between
3 Medicare and Medicaid MOUD utilization management policies.

4 Though PA of buprenorphine is not allowed more
5 than once per plan year for Medicare Part D enrollees,
6 state Medicaid programs can require PA for all types of
7 MOUD more than once per plan year if the process is not
8 overly restrictive and does not violate federal parity
9 requirements. And while Part D plan sponsors cannot
10 include buprenorphine in the required opioid safety edits,
11 they can implement separate safety edits, PA, or quantity
12 limits for buprenorphine based on FDA labeling. And CMS
13 notes that states are expected to include MOUD in their
14 prospective safety edits for Medicaid.

15 Lastly, Medicaid requires a refill threshold be
16 shared as part of their DUR reporting, whereas Medicare
17 does not require a refill threshold.

18 Thank you all for listening so far. We welcome
19 thoughts on the findings, and if there are further
20 questions from the Commission based on the evidence
21 presented. Our Next Steps slide notes the particular areas
22 that we have talked about, and we would appreciate hearing

1 your feedback on these issues.

2 And I will pass it back to our Madam Chairwoman,
3 Verlon.

4 CHAIR VERLON JOHNSON: Oh, I like that, Madam
5 Chairwoman. Thank you both. That was very, very helpful.
6 I will open it up now for Commissioner comments or
7 questions. Doug.

8 COMMISSIONER DOUG BROWN: Thank you. Thanks, you
9 guys. Great presentation. Complete. Thoughtful. I think
10 you hit all the major points, which is nice.

11 I do struggle a little bit, as we think about
12 this whole category and the whole disease state, because I
13 am not sure that PA and refill edit and refills and
14 quantity limits is really that element that's limiting
15 treatment in this. I think it's more on the front end of
16 this.

17 And when we get to the point where we complete a
18 chapter and submit a chapter, I want to make sure that we
19 talk about providers and the number of providers that treat
20 patients and the number of patients that are in need of
21 treatment, and what that process looks like, from beginning
22 to end. Certainly this is the end part of that process as

1 we kind of go through.

2 I know you are going to do some claims analysis
3 that is going to be coming up next. You talked about that
4 a little bit. In the data that you have for the claims,
5 can you talk a little bit about what data elements you have
6 there? Does that include individual patients where you can
7 track individual patients, look for things like early
8 refill, look for compliance, days' supply, quantity,
9 prescriptions? Can you talk a little bit about what your
10 analysis is going to look like?

11 ANUPAMA WARRIER: Our claims analysis is using T-
12 MSIS Medicaid claims data from the calendar years 2019 to
13 2023. We are able to obviously see some individuals over
14 time, but the actual measures not requiring that the
15 patient is enrolled the entire however many years that is,
16 four years.

17 There are also certain outcomes that are looking
18 at continuity, let's say MOUD treatment continuity was one
19 we had looked at. Refill thresholds was a tricky one,
20 where the way we had defined it in our analysis was using
21 that percentage that we described when Sheila was
22 presenting. And what that meant was when you're looking

1 for decreases or increases in those refill thresholds over
2 time, sometimes they are, in actually, in practice, kind of
3 meaningless. You have to kind of decide how much of a
4 decrease is meaningful in clinical practice or at the
5 pharmacy level.

6 So we have ended up kind of de-emphasizing the
7 refill threshold part of the claims analysis, but what we
8 will focus on is looking at states that removed prior
9 authorization for at least one, having at least one form of
10 buprenorphine/naloxone combination product available
11 without prior authorization. That's according to the DUR
12 report. So we will track certain outcomes based on those
13 states.

14 And then we are looking at daily dosage limits,
15 states that increased the daily dosage limit of
16 buprenorphine to at least 32 milligrams per day in that
17 same study period, and again, looking at different types of
18 measures such as MOUD utilization.

19 COMMISSIONER DOUG BROWN: Will you be able to see
20 the dosages? I mean, you'll be able to see the
21 prescriptions, but if you are talking multiple units of the
22 same prescription, are you seeing the prescription and the

1 total units that were dispensed and then doing the math in
2 order to calculate --

3 ANUPAMA WARRIER: That's right. I'll have to
4 double-check on the methodology, and I can share that with
5 you, but that is my understanding.

6 COMMISSIONER DOUG BROWN: And then is there other
7 health-related outcomes like hospitalization?

8 ANUPAMA WARRIER: ED visits, opioid-related ED
9 visits.

10 COMMISSIONER DOUG BROWN: ED visits after they
11 started treatment, so that you could kind of see where that
12 occurs after the patient has been stabilized and if they
13 have a hospitalization after that.

14 ANUPAMA WARRIER: I believe we are looking for
15 the patients that have had at least one buprenorphine fill,
16 yeah, and then seeing if they have had an opioid-related ED
17 visit or an opioid-related overdose. But I will double-
18 check and get back to you.

19 COMMISSIONER DOUG BROWN: Okay. And then I want
20 to also talk about the misalignment -- maybe misalignment
21 is not the right word. Medicare has a certain way they are
22 managing their coverage of these drugs. Medicaid is

1 different from that. Medicare is federal. It is one
2 program. We are talking 50 states plus D.C. and
3 territories. They each have their boards. You mentioned
4 them in the slide -- DUR board, P&T, State Board of
5 Pharmacy -- all have different rules and regulations. It's
6 going to be difficult to kind of align those across all
7 those different entities, I think, in that way, because
8 many times you've got individual boards in states that are
9 making a decision, and many times those decisions are based
10 on best evidence that is presented, label guidelines, other
11 things like that.

12 I think if you are going to make a recommendation
13 that moves forward you have to start at HHS and then work
14 down through what FDA is saying and then work down through
15 what SAMHSA is saying, and other. But it has to probably
16 come from HHS and the Secretary to say, you know, the way
17 we're going to do this is we want you to use more than what
18 is in the label. Because if it's just two products so far
19 that have changed their label, according to what you said
20 today, to go beyond that 24 milligram dose, and states
21 aren't doing that because clearly not from the evidence you
22 shared, then that has to be something that we need to talk

1 about, and it's got to be overtly stated or recommended.
2 But it's got to be stated by HHS to push down through the
3 rest of the organizations that manage that. So I think
4 those are some of the places.

5 I'm going to stop talking for a minute and let
6 other Commissioners chime in.

7 ANUPAMA WARRIER: Thank you.

8 COMMISSIONER DOUG BROWN: But thank you, guys.
9 Really good work.

10 CHAIR VERLON JOHNSON: Thank you, Doug. Heidi?

11 COMMISSIONER HEIDI ALLEN: Yeah. I think I hear
12 what you're saying about in all of this policy we've kind
13 of had to wait for federal action to lead the way. And
14 what we've seen, the number of providers that are allowed
15 to prescribe MOUD, it took a long time for that to happen.

16 But we are seeing really rapid evolution of the
17 drugs on the streets, and very clear evidence that some of
18 the newer opioids on the street, you cannot prevent an
19 overdose with what the standard treatments are.

20 So I worry that PA was such a bureaucratic thing,
21 right. It's a lever that we have to try to control costs.
22 It is also a lever to try to avoid diversion, like was

1 spoken before. But it sounds like there are bigger issues,
2 trying to save people's lives, and that if PA is what is
3 getting in the way of people getting a dose that could
4 actually save their life, then waiting for a big process by
5 which there a committee that's formed and they're like,
6 wow, there's new drugs, and they're too strong for our
7 current medications to prevent loss of life.

8 I guess I would just err towards trying to have a
9 more generous, more meaningful PA policy that aligns with
10 what's happening on the streets for this population. I
11 would be interested to hear what other Commissioners have
12 to think about that. But I know that I worry for my kids,
13 and I worry for the community that I live in. And when you
14 get people that are willing to start treatment, you really
15 want to go all in, in trying to keep them alive and on
16 their meds.

17 So bureaucracy that might be penny wise, pound
18 foolish, particularly when stacked up against a human life,
19 I think is worth really taking a closer look at.

20 CHAIR VERLON JOHNSON: Other Commissioners?

21 Patti.

22 COMMISSIONER PATTI KILLINGSWORTH: I feel like I

1 just lack the clinical expertise to speak into this issue,
2 and so, Doug, I'm going to put you on the spot, because I
3 hear everything that Heidi is saying, and yet what I don't
4 know is the risks of not having these kinds of reasonable
5 limits. Are these limits primarily about managing
6 utilization as it relates to the cost of these services, or
7 is it really about patient safety and not over-prescribing
8 or prescribing unsafe doses?

9 You know, lots of drugs have these kinds of
10 limits on them, and we're used to those and understand them
11 to be appropriate for patient safety, but just can you talk
12 a little bit about pros and cons in this?

13 COMMISSIONER DOUG BROWN: To the degree that
14 prior authorization is commonly used in Medicaid programs,
15 we see it in preferred drug lists. We don't really talk
16 about the cost of this class. There's some recent
17 information that's out in a Medicaid report that talks
18 about just that this is the tenth most cost driver from a
19 net cost perspective class for state Medicaid programs,
20 behind antipsychotics, HIV, and some other classes. So
21 there is certainly a cost that states have to think through
22 with this class.

1 But I've never been in a situation where the
2 state said we need to ratchet down the choices here because
3 we're spending too much money. Everybody understands the
4 dynamics of this class, the urgency for treatment, as Heidi
5 was talking about, and the need to get people on meds, stay
6 on meds, et cetera.

7 I think where the PAs in this class come in is
8 you have first-line treatments that are available,
9 preferred drugs that are available, and then there's PAs
10 for other drugs that for safety reasons where you should
11 try one product before you go to a long-acting product, for
12 example, to make sure you can tolerate the product, or you
13 have to be detoxed before you can go on a product. There
14 should be prior authorization there to make sure someone
15 just doesn't start on that product or you're going to put
16 someone right into withdrawals. So there's some safety
17 elements in there that are prior auth.

18 But P&T committees, part of their role is to make
19 sure that drugs are used safe and effectively, and part of
20 the DUR and part of the P&T is not only to preferred drugs,
21 but to review all the clinical information to make sure
22 that the state sets the right limits around particular

1 products.

2 I hope that helps.

3 COMMISSIONER PATTI KILLINGSWORTH: That's super
4 helpful.

5 So, as we think about what's our proper role as a
6 Commission in terms of thinking about access, it doesn't
7 seem that we would want to take away authority from those
8 entities that we believe are attempting to make clinically
9 sound recommendations around what's best for the people who
10 actually need these drugs.

11 So I'm just trying to think through, like, what
12 would the policy options be? Is it Medicaid: you should
13 align with Medicare? But I don't know if that's a good
14 idea or not.

15 And I wonder if in all of the work that we've
16 done so far, if we've talked with people on those
17 committees, if we've kind of had a chance to vet with them
18 -- for lack of a better term, I'll call them
19 "inconsistencies," but that may not be the right term here.
20 You would think that what's clinically best is just
21 clinically best and not clinically best in 50 different
22 ways.

1 But I'm struggling, just because I feel like this
2 is a really important issue. Obviously, we all agree that
3 access is really important, but so is safety. So, in order
4 for us to step into this and think about any kind of a
5 policy recommendation, there's really important issues.

6 COMMISSIONER DOUG BROWN: I think another area or
7 another evidence that would help us is if we could see
8 actual prior authorization criteria from a couple of states
9 as to what they require, which would then give us an idea
10 of what states are doing.

11 We know that there's a 24-hour clock that runs on
12 a prior authorization, and that applies to MCOs also. So,
13 having evidence or having information from states, what
14 their prior authorization criteria looks like to get some
15 of these products, maybe some that kind of don't have a
16 limit and then some that have limits, 16-milligram or 24-
17 milligram like we saw on the chart, and get a couple of
18 examples of what they have or if we can get their criteria
19 exactly, and then we can put it in a chart and kind of
20 compare that to maybe what Medicare has and kind of put
21 them side by side in kind of a chart that would help us to
22 make a more informed decision.

1 CHAIR VERLON JOHNSON: Thank you.

2 Oh, John.

3 COMMISSIONER JOHN McCARTHY: I guess that's --
4 your question to us was what is it that you -- you're doing
5 your next step of analysis, right? So your question to us
6 is, what is it that you need to look at? And so I'm just
7 going back to what, Patti, you were just saying. We're not
8 jumping to the policy part yet. They're going to go do
9 some analysis for us, and if I'm reading this correctly,
10 there's only three states that PA buprenorphine now, right,
11 according to the chart that you had, the map that you
12 showed in there.

13 ANUPAMA WARRIER: So it was three states that
14 still have a daily dosage limit of 16 milligrams per day.
15 That was what we had read out from our presentation.

16 COMMISSIONER JOHN McCARTHY: In the memo on page
17 7, there's a map, and it says prior authorization policy in
18 state fee-for-service programs for at least one form of
19 buprenorphine in federal fiscal year -- in fiscal year
20 2023. And only three states have -- on that map, are gray.
21 Right? So doesn't that say only three states require PA?
22 Okay. So only three states require PA to get

1 buprenorphine.

2 ANUPAMA WARRIER: So the DUR question is, do you
3 have at least one buprenorphine/naloxone combination
4 product available without prior authorization in your
5 state, and those three do not.

6 COMMISSIONER JOHN MCCARTHY: Right. So, in every
7 other state, though, you can get one. There's at least one
8 you can get. And this is back to what Doug was saying,
9 like fast-acting versus slow-acting.

10 I do sit on the board of an SUD company. Just
11 saying, like, you know, when I talk to our clinicians, when
12 somebody first comes in, they use the -- not the long-
13 lasting because you're trying to figure it out and that
14 type of thing. So I'm assuming it's a quick -- so my point
15 is the analysis for you is to do on these things is looking
16 at those claims, and we're going to be able to look at
17 those states and their outcomes versus other states that
18 don't have PA.

19 And then on the limits one, same thing, right?
20 That's the 16, the 24, and the 32, and some states have
21 just been moving up. So, that would be what would be
22 interesting to me, is when you're looking at claims data

1 and you're looking at, you know, the claims data around
2 these medications plus looking at things like ER
3 utilization and inpatient utilization for overdoses or
4 things like that. That will give us our comparison. It
5 seems like -- or not give us our comparison, but it will
6 help make us -- help us make decisions with some type of
7 data to say, do these things make a difference in these
8 different pieces?

9 I think the other thing -- and I brought this up
10 before -- we have to be a little bit careful of, is if you
11 look at this, you know, two of the states on here, maybe
12 three -- I don't know about Montana, but they're not
13 expansion states. So Texas and Alabama are not expansion
14 states. So, again, what does that look like versus an
15 expansion state? Because, you know, one of the issues in
16 expansion states, many of the people who need these drugs
17 are covered through group VIII. So, you know, we've got to
18 make sure that when you're doing your analysis, you're
19 separating those two things so we're able to compare apples
20 to apples.

21 So, from my standpoint, it's as you're pulling
22 those things out for us, we'll be able to look at that and

1 use some data and make some decisions around policies of
2 saying, you know, is PA good or bad and some of these other
3 different pieces. Thanks.

4 CHAIR VERLON JOHNSON: Thanks, John.
5 Angelo?

6 COMMISSIONER ANGELO GIARDINO: Thanks for the
7 work. It was really interesting to read the prep
8 materials.

9 I guess a couple things. I would love to have
10 some context for the conversation. So I feel like we're
11 really wading into clinical decision-making here. And, of
12 course, policy always is balanced with the people at the
13 sharp end of the spear doing the actual clinical care, but
14 this seems particularly relevant to what's happening
15 clinically.

16 So I'd be particularly interested in what some
17 national groups that have expertise in this have said about
18 best practices and care guidelines and approaches to
19 reducing barriers to treating this problem. And I don't
20 know what those groups are, but I'm almost sure there's
21 probably one that has psychiatrists in it. There's another
22 one that probably has people that have lived experience

1 that have said something. There's probably a group of
2 pharmacists that are involved in the dispensing of this.
3 So I would really want to have some professional input in
4 terms of what best practices are.

5 The other thing is, you know, when we compare
6 Medicare and Medicaid, I would really need to see an age
7 breakdown of the people that have used those products. I'm
8 not an expert in this field, but I'm almost sure a 69-year-
9 old with this problem is a lot different than a 27-year-
10 old. So that is really important to understand the tiering
11 and the drill-down of age groups and how people deal with
12 stigmatized diagnoses and whatnot.

13 So I would really want to have some clinical
14 input, and maybe that's a panel or people with lived
15 experience. But I'm assuming that the simpler we make
16 this, the more people we're going to treat who need the
17 care. And there's other elements to our regulatory
18 environment that can catch the people that are using this
19 in a nefarious way.

20 So I think we should pursue a guiding principle
21 of simplification so that people that have a really serious
22 medical problem get the treatment, and I'd love to see some

1 work from the field because I know people in this field
2 talk about promoting the treatment of a stigmatized
3 diagnosis. And the more barriers we erect, the harder it
4 is.

5 I would say, you know, when there's a barrier to
6 getting primary care and preventative care, which is not
7 stigmatized whatsoever, people get less of that care. So
8 the more complicated we make it, people get less care. The
9 more complicated you make something related to a
10 stigmatized diagnosis, I know they don't get the care.

11 So I would really want to see some of that
12 information before we start weighing in on whether or not
13 an element of a regulatory environment like prior
14 authorization is useful or not. That, to me, is like three
15 steps away from what the issue really is. Thank you.

16 CHAIR VERLON JOHNSON: Thank you, Doug.

17 Any others?

18 Heidi.

19 COMMISSIONER HEIDI ALLEN: What did the person
20 with lived experience have to say in the report?

21 COMMISSIONER ANGELO GIARDINO: I can answer that.
22 They don't like the PAs.

1 SHEILA SHAHEED: Sorry. Just to clarify, were
2 you asking for the person with lived experiences? On prior
3 auth, pretty much they were able to just explain that
4 sometimes when they go to the pharmacy, prior authorization
5 can -- essentially, their pharmacist might have to call
6 their prescriber in order to verify things. So,
7 essentially, they just explained that prior auth can
8 sometimes cause delays in getting the medication due to
9 sometimes their pharmacist having to contact their
10 provider. That was pretty much their extent on prior
11 authorization.

12 COMMISSIONER HEIDI ALLEN: I mean, one thing to
13 think about -- and I really appreciate Angelo's suggestion
14 that we look at what different bodies of experts think is
15 the right approach to that. But this also may be why some
16 providers don't like to provide this kind of care if
17 they're constantly being called and having to connect with
18 the pharmacy to say that they approve something like that,
19 so thinking of the burden. And I do remember that as part
20 of our chapter, I think, that there had been difficulties
21 with getting providers who were willing to see these
22 patients and do this work, also, thinking of prior auth on

1 the provider side and whether or not that's a disincentive
2 for working with people with substance use disorder.

3 CHAIR VERLON JOHNSON: I like that a lot. I was
4 going to say the same in terms of the provider perspective
5 and the lived experience is important.

6 I guess the other thing I'm just curious about
7 is, does it operate differently, these policies for,
8 depending upon where people live geographically, depending
9 upon if they're pregnant or other things like mental
10 health? Are there any differences in that perspective that
11 could potentially be a little bit different in how they
12 obtain these?

13 SHEILA SHAHEED: So our analysis did not look at
14 urbanicity versus rurality.

15 For pregnancy, did you want to speak to
16 pregnancy?

17 ANUPAMA WARRIER: So one thing that we found is
18 that there are different types of buprenorphine products.
19 One, like I said, is the naloxone combination product, and
20 then one is the monoprodut. So what we had heard from
21 some of these interviews is that patients sometimes have a
22 preference for the product without naloxone in it, because

1 naloxone can sometimes cause gastrointestinal issues.

2 CHAIR VERLON JOHNSON: Okay.

3 ANUPAMA WARRIER: Some patients do not tolerate
4 it well, and one of the populations that they mentioned
5 were pregnant people that cannot tolerate naloxone as well.
6 But, again, that's anecdotal. We didn't dig into the
7 clinical work on that.

8 CHAIR VERLON JOHNSON: Okay. Very helpful.

9 Any other thoughts or questions before we close
10 out?

11 [No response.]

12 CHAIR VERLON JOHNSON: I know we're looking
13 forward to more about the claims data and the outcomes for
14 that. So thank you both for this presentation. We
15 appreciate it.

16 SHEILA SHAHEED: Thank you.

17 CHAIR VERLON JOHNSON: All right. Next up, we're
18 going to talk about children and youth in foster care and
19 roles in Medicaid managed care. So we'll give the analysts
20 some time to get up here.

21 [Pause.]

22 CHAIR VERLON JOHNSON: Okay. This is a topic

1 that's been near and dear to us for a minute, so looking
2 forward to hearing from Ava and Audrey about this topic.
3 So I will turn it over to both of you.

4 **### CHILDREN AND YOUTH IN FOSTER CARE ENROLLED IN**
5 **MEDICAID MANAGED CARE**

6 * AVA WILLIAMS: Good afternoon, Commissioners.
7 Audrey and I are here to talk about children and youth in
8 foster care enrolled in Medicaid managed care. This is the
9 second phase of work related to children and youth in
10 foster care. Last year we examined access to care for this
11 population and published a chapter in the March 2026 Report
12 to Congress. During that project, Commissioners showed
13 interest in learning about this population's experience in
14 managed care. So, this project is meant to address
15 Commissioner comments and examine how states use Medicaid
16 managed care to serve children and youth in foster care.

17 First, I will present some background, including
18 information about how children and youth in foster care are
19 enrolled in Medicaid and requirements for child welfare and
20 state Medicaid collaboration. Then I will present federal
21 policies related to managed care, including authorities
22 states can use to enroll this population into managed care,

1 and federal requirements related to managed care.

2 Lastly, Audrey will present findings from our
3 state policy scan which examined state Medicaid policies
4 related to children and youth in foster care. Finally, we
5 will end with next steps and questions for Commissioners.

6 Now let's move on to the background.

7 Children and youth in foster care, children
8 receiving adoption assistance, and youth formerly in foster
9 care are eligible for Medicaid through several eligibility
10 pathways. Children and youth who receive foster care
11 maintenance payments under Title IV-E of the Social
12 Security Act are automatically eligible for Medicaid, and
13 states are required to enroll former foster care youth in
14 Medicaid up to age 26, regardless of income and assets.

15 I also want to highlight that children and youth
16 in foster care are entitled to the same coverage and
17 covered benefits as other beneficiaries. For example,
18 states are required to provide 12 months of continuous
19 coverage to beneficiaries up to age 19. Additionally, if
20 beneficiaries younger than age 21 are entitled to medically
21 necessary services under the Early and Periodic Screening,
22 Diagnostic, and Treatment requirement.

1 The previous work found that state child welfare
2 and state Medicaid agencies collaborate on serving children
3 and youth in foster care. This project will examine how
4 managed care plans play a role in this collaboration. But
5 as a reminder, state child welfare agencies are required to
6 coordinate with state Medicaid agencies on the health care
7 of children and youth in foster care, including developing
8 a health oversight plan and sharing necessary medical
9 information. State Medicaid agencies do not have a
10 parallel requirement to coordinate with child welfare
11 agencies, but they can share beneficiary information for
12 certain purposes, such as the administration of services.

13 Now I am going to go over the federal managed
14 care policies, including ones related to children and youth
15 in foster care.

16 There are several federal authorities states can
17 use to enroll children and youth in foster care into
18 managed care. States can use Section 1932 state plan
19 authority to enroll this population into managed care on a
20 voluntary basis. However, this authority does not allow
21 states to mandatorily enroll this population into managed
22 care.

1 Section 1915(b) waiver authority allows states to
2 mandatorily enroll children and youth in foster care into
3 managed care. Similarly, Section 1115 demonstration
4 authority allows states to waive Section 1932(a) exclusion
5 of mandatorily enrolling this population into managed care.

6 States can use different types of managed care
7 plans to serve children and youth in foster care. For
8 example, states may choose to enroll this population in the
9 same general managed care plans that serve non-foster care
10 populations. In some cases, states do have policies
11 designed to meet the needs of this population in their
12 managed care contracts.

13 States can also choose to enroll this population
14 into a specialty managed care plan that is designed to meet
15 the unique needs of these beneficiaries. These plans often
16 cover children and youth in the child welfare system,
17 including children in foster care and children in
18 subsidized adoption. Additionally, states may also enroll
19 children with chronic and complex conditions into these
20 plans.

21 Lastly, I would like to go over some of the
22 federal managed care requirements. For example, there are

1 requirements around the scope of services a plan can
2 provide: maintaining an adequate provider network,
3 capitation rate development, and oversight of quality of
4 services. Additionally, if a state mandatorily enrolls
5 beneficiaries in managed care they must provide a choice of
6 at least two managed care entities.

7 Thank you for your time. I will now turn it over
8 to Audrey.

9 * AUDREY NUAMAH: Thank you, Ava. Now I will
10 discuss the findings from our state policy scan that we did
11 with a contractor.

12 The state policy scan included a review of
13 publicly available documents such as managed care plan
14 contracts, external quality review reports, and managed
15 care program annual reports, also known as MCPARs, for 10
16 states. We looked at 4 states that use these general
17 managed care plans, and those were Hawaii, Iowa,
18 Massachusetts, and Oregon, and then we looked at 6 states
19 that used specialty plans, and those were Arizona,
20 Illinois, North Carolina, Tennessee, Texas, and West
21 Virginia. Through this scan we identified state
22 requirements for plans related to covered benefits,

1 provider networks, transitions of care, payment, and
2 quality, and we will go over these findings now.

3 When it comes to covered benefits, some states
4 with general managed care plans require plans to provide
5 enhanced benefits to certain children and youth in foster
6 care. For example, in one state a plan provides intensive
7 care management to youth in foster care who have medically
8 complex conditions. In the other three general states,
9 some of these plans provide intensive care coordination for
10 children and youth with special health care needs, and that
11 can include children in foster care.

12 However, states with specialty managed care plans
13 require the plans to provide enhanced benefits for all
14 children and youth in foster care. That can include
15 targeted case management, intensive care coordination, and
16 therapeutic foster care. As a reminder, therapeutic foster
17 care is a family-based option for kids who need an
18 intensive level of care but not quite at the level of
19 institutionalization.

20 Additionally, states apply the same utilization
21 management policies and approaches for children and youth
22 in foster care as they do with non-foster care population.

1 When it comes to coordination with other
2 agencies, both states with general and specialty plans
3 require plans to coordinate with other agencies that
4 interact with children and youth in the foster care system.
5 That can include the child welfare agency, juvenile justice
6 agencies, as well as social service agencies.

7 For the provider networks, one general managed
8 care state requires its plan to have an adequate number of
9 behavioral health providers with experience in treating
10 children in foster care. The other general managed care
11 states did not have any provisions that were unique to the
12 foster care population. They often relied on the same
13 federal requirements for network adequacy. However, all
14 states required specialty plans to have foster care-
15 specific network requirements that are more prescriptive
16 than general plans, and these can include travel and
17 distance standards, appointment availability, provider
18 qualifications that may include experience working with
19 kids in foster care, as well as expertise in trauma-
20 informed care, as well as monitoring strategies to make
21 sure that network adequacy is being met.

22 When we looked at the external quality review

1 reports we found that all states identified challenges when
2 it came to workforce shortages, especially when it comes to
3 behavioral health and dental, as well as ensuring network
4 adequacy was being met in rural areas. They also expressed
5 that was a challenge.

6 Several states, including two states that use
7 these general plans and three states that use specialty
8 plans, have detailed plan requirements to address the
9 frequent foster care placement changes that these kids may
10 face. For instance, one state shared that they do
11 comprehensive health screenings for children entering
12 foster care. Another state had in their contracts that
13 they do coordination with a state child welfare agency when
14 these kids make placement changes, as well as another state
15 required that they transfer the records of care management
16 documentation between the plans.

17 Specialty managed care states require plans to
18 develop transition plans as youth age out of foster care,
19 while general managed care contracts do not speak to
20 anything or have this kind of requirement.

21 When it comes to provider payment, CMS has
22 already provided guidance to the states that encourages

1 them to pay an enhanced provider rate for primary care
2 visits, for the extra time that they may spend when working
3 with children and youth, especially when they first enter
4 the foster care system. Only one state, though, in their
5 contracts requires that the specialty managed care plan
6 offer an incentive to their providers to conduct a
7 comprehensive screening for children and youth when they
8 enter foster care.

9 As we learned from our prior work, and what we
10 have presented on in the past, is that states with general
11 plans have limited visibility on health care outcomes for
12 children in foster care due to the challenges in
13 stratifying the data. Our policy scan found similar
14 findings, that they did not have these requirements laid
15 out in their contracts.

16 However, with the specialty plans they did have
17 certain comprehensive quality oversight mechanisms. Two
18 states integrated behavioral health into their quality
19 assessment and performance improvement programs, one state
20 conducts continuous monitoring of care coordination
21 performance, and all the states had foster care-specific
22 performance improvement plans, also known as PIPs.

1 I know I'm the last session after a long day, so
2 if you were tuning me out, pretty much the TLDR for this is
3 that states have the flexibility to set their plans how
4 they want when it comes to serving children and youth in
5 foster care, both for general plan states and specialty
6 plan states.

7 We will continue doing more research into this
8 topic, and we will return in December with more findings,
9 all culminating in a March 2027 chapter in the Report to
10 Congress. And right now we welcome Commissioner feedback
11 and questions on what you have heard today. We have some
12 questions listed here. Do you have any clarifying
13 questions on anything Ava and I shared today? Do you have
14 any feedback about these state flexibilities for serving
15 children and youth in foster care? And what are your
16 thoughts on these similarities and differences that you are
17 hearing between the states with general and specialty
18 plans.

19 I will turn it back to the Chair.

20 CHAIR VERLON JOHNSON: Thank you, and we would
21 never tune you out. This is very, very good stuff. All
22 right. Angelo is first.

1 COMMISSIONER ANGELO GIARDINO: Thank you for
2 addressing this issue, and always learn something when I
3 hear you talk about this topic.

4 I would be particularly interested in hearing
5 more information around the different approaches that
6 states have taken, and then what their annual quality
7 reports look like and what are the trends. I fundamentally
8 support and believe in the idea that there are 50 different
9 Medicaid programs, another one in D.C., and then the
10 territories. So that is how the program is designed. It
11 is meant to be variable, and I embrace the variability.

12 But if there are two approaches where some states
13 have enrolled people in specialty managed care plans and
14 others where they have enrolled them in the general plans,
15 I would love to understand, over a period of time, what
16 have the quality outcomes been reported on those
17 approaches. And I would be particularly interested in
18 access to services like mental health. How are their
19 physical needs being met? And then also other elements
20 that you may have access to in these reports.

21 But one of the real issues with children in
22 foster care is that they go to different places and then

1 their care is discontinuous. I would assume if you are
2 focused on these kids you might have a way of, when they go
3 to a different placement, making sure that they stay with
4 the same provider.

5 So I would love to see if there is any kind of
6 measure of continuity. So if you could just add some of
7 that I think it would be really helpful. And I am just so
8 happy that you are looking at this super-vulnerable
9 population and helping us make sure that the Medicaid
10 program delivers. Because as you know, the reason why the
11 kids are in foster care is because their family of origin
12 failed them. So I would like to think that our nation's
13 government would not fail them. So I want to make sure
14 that this program really delivers at the point of care for
15 the kids in foster care.

16 CHAIR VERLON JOHNSON: Thank you, Angelo. And
17 just to tag on, everything that he said. I'm just curious,
18 though. How are states holding their managed care plans
19 accountable for outcomes beyond just utilization would be
20 helpful, too, as well.

21 And with that, Patti.

22 COMMISSIONER PATTI KILLINGSWORTH: So while all

1 of the presentations today have been really, really good,
2 Ava and Audrey, I want you to know that I have waited all
3 day just for you, so I did not tune you out. Such an
4 important topic.

5 I appreciate the way that we are sort of looking
6 at it in terms of the current delivery models. I would
7 kind of like for us to maybe take a step higher, if you
8 will, and think about best practices irrespective of
9 delivery system model.

10 You sort of looked at various things, like
11 enhanced care coordination requirements, incentivizing
12 primary care providers to spend more time. Those kinds of
13 things, like what are those best practices that we are
14 finding to be really effective and important for the
15 population, whether they are delivered through a general
16 managed care plan or through a specialty plan. Because it
17 seems to me that those kind of point to program guidelines
18 or contractual requirements in the managed care world that
19 you could implement with any entity that you chose to
20 implement them with.

21 I do, based on my own personal experience, think
22 that there is some value in being able to have a plan

1 that's on point and really structured around serving this
2 population. That was certainly our experience in
3 Tennessee.

4 But I think these are competencies that all plans
5 can develop. So I would like to think of them sort of in
6 that way, and be able to really look at do we have specific
7 outcomes that have been observed when those kinds of
8 policies or practices have been implemented. Maybe
9 drilling down a step further to really think about
10 providers who are bringing particular value in serving this
11 population in partnership with health plans or in fee-for-
12 service delivery systems, just what's the model of care
13 that's really effective.

14 And then I would point to colleagues at -- got to
15 love this acronym -- the National Association of Directors
16 of Developmental Disability Services, NASDDDS, because I
17 think they have been doing some really good work with a
18 broader group of folks around children with complexity who
19 use agencies across the system. So kids with juvenile
20 justice involvement and child welfare system and Medicaid
21 and education and all of that.

22 And I would be really curious to bring them into

1 the conversation about their learnings in those
2 conversations. Clearly they are focused on children with
3 intellectual and developmental disabilities, but when we
4 find the things that work for the most complex population,
5 they tend to work for all of the other populations too.

6 So within this group of kids who have
7 extraordinary needs there are even subpopulations of
8 children who have more extraordinary needs. So I want us
9 to be attuned to that as we really look at the best
10 recommendations that we might make to better serve these
11 children.

12 CHAIR VERLON JOHNSON: Thank you, Patti. Heidi.

13 COMMISSIONER HEIDI ALLEN: Thank you so much. I
14 have a very, very small question, which is I'm just
15 curious. In the specialty plans where they have providers
16 that have designated training, I'm just curious, is that a
17 self-attestation, like what thing are they getting added to
18 their names that makes them designated as a specialty
19 provider? I train social workers to be therapists, and
20 there are a lot of programs that they can take, post-
21 graduation, to get these certifications. And for the most
22 part I'm always like, you know, it's great to get

1 continuing education, but some of these are like "level 5
2 black belt", and da-da-da. And I'm like, I'm not sure who
3 pays what for those kinds of things, so I'm just curious
4 how they are thinking about that. Thank you.

5 CHAIR VERLON JOHNSON: All right. Thank you.
6 April.

7 COMMISSIONER APRIL HARTMAN: Thank you. Thank
8 you for your work on this. This is near and dear to my
9 heart because I do this every day.

10 And Heidi, one thing I will say in response to
11 your question, we are making a concerted effort to train
12 physicians in trauma-informed care, so that everybody does
13 it, and it's not just something that has to be added if you
14 are going to take care of these kids. And I think it is
15 becoming a part of medical school education and also in
16 nursing schools and everywhere. This is something that is
17 seen as a needed component.

18 One thing I would say, in looking at your
19 presentation, I think it was Slide 12, maybe. I just
20 wondered if this information could be in a table form,
21 because I'm just wondering is there one state that does all
22 of this and then they have better outcomes? How is it

1 related to the outcomes? So maybe putting that in a table
2 form would be helpful.

3 And then just thinking about the specialty plans
4 versus the general plans, in the state where I am in it is
5 a specialty plan. But because of that it felt almost more
6 restrictive rather than more beneficial. We had to do more
7 PAs, it felt like, or maybe those are just the ones we did
8 PAs for. But it seems like there was an excessive number
9 of PA. It had a more restrictive formulary. It was almost
10 like we had to jump through a lot more hoops to even
11 provide the care that we were trying to provide.

12 So I just wonder what the outcomes look like for
13 those specialty plans. All the plans try to use workforce
14 shortage as an excuse, right. You say, "Oh, they need a
15 care coordinator. We need someone assigned to them," and
16 the say, "Oh, we'll get it. They're on a waiting list.
17 It'll happen." But they all use workforce shortage. And
18 that may be what it is, but I'm just curious as to, like
19 when you look at the amount of time spent in care
20 coordination, or the number of people served, or the time
21 spent in those services, is it different in the specialty
22 plans? Like is there an actual improvement, more time

1 spent, more effort placed, or is it just, you know, I don't
2 know. I just wonder if the specialty plan, if that played
3 out in a way that was more beneficial.

4 CHAIR VERLON JOHNSON: Thank you, April.
5 Adrienne, then Sonja, and Angelo.

6 COMMISSIONER ADRIENNE MCFADDEN: I just have a
7 real quick question around, again, Slide 12. The
8 interagency coordination, I think is an imperative part of
9 this, this area. And although the states may require
10 coordination, I'm just wondering which of these models
11 actually had more effective coordination. So I would just
12 like to dive a little deeper into that.

13 CHAIR VERLON JOHNSON: Great question. Sonja.

14 COMMISSIONER SONJA BJORK: Thanks. I really like
15 the idea of looking into some best practices, because it
16 might not be one size fits all for different areas.

17 In California, the contract with the managed care
18 organizations (MCOs) requires that each health plan has a
19 foster care liaison, like a staff member and that's their
20 title. That, combined with a requirement that every MCO
21 has a memorandum of understanding (MOU) with the county
22 Child Welfare Department, and in that MOU it lays out how

1 often are you going to meet, what kind of data can you
2 exchange. And everyone is required to report out on what
3 was the agenda and the minutes, so there is some
4 accountability built in. Those are all just words, though.
5 It's got to be the intention and the action behind it.

6 At our health plan we do have a foster care
7 liaison, but she has a team of people, and they are in our
8 Behavioral Health Department. Because with 24 counties,
9 that's a lot of MOUs and a lot of meetings, et cetera.

10 Some of the topics that come up are real run-of-
11 the-mill and some cases, they need the coordination between
12 so many different agencies. So you can imagine a young
13 person, involved with child welfare. Maybe they also have
14 a developmental disability so the regional center is
15 involved. What if they were pregnant or have an eating
16 disorder? This just crosses so many different, very well-
17 intentioned agencies, but that's not helpful for the
18 children or the foster family or the birth family that's
19 trying to do reunification. So it takes some intentional
20 coordination.

21 So I think the regular meetings are fine, but
22 more it's the relationships and the ability to escalate

1 when things get complicated, so that people know who to
2 contact to make all these authorizations or arrangements,
3 figure out who is paying for what. The child does not
4 care. The family does not care who is paying for what.
5 That's all of us that care about that. And the most
6 important thing is getting the services in place quickly,
7 and when they are needed.

8 That model has been in place just for a few years
9 now, so it might be worth looking at to see if it has made
10 a difference.

11 In our experience, one thing that helped get
12 everybody on board is that the child welfare agencies, they
13 like it that we have a lot of data. So we made a dashboard
14 that they very much want to look at. And the dashboard
15 has, in their county, of the young people that have a
16 foster care aid code -- so that's how you tell if they're
17 involved in the child welfare world -- how many well child
18 visits have occurred, how many mental health visits, any
19 specialty care. My goodness, that gives them a view that
20 they haven't had before.

21 Every child that goes into foster care you're
22 supposed to go to the doctor within the first 30 days, but

1 that doesn't help for the bigger picture things. So just
2 this working together, setting up a real baseline for
3 working together, has borne a lot of fruit. And that's not
4 the only way to do it.

5 I did want to mention, in some cases specialty
6 plans for foster youth, that's a great approach. In some
7 areas, that does not help at all. Like if you think of
8 very rural areas, there is one health center. So the
9 specialty managed care plan will contract with that center
10 and so will the regular MCO. It's not helpful to have
11 multiple health plans, especially since other people in the
12 family will be covered by the regular MCO. And then they
13 have a child in their care who is in a different health
14 plan, and they have to figure that out.

15 Also from the provider point of view, it's hard
16 for them, administratively. If they're used to billing a
17 certain health plan and then someone comes along, it's like
18 an unusual situation and they have a foster youth who has
19 got a whole different health plan, that they didn't have an
20 agreement with, then it can just make it more
21 administratively burdensome. And I think we're all trying
22 to ease the way.

1 So like I said, it might not be one-size-fits-all
2 across the country. There has to be some menu or some best
3 practices to choose from.

4 So just like everybody else I'm very glad we're
5 working on this, and I think we've been working on this for
6 a while, and it just is complicated, and we are trying to
7 find our way. So thank you.

8 CHAIR VERLON JOHNSON: Thank you, Sonja. Angelo.

9 COMMISSIONER ANGELO GIARDINO: Adrienne, did you
10 have something? Okay.

11 I was so excited that you did this that I forgot
12 the one thing I wanted to say. About a decade ago I was
13 very involved with the formation of the specialty plan in
14 Texas. And one of the thing that really prompted that was
15 a report issued by the state. It was called "Forgotten
16 Children." And it was determined that the children in
17 foster care were, on average, on five psychotropic
18 medications per child. And in working with the experts
19 across Texas -- and, you know, Texas is enormous, right?
20 It's the second-largest state at that point. It had 28
21 million people.

22 So we had people to draw upon, and they felt that

1 was likely excessive. And with this specialty plan they
2 were able to, you know, using best practices, get that down
3 to an average of two psychotropics per child that had a
4 behavioral health issue.

5 So I suspect in the foster care world how many
6 psychotropic meds that kids are on is measured and
7 reported, and I think it would be really important to look
8 and see, the kids that have behavioral health diagnoses,
9 are they getting evaluated by behavioral health teams and
10 specialty centers and referral centers, regardless of
11 whether or not they live in rural areas or urban areas.
12 And then are they getting the best practice in terms of the
13 medications.

14 I think the drug utilization of psychotropic meds
15 in this population would be really important to understand.
16 And ultimately, with the variation that states choose to
17 deliver this care, they should have the same outcome, and
18 the outcome should be good. So a different model is fine,
19 but it should produce the same outcome. Thank you.

20 CHAIR VERLON JOHNSON: Thank you, Angelo. Anyone
21 else? Oh, Sonja.

22 COMMISSIONER SONJA BJORK: Just a follow-up about

1 psychotropic medication. In California, the judge has to
2 review the proposal that a child be on a psychotropic
3 medication. The judge is not a clinician, though. But at
4 least there is a close look. And the judge, him or her,
5 wants information. So then everyone has to pause, make
6 sure the doctor provides some information, the parents have
7 a chance to weigh in, the child has an attorney. So
8 there's a moment where more information gets considered.

9 I am not sure if that has changed the outcome in
10 every case, but at least there is a closer look at who is
11 doing what on the medication for a child. And the purpose
12 for that was exactly what Angelo has raised. So I'm not
13 sure if that differs state by state, that process of having
14 to have the judge who is in charge of the dependency case
15 actually issue orders regarding psychotropic medication.
16 So you might see difference as you look across states.

17 COMMISSIONER APRIL HARTMAN: And if I could just
18 comment on that. I met with a council of juvenile court
19 justices, and they want advice. They are court ordering
20 things and they don't know what to order. So they have
21 asked for a best practice for family assessments,
22 comprehensive family assessments, and there are groups that

1 are starting that training, where pediatricians and others
2 will form a team to do comprehensive family assessments for
3 juvenile courts. And this is something that you're seeing
4 more and more across the country.

5 CHAIR VERLON JOHNSON: Thank you both for that.
6 Any other comments?

7 [No response.]

8 CHAIR VERLON JOHNSON: Okay. See, last session
9 and we all enjoyed it very much, so thank you so much for
10 all your work. We are looking forward to hearing from you
11 in December on the findings, as well, so thank you both.

12 CHAIR VERLON JOHNSON: All right. With that we
13 will go to our final public comment period today. At this
14 point we do invite people in the audience to raise your
15 hand if you would like to offer a comment. Please
16 introduce yourself and the organization that you represent.
17 And then also we do ask that you keep your comments to
18 three minutes or less.

19 **### PUBLIC COMMENT**

20 * [Pause.]

21 CHAIR VERLON JOHNSON: Okay. Seeing no public
22 comments, I just remind you that if you do have a comment

1 later then you can definitely go to our website and submit
2 one there. And with that we will go ahead and close out
3 today's meeting, and we will see you tomorrow at 10 a.m.
4 Thank you all. Have a great evening.

5 * [Whereupon, at 4:44 p.m., the meeting was
6 recessed, to reconvene at 10 a.m. on Friday, September 25,
7 2026.]

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PUBLIC MEETING

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

Friday, September 25, 2026
10:00 a.m.

COMMISSIONERS PRESENT:

VERLON JOHNSON, MPA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
DOUG BROWN, RPH, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
APRIL HARTMAN, MD, FAAP
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

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1 some next steps for your consideration. With that we'll
2 move on to the background.

3 As the Commission will recall, self-direction is
4 a Medicaid HCBS delivery model that allows individuals to
5 choose their HCBS providers and to have control over the
6 amount, duration, and scope of services and supports in
7 their person-centered service plan or PCSP.

8 The nature of self-direction allows and requires
9 beneficiaries to operate with increased choice and autonomy
10 in their service delivery. This includes informed choice
11 to take risks, which CMS has described as the dignity of
12 risk.

13 Self-direction programs operate within the
14 existing framework of Medicaid HCBS, so self-direction does
15 not fundamentally change things like the level of care
16 determination process or HCBS policies, more broadly.
17 Federal authorities require, among other things, the
18 person-centered service planning process, known as PCSP,
19 which are hallmarks of the HCBS program more broadly than
20 just self-direction. It also requires a framework of
21 oversight of the quality of care, which again is also
22 applied to other HCBS programs.

1 In self-direction federal authorities also
2 require supports that are more specific to this delivery
3 model, which creates a self-direction support system that
4 includes information and assistance and financial
5 management services, or FMS. Beneficiaries also have an
6 individualized budget when they have a program with budget
7 authority, that allows them to make choices about how they
8 spend the funds they have allotted to them for their HCBS.

9 The Commission will recall that over the past two
10 cycles we've characterized the stakeholders in self-
11 direction as shown in this figure. You can see here the
12 beneficiary is at the center of the self-direction model
13 and must interact with all of these different entities and
14 actors to manage their care. All of the arrows indicate
15 interactions across these entities.

16 After conducting additional research this last
17 cycle you'll notice that we updated this figure since you
18 last saw it to more clearly describe the role of the
19 managed care plan as a separate entity the beneficiary is
20 also interacting with. States have considerable
21 flexibility when designing and administering self-direction
22 programs, which has led to an array of different

1 approaches. So every state may not have all of the
2 different entities included in this model.

3 In the June 2025 Report to Congress we found
4 states vary in how they define and structure these
5 stakeholder roles and the level of collaboration across
6 entities providing these supports. Beneficiaries
7 ultimately must navigate this web of different entities and
8 supports in order to effectively self-direct their HCBS.

9 Information and assistance and FMS providers are
10 both unique stakeholders in self-direction and comprise
11 what we call the support system. So let's take a closer
12 look at what this entails.

13 A support system is defined in either statute,
14 regulation, or through subregulatory guidance, depending on
15 the authority, and the intent is to assist the beneficiary
16 in managing their HCBS, providers, and administrative
17 activities. Information and assistance supports provide
18 counseling and training about the program, they assist the
19 beneficiaries in identifying personnel such as an HCBS
20 workers, and they help ensure that supports and services
21 are properly managed and provide resource navigation.

22 Although information and assistance is often

1 construed as a single support in the support system and the
2 state may engage a distinct entity identified as a provider
3 of information and assistance, multiple entities provide
4 information and assistance in self-direction. For example,
5 there could be a case manager who initially counsels the
6 individual about the program, as well as FMS entities that
7 also provide information and assistance.

8 FMS are services that assist the beneficiary with
9 some of the administrative functions in self-direction.
10 These could include things like support with managing the
11 budget, assist with handling payroll, they withhold and pay
12 for taxes, and then they also monitor and track expenses
13 and payments in the beneficiary's budget.

14 Together these two supports make up the support
15 system in self-direction and multiple entities are
16 providing these services. These activities support health
17 and welfare in self-direction programs by giving
18 beneficiaries the information and resources they need to
19 successfully manage their care.

20 In addition to the policies I just reviewed
21 around the coverage of self-direction in HCBS, all HCBS
22 which includes self-direction, must promote high-quality

1 care that ensures beneficiary health and welfare and allows
2 participants to remain safely in the community. This
3 requirement is defined in regulation and known as the
4 health and welfare assurance, which is among several
5 assurances that states must make when they operate an HCBS
6 program.

7 The health and welfare assurance encompasses a
8 variety of safeguards intended to promote high-quality care
9 and person-centered care and meets the needs of the
10 population served. These safeguards are outlined in
11 regulations governing Section 1915(c) authority, and other
12 authorities generally mirror them, with minor differences.
13 They include establishing standards for HCBS providers such
14 as licensing certification or screening requirements,
15 operating and maintaining an incident management system
16 that allows the state to assess, monitor, and improve the
17 quality of services delivered, and address any risks
18 confronted by participants, and other regulatory
19 requirements such as ensuring services are provided in home
20 or community settings.

21 In addition to these safeguards, state programs
22 must implement and monitor certain conflict of interest

1 standards which, among other things, can protect
2 beneficiaries from potential abuse, neglect, and
3 exploitation.

4 In self-direction programs states also monitor
5 utilization and other data, ensure continuity of care
6 during transitions between self-direction and other service
7 delivery models, and provide the specialized support system
8 we just discussed in the last slide. These specialized
9 requirements for self-direction are most explicit under
10 Section 1915(j) authority.

11 And now I'll pass it over to Katherine who is
12 going to discuss the state approaches to ensuring health
13 and welfare, in keeping with these federal safeguards.

14 * KATHERINE ROGERS: Thanks, Gabby. Good morning,
15 everyone. Before I get into state policy I'll talk a
16 little bit about our methodology.

17 As part of this work we conducted a scan of
18 federal policy germane to assuring beneficiary health and
19 welfare specific to authorities under which self-directed
20 programs are authorized. This included the Medicaid
21 statute, regulations, guidance, and trainings by CMS. We
22 focused primarily on incident management, conflict of

1 interest standards, and safeguards applied specifically for
2 self-directing beneficiaries.

3 After that scan, and in partnership with the
4 Lewin Group, we conducted three comprehensive case studies
5 with states operating self-directed programs. We selected
6 states that varied in their design of self-directed
7 programs, delivery systems, and other features like
8 geography. We conducted an in-depth review of policy
9 documents, including managed care contracts, program
10 manuals, regulations, and conducted interviews with
11 stakeholders across the self-direction spectrum and
12 landscape, including national experts. We conducted a
13 cross-case analysis, synthesizing the data collection
14 across the case states to see what findings emerged from
15 this research.

16 Throughout the rest of this presentation, we are
17 referring to our case states unless we specifically say
18 otherwise.

19 As I mentioned, we focused a lot on states'
20 policies around incident management. Foundationally,
21 states generally define incidents for reporting purposes
22 similarly and in keeping with the federally set minimum

1 standards. Their definitions may differ a little bit in
2 how they have expanded that definition, including other
3 specific events that might not be listed in other states'
4 definitions, or they may have incorporated some broad
5 language that says something like any event that could have
6 an adverse impact on the health, safety, or welfare of the
7 beneficiary or others.

8 One state also requires some monitoring of other
9 events as sort of a warning sign or a precursor for events
10 that do not yet meet that standard of what is required for
11 incident reporting.

12 States also share similar policies related to
13 designation of mandatory reporters for serious harms and a
14 pathway for immediate reporting of things like abuse,
15 neglect, and exploitation.

16 Obviously, the mechanisms and systems through
17 which these things are reported and how data are captured
18 vary by state but also by programs within states.

19 State vendors and managed care plans operate and
20 rely on their own data systems, even when reports are
21 submitted to the state, and they rely on different systems
22 for different information. States may impose contractual

1 requirements to track and trend incidents on health plans
2 or on self-direction program contractors like I&A or FMS
3 providers.

4 These entities are using administrative data from
5 their own systems, their own data, or state systems such as
6 claims or electronic visit verification, or EVV, data to
7 track services, flag potential health and safety risks, and
8 also initiate outreach or intervention.

9 In our interviews underutilization was cited as a
10 trackable, data-driven means to identify potential safety
11 concerns. For example, this might be due to the loss of a
12 worker or another event that is preventing access to
13 authorized and needed services.

14 We heard through our research that entities in
15 the self-direction system might not have access to data
16 that's held elsewhere, that they might need to monitor
17 services. And while in some cases data are aggregated to
18 allow the states to track incidents systematically,
19 information about how incidents are followed or mediated
20 and closed may not be visible to everybody.

21 One unique feature of self-direction is the fact
22 that beneficiaries and their representatives and their

1 workers must all access effective and comprehensive
2 training on incident management to ensure there is complete
3 and accurate reporting. While incident reporting might be
4 a routine part of a case manager or a home health aide's
5 routine activities, self-directing beneficiaries interact
6 with many of those supports, including a case manager,
7 including other parts of the health care system, and there
8 might be confusion on the part of the beneficiary or their
9 worker as to who is responsible for reporting.

10 We also heard there can be confusion about
11 reporting in gray areas around defined incidents, such as a
12 fall with no injury.

13 Overall, our stakeholders reported that incident
14 reporting is a key part of the oversight and assurance of
15 beneficiary health and welfare, but it is one tool among
16 many. While our interviews cited operational challenges in
17 incident management, we didn't necessarily hear about
18 policy constraints to effective incident management.

19 Alongside incident reporting, states establish
20 standards for follow-up when incidents arise. It is
21 important to acknowledge also that intervention pathways
22 exist not solely in response to formal critical incident

1 reporting but also after routine monitoring. It might flag
2 a trend or a change and also through routine care
3 management activities, outreach, and engagement.

4 In state policy there are specific thresholds
5 that indicate or recommend a service change. This might be
6 a required change in worker, for example if there is a
7 credible allegation against a worker, or there may be a
8 recommendation to transition from self-directed services to
9 another service model when the beneficiary cannot safely
10 self-direct or cannot comply with the requirements of the
11 program.

12 One of the themes that emerged through our case
13 studies was the impact to health and welfare operations and
14 oversight that stems from the complexity of self-direction
15 systems. This complexity also emerged in the research
16 supporting our June 2025 chapter on self-direction and is
17 observable in that diagram you saw earlier at the beginning
18 of today's presentation.

19 States operate self-direction under both managed
20 care and fee-for-service delivery systems, and these
21 programs often have multiple vendors within these systems.
22 These can include multiple health plans but may also

1 include multiple FMS or I&A entities, as well.

2 Gabby will talk a little bit more about this in a
3 few minutes, but it is important to note that health and
4 welfare activities specifically are distributed throughout
5 these multi-party and multi-layered arrangements, across
6 many different related and intertwined activities,
7 including how services are authorized, how they are
8 monitored, how they are tracked, and how adverse events are
9 reported, tracked, and resolved.

10 With complex operations comes complex oversight.
11 While these arrangements offer the benefit of some
12 intentional redundancy—ensuring that services for
13 beneficiaries who need them are authorized, delivered, and
14 monitored effectively—it can create overlapping
15 responsibility and unclear lines of accountability.

16 One solution we heard was creating clear
17 contractual requirements for entities in the self-direction
18 space and performance standards that communicate and be
19 used to enforce responsibilities, expectations, and create
20 effective, clear accountability pathways.

21 And with that I will turn it back over to Gabby
22 who will take us through more of the findings.

1 GABBY BALLWEG: Thanks, Katherine. As you just
2 discussed, throughout our interviews we asked stakeholders
3 about their roles and responsibilities in ensuring health
4 and welfare per the federal and state guidelines. As
5 Katherine just mentioned, interviewees did not identify
6 significant policy barriers with the incident management or
7 monitoring safeguards, although they did emphasize
8 complexity and oversight.

9 Instead, our interviewee feedback kept
10 redirecting us to the themes that we heard in our first
11 cycle, which was published in the June 2025 Report to
12 Congress. They consistently identified overlapping roles
13 and responsibilities and a lack of clarity in the
14 information and assistance supports provided as issues
15 impacting health and welfare.

16 We grouped our findings here into two theme
17 groups, the first around ensuring effective quality,
18 oversight, and accountability in information and assistance
19 supports, and the second around limited data systems
20 infrastructure and interoperability in a self-direction
21 system where there are multiple entities. Now I will
22 discuss these findings across the two groups.

1 Beginning with our quality, oversight, and
2 accountability in information and assistance supports, we
3 found that information and assistance, and that role in
4 particular, is unclear in self-direction. As Katherine
5 mentioned, across states self-directed HCBS programs are
6 structured as a multi-actor system, involving the
7 beneficiary, HCBS worker, case manager, supports broker,
8 FMS entities, state agencies, and health plans. State
9 program design choices dictate how the roles are
10 distributed across each of these entities, and states vary
11 in how clearly their policies define roles and how they
12 assign accountability across these actors.

13 While distributing oversight across different
14 entities creates multiple opportunities for them to
15 identify concerns, interviewees emphasized that overlapping
16 responsibilities creates ambiguity about which entity
17 should ultimately report, follow-up, or remain accountable
18 for the resolution of an issue.

19 For example, in self-direction multiple entities
20 and individuals monitor and report on service utilization
21 levels, including supports brokers and FMS entities. Many
22 stakeholders are responsible for reporting, following up,

1 and remediating critical incidents, and multiple entities
2 provide information and assistance, including case
3 managers, supports brokers, and FMS entity staff.

4 When issues in any of these areas arise, multiple
5 interviewees described beneficiaries not knowing which of
6 the responsible entities to turn to for support, and
7 ultimately, supports brokers or case managers ended up
8 taking on additional responsibility beyond what is required
9 in their role to compensate. For example, a case manager
10 described regularly counseling and assisting beneficiaries
11 with paperwork in order to enroll and pay HCBS workers.
12 All of this information and assistance support is the role
13 of the supports broker in that state.

14 Because of this challenge with overlapping roles
15 and responsibilities, interviewees consistently asked for
16 clearer policies around how self-direction programs
17 structure and reimburse information and assistance
18 supports, which I will discuss further on the following
19 slides.

20 Regarding how information and assistance service
21 delivery is structured, stakeholders characterized
22 information and assistance quality as highly variable,

1 noting poor quality information and assistance leads to
2 inappropriate service delays or denials, including
3 inaccurate paperwork, delayed payment for HCBS workers, and
4 enrollee frustration.

5 Interviewees often linked this variability in
6 quality to how the services are distributed across entities
7 and their reimbursement methodology. When information and
8 assistance is delivered and financed as a distinct self-
9 directed service, states have few oversight and
10 accountability mechanisms to confirm its provision meets
11 expectations, and I will talk a little bit more about this
12 in the next slide as well.

13 The burden for beneficiaries having to
14 communicate across multiple different entities for support
15 further exacerbates these quality issues, requiring the
16 information and assistance supports providers, who are
17 often supports brokers, to understand all of the unique
18 policies for different payers and programs operating within
19 a single state.

20 For example, a supports broker must understand
21 the differences in self-directed services and resources
22 offered under different delivery systems, with unique rules

1 among different health plans and FMS entities, and
2 variations in monitoring requirements and available
3 supports across multiple self-direction programs within a
4 state. They must also navigate these programmatic
5 differences, despite having limited communication with
6 states, health plans, and FMS entities.

7 Advocates describe the design of information and
8 assistance supports, especially the supports brokerage
9 service, as disconnected from how it functions in practice,
10 with minimal in-person support, a lack of clarity around
11 who to contact for assistance, and a reliance on websites
12 and call centers rather than meaningful resource
13 coordination and navigation from providers.

14 When discussing these challenges with information
15 and assistance, FMS entities, health plans, and supports
16 brokers highlighted disconnected information and assistance
17 from other roles as a limitation in self-direction. Having
18 separate information and assistance limits visibility into
19 the beneficiary experience and verification of follow-up
20 across entities, for example, when an FMS provider
21 identifies issues that require beneficiary outreach.

22 As I briefly mentioned earlier, interviewees also

1 identified reimbursement for the support as a key factor
2 that impacts quality. There are three different
3 reimbursement mechanisms states may choose from for
4 information and assistance. It can either be financed as
5 case management, a distinct service, or an administrative
6 expense.

7 Under case management, the case managers provide
8 information and assistance. Although some beneficiaries
9 may prefer this more streamlined approach with fewer
10 separate entities to contact, many interviewees emphasized
11 limited capacity and self-direction-specific knowledge
12 among case managers as a key challenge to them providing
13 effective information and assistance in support of self-
14 direction.

15 When information and assistance supports are
16 delivered as an individual Medicaid service, states must
17 enroll any willing and qualified information and assistance
18 provider, allowing for a large array of providers to choose
19 from. However, when states elect this approach and the
20 information and assistance support services are billed as a
21 part of the beneficiary's self-directed budget,
22 beneficiaries risk overutilizing the service and depleting

1 their self-directed budgets on information and assistance
2 supports. Under this model, beneficiaries may have to make
3 a hard choice between getting additional support with self-
4 direction or using their full service allotment in their
5 PCSP.

6 Some beneficiaries may also not be aware that
7 information and assistance supports are available to them
8 under this model in particular.

9 Regardless of whether information and assistance
10 is financed as a part of the beneficiary's budget under
11 this model, stakeholders emphasized highly variable quality
12 in this reimbursement model, as states can't set
13 contractual performance expectations.

14 Lastly, information and assistance can be
15 reimbursed through an administrative contract. This allows
16 states to establish and enforce quality and performance
17 expectations. Interviewees expressed interest in this
18 model, in particular, for its ability to improve
19 accountability and reduce variability in the quality of
20 information and assistance through contractual requirements
21 and cures for performance issues.

22 Now let's move on to our second theme group on

1 data systems infrastructure and interoperability. Self-
2 directed programs face barriers to data integration,
3 access, and analysis. Stakeholders consistently described
4 information and data exchange across entities as fragmented
5 and confusing. For example, supports brokers who are
6 required to monitor service alignment with the PCSP often
7 lack direct access to the full care plan that is available
8 in the FMS system.

9 Because of this fragmentation, state officials
10 must reconcile multiple data sets such as the incident
11 utilization spending, EVV, and service authorization data
12 across health plan portals, FMS systems, information and
13 assistance providers, and others.

14 Interviewees shared that a lack of
15 standardization and data systems increases the likelihood
16 of miscommunication, missed deadlines, service disruptions,
17 and delayed payment to workers. They emphasized
18 coordination across administering entities as important,
19 especially with fragmented data systems and multiple
20 stakeholders supporting self-direction.

21 We also heard that distributed data systems
22 create blind spots that can allow bad actors to operate in

1 a self-directed program, and as discussed on the previous
2 slide, require state officials to manually review data
3 across systems.

4 Stakeholders throughout all of our interviews are
5 committed to program integrity in self-direction,
6 continuously seeking data outliers and ways to link data
7 behind the scenes in order to maintain self-direction
8 program compliance. State officials mentioned current
9 efforts to improve data systems infrastructure and
10 interoperability, such as standardizations in their
11 incident management systems.

12 Some health plans also exchange hospitalization
13 data with FMS entities to flag beneficiary admission,
14 discharge, and transfer information, so that beneficiaries
15 can receive support after discharge and to prevent
16 unauthorized service provision during a hospitalization.

17 These findings and their consistency with our
18 prior work on self-direction has led us to develop the
19 following policy option for your consideration: Congress
20 and CMS should clarify and streamline all self-direction
21 supports under a single entity and reimburse these supports
22 through an administrative contract.

1 This policy option addresses the key findings,
2 which are the overlapping information and assistance
3 responsibilities create ambiguity about which entity should
4 follow up and remain accountable; information and
5 assistance breakdowns have widespread consequences that can
6 result in health and safety concerns for beneficiaries as
7 well as service disruption; reimbursement methodologies for
8 information and assistance providers have an influence on
9 information and assistance quality; and data fragmentation
10 increases other issues like miscommunication, missed
11 deadlines, service disruptions, and delayed provider
12 payments.

13 This approach increases the likelihood of
14 identifying health and welfare concerns by reducing
15 potential duplicative supports functions and identifying
16 clear accountability through a single responsible entity.
17 Beneficiaries would ultimately have fewer entities with
18 which to coordinate; states would oversee fewer entities
19 and set clear, enforceable expectations through an
20 administrative contract; and streamlining the supports
21 system reduces data fragmentation.

22 Ultimately, this option offers reduced

1 administrative complexity and expense, more data
2 integration, and aligns information and assistance
3 requirements across authorities.

4 Currently, a support system is statutorily
5 defined under Section 1915(j) of the Social Security Act.
6 Regulatory language and subregulatory guidance across
7 authorities, including Section 1915(c), (i), (j), and (k)
8 generally lack specificity into the roles and
9 responsibilities of information and assistance providers,
10 however, with the most specificity under the Section
11 1915(j) authority.

12 It is important to note that only 10 states
13 authorize self-direction under Section 1915(j), and in
14 2023, 46 states offered self-direction under Section
15 1915(c) authority, which doesn't have any parallel
16 statutory or regulatory requirements for information and
17 assistance. Instead, requirements for the support system
18 are under subregulatory guidance in the waiver application
19 and technical guide.

20 Given the variability and ambiguity of what
21 constitutes information and assistance across authorities
22 in self-direction programs, states do not have sufficient,

1 specific guidance for establishing effective information
2 and assistance in self-direction. This policy option would
3 require both a statutory and regulatory change.

4 So now moving on to our next steps. During this
5 discussion, we would really appreciate your feedback on
6 this policy option and if you would like to assess it as a
7 recommendation. Specifically, does the presented evidence
8 support the policy option? Are there outstanding questions
9 about the policy option that we can answer? And are there
10 other factors for us to consider as we're developing
11 recommendation language and the rationale?

12 Depending on the feedback from Commissioners, we
13 will return to present draft recommendation language for
14 your consideration.

15 Thank you for your time and I will turn it back
16 over to you all for discussion.

17 CHAIR VERLON JOHNSON: All right. Thank you so
18 much. Very helpful. Appreciate the background, too, at
19 the beginning and the policy options.

20 And let's have the conversation. It looks like,
21 Patti, you're up first.

22 COMMISSIONER CAROLYN INGRAM: Katherine, Gabby,

1 thank you. It is an incredibly complicated topic and
2 you've done a really great job of elevating important
3 issues that we need to pay attention to, particularly in
4 light of how much consumer direction or self-direction has
5 grown as a delivery model in light of an ongoing workforce
6 shortage that's only been exacerbated during and since the
7 public health emergency.

8 I think all of the issues that you have raised
9 are important issues. As you said, I think these are
10 complex operations which lead to the need for complex
11 oversight, and I think sometimes our tendency is to want to
12 simplify the operations in order to simplify the oversight.
13 And sometimes that's a good thing, but it's also a trade-
14 off.

15 This is one of those unique parts of the system
16 where we are offering a model which is, yes, more
17 complicated to oversee, but we're doing it in order to
18 honor the choice of individuals who receive services to be
19 able to employ and oversee the workers who deliver the
20 supports that they require. And so that -- it adds
21 complexity for us. There's no question it's a more
22 challenging system to operate and to be able to monitor on

1 an ongoing basis.

2 And both of those things are important. It's
3 important for people to have choice and control and
4 autonomy in the supports that are really essential to their
5 daily lives. It's also important for us to make sure that
6 in the course of that delivery that their safety is
7 assured, that their health and welfare is assured.

8 My biggest concern is that maybe we've leapt too
9 quickly to a policy option which would sort of begin to
10 mandate a single model of delivery for all self-direction,
11 and I say that having my own personal bias and experience,
12 which is we used a single entity to deliver all I&A
13 services to the supports broker function as well as the FMS
14 function. It was a single entity. And I found that model
15 -- and we prescribed it across all of our health plans -- I
16 found that model to work best. But I'm not sure that I
17 would want Congress to say, everybody has to choose that
18 particular model.

19 And so I wonder if there's not at least an
20 interim step that we should look at first where we look at
21 each of the issues that have been identified. We've talked
22 about critical incident management systems. We've talked

1 about information and assistance structure and
2 reimbursement. We've talked about data systems,
3 infrastructure and interoperability, and program integrity
4 and accountability. And it seems to me that CMS could
5 either issue additional guidance or perhaps even additional
6 clarification from a regulatory perspective around these
7 essential parts of an effective delivery model that uses
8 self-direction, while still complying with all of the
9 expectations in each of these important areas, laying out
10 things that systems must do, that it must create specific
11 guidance and responsibility for who performed different
12 functions, for how critical incidents are investigated, for
13 how data is exchanged to really facilitate both ongoing
14 program monitoring but also program integrity, without
15 taking that additional leap of saying thou shalt, all
16 states and territories, use a single entity for the
17 administration of these services.

18 And, truthfully, states may find as they really
19 struggle and grapple with how to make sure that all of
20 those things are addressed, that a single entity is the
21 right way to go. But they may not. They may find other
22 ways to be able to address these issues that have been

1 identified without necessarily being limited in the way
2 that they implement self-direction as a model. So I'd just
3 like to see us do some more work and exploration before we
4 jump to that kind of a policy recommendation.

5 But I really, really appreciate the work. It is
6 super important to address these issues and look forward to
7 working with you on finding the right way to do that.

8 CHAIR VERLON JOHNSON: Thank you.

9 Anne.

10 COMMISSIONER ANNE KARL: So I will admit that
11 this is not an area of particular expertise for me, but
12 sometimes I think it's helpful to have a bit of a fresher
13 perspective.

14 So, first, I want to thank you for carefully
15 walking through everything and making it really
16 understandable to someone who isn't incredibly deep on
17 this.

18 I also really understand and appreciate Patti's
19 comments to say there may be multiple ways that states
20 could go about doing this.

21 I think the one thing I just wanted to highlight
22 that to me was quite surprising and seems I'm not

1 supportive of is just, in the current practice, is the fact
2 that someone could be using up some of their self-directed
3 budget getting assistance on trying to figure out how to
4 use their self-directed services.

5 So, the fact -- that really struck me as, like,
6 if the system is so complicated that you need someone to
7 help hold your hand and help you figure out how to use the
8 benefit, but in doing that, that actually reduces the
9 budget available to use the benefit, that just struck me
10 as, you know, not helpful to beneficiaries.

11 So, as someone, again, who is not super close to
12 this area, I just wanted to highlight that that seemed like
13 a real problem worth solving. Whether this is the right
14 solution, I don't feel like I have an opinion on that yet,
15 but that does seem like a problem worth solving.

16 CHAIR VERLON JOHNSON: Thank you, Anne.

17 Mike and then Carolyn.

18 COMMISSIONER MICHAEL NARDONE: Thanks for this
19 work.

20 And, as Patti said, this is really a complex
21 topic and trying to -- given the growth in self-direction
22 and some of the workforce challenges that we're going to be

1 facing, I think that this is obviously going to be a
2 continuing trend, and so I think it's really important to
3 be able to address these issues.

4 I guess I just wanted to reinforce -- I think I'm
5 in the same place where Patti is in terms of not really
6 sure that kind of going to this one model is really the
7 solution, that there might be other options that states
8 could be implementing, because they could be implementing
9 this model right now, as I understand it. And there's a
10 reason why they didn't. Some of it is to give consumers
11 more choice in terms of who their support brokers might be.

12 Maybe creating one FMS entity that has all these
13 responsibilities in a state like Pennsylvania might not be
14 the most welcoming to consumers with respect to some of the
15 support worker functions, but I think that's an issue that
16 kind of plays out in every state in different ways. But I
17 just think moving to that step of recommending one entity
18 that's doing this, I'm just not there yet.

19 And some of the issues that you've raised, like
20 the data interoperability, it seems to me there might be
21 other solutions for those types of issues and kind of
22 understanding a little bit what might be solutions there.

1 I think one of the things I think would be really
2 helpful is that, as you mentioned, most of the self-
3 direction is happening in 1915(c). And 1915(j), only 10
4 states use that, employ that model.

5 I think there is some -- I think consistency
6 across the programs around what should be part of the self-
7 direction model around information assistance would be
8 helpful across the authorities, and I'm not sure what is
9 the right way to get at that. Is it through congressional
10 action or through CMS providing guidance? I don't know if
11 CMS feels they need the congressional language in order to
12 do that, but it does seem to me that kind of having
13 consistency across all the models and what should be the
14 component parts of the information assistance and some
15 clarity around that would be really helpful.

16 CHAIR VERLON JOHNSON: Thank you, Mike.
17 Carolyn?

18 COMMISSIONER CAROLYN INGRAM: Yeah, a couple of
19 questions and then a couple of points, I think.

20 Can you just remind us, if you already provided
21 us, how many people are in self-directed programs across
22 the states, and if we did any accounting for how much

1 states are spending on this administrative structure that
2 they've created?

3 GABBY BALLWEG: Yeah, that's a good question. We
4 didn't talk about it in this presentation. I think it was
5 in our memo, but it's about 2 million people.

6 In terms of the cost, we -- so self-direction is
7 a little bit hard to quantify, and we talk about this in
8 our first chapter on self-direction, that we can't tease
9 out at a national scale how many beneficiaries there are or
10 what the cost is associated with self-direction. But that
11 2 million figure is from an AARP presentation from 2026
12 that they just released.

13 In terms of how many people are using self-
14 direction, what we can see from the administrative data, we
15 can quantify how many people are in a (j). And I don't
16 have that number off the top of my head, but I can get back
17 to you on that front if that would be helpful as well.

18 COMMISSIONER CAROLYN INGRAM: Yeah, I'm wondering
19 -- that would be great, and I'm wondering, in terms of the
20 policy concept, how many states are going to have to start
21 looking at these types of services, how they provide them.
22 And probably, to Patti and Commissioner Nardone's point,

1 they're going to have to start thinking about how they
2 streamline things anyway because of all the other cost
3 pressures that we talked about yesterday around changes
4 that are going to be happening around the self-directed
5 payments and -- I'm sorry -- around the state-directed
6 payments and the taxes, that they're going to have to be
7 making decisions to streamline these services because
8 they're not going to have the money and the dollars spent.

9 So, I think that might be something overall, not
10 related specifically to this work, but overall that the
11 Commission should probably look at, what are all these
12 changes doing to access to care across the board.

13 So, having created these programs in my state,
14 self-directed waiver programs, and trying to come up with
15 ways to help consumers, it is really difficult. Sometimes
16 the vendors are not great in certain areas, and so that's
17 sometimes why states end up with two vendors. You have one
18 that's really good at doing one thing, one that's really
19 good at doing something else. They come and sell to you
20 that they can put everything together. You try that; it
21 doesn't work.

22 I think in some states, they've made it work

1 because maybe they've got better contract oversight or
2 other key factors. And so I'm wondering if one of the
3 things we can step back and do instead of this type of
4 policy option is start to think about what are the key
5 things that states can do in terms of overseeing these
6 types of administrative functions, and how can they be
7 streamlined? What are recommendations for criteria in
8 terms of how you oversee the contracts to get out of the
9 vendors what you need? That's from my experience of being
10 a Medicaid director.

11 I then want to put on my kind of experience being
12 in a managed care program, and we operate across 21 states.
13 So we have self-direction in a lot of our different
14 programs and have seen different models.

15 I think states will also go to a model where they
16 want one vendor because they think it is going to cut down
17 on fraud and abuse, and maybe that does help in terms of
18 just having data sharing from one vendor. But it doesn't
19 always result in quality outcomes. It doesn't result in
20 savings. That allows one vendor to really drive up the
21 cost as they need to, and then you're left without any
22 other options for consumers.

1 So I go back to maybe Patti's recommendation that
2 we don't want to require just one single entity. We want
3 to talk about what are the criteria you can do to best
4 serve somebody to support access to care? What are the
5 criteria you can give a state to oversee these contracts so
6 that administratively they're not wasting money? How can
7 you have fair competition in a state so that those costs
8 don't just get driven up through the roof?

9 And then the one that's really important, I
10 think, for us to consider is what can you tell states they
11 really should do so that we can cut out some of the fraud
12 and abuse and some of the bad actors? Unfortunately, when
13 those people float around in the program, whether it's from
14 state to state or maybe they work for different entities,
15 it kind of ruins it for everybody. And there are few bad
16 actors, but we need to give some criteria there, I think,
17 to states about how you require these entities that are
18 participating, whether it's the managed care companies, the
19 vendors, the recipients, that that data get reported and
20 shared back with the proper entities to cut out those bad
21 actors.

22 So I'll stop there and leave it to the other

1 Commissioners who've got their hands up. Thank you.

2 CHAIR VERLON JOHNSON: Thank you.

3 John?

4 COMMISSIONER JOHN MCCARTHY: Your question to us
5 was, you know, is this a policy option? Should we move
6 forward with it? For me, I can't say yes, move forward
7 with this policy option. I think a lot of people have
8 already brought up some issues. I'm going to bring up a
9 couple more.

10 Number one, when we started looking at some of
11 these things over this year where issues have come out
12 around fraud and abuse, one of the biggest issues was
13 family caregivers. So this doesn't address that at all,
14 right? That's not in here. I'm not saying it should be,
15 but that was one of the big issues that has come up.
16 Especially even if you're using EVV, it doesn't matter.
17 The family caregiver lives in the house. Like, how do you
18 monitor those different pieces? So there's still, I think,
19 work we need to look at around those different pieces.

20 The second part is, I agree with what everyone
21 said, just saying, hey, here's one model. I understand it
22 seems like a streamlined way to do it, but I just believe

1 in competition to keep costs down. So just going to one
2 just makes it difficult, because even if the state
3 contracts with that entity and they're rebidding that
4 contract every five years, that leads to other issues too,
5 right? So, it's like they can raise the prices for five
6 years straight, and then you rebid, and then if you pick
7 somebody else, everyone's upset, and then you make a bunch
8 of changes.

9 So, it's back to, do you really need one, or the
10 flip side of it is you have a state where you have just
11 unlimited number of FMS, and that's a whole problem too
12 because then you're paying a whole bunch of people. So,
13 there's got to be some level of administrative savings of,
14 you know, do you have three or five or something? And I
15 don't know the number.

16 I also want to agree with Anne completely on the
17 I&A piece of it and making people pay for information. I
18 just like that part. I don't understand. Hopefully, I
19 didn't do that in Ohio. I just can't remember how we did
20 it. Probably did.

21 So, anyway, but it's kind of like the issue that
22 it seems to me, if you're designing that program as a

1 state, you're like, hey, I don't have enough money to pay
2 for this. So I'll just put it in people's budgets, and
3 they'll use it, and so it's a way to save money in the
4 state. And I don't know if that's the perfect way to do
5 those things. So, to me, I think we need a little bit more
6 work.

7 I think we do need to make some recommendations
8 in these areas. I think we just need some more work on
9 some of these recommendations around, you know, what it's -
10 - I would also love to hear from the state that does the
11 model that we just talked about. Maybe we're missing
12 something. Maybe there's something in here that makes it
13 really good. I just don't know what that is.

14 And so, before making a recommendation on that,
15 it's like, well, what's behind there that makes that, you
16 know, a reasonable way to go?

17 Again, I do think we need to do something. I
18 just don't think this recommendation is exactly there, and
19 hopefully, we can work to get some other pieces in there.

20 CHAIR VERLON JOHNSON: Thank you, John.

21 Jami?

22 COMMISSIONER JAMI SNYDER: Thanks so much for

1 this work.

2 I think one of the things that struck me in your
3 presentation was around the role of the case manager in the
4 I&A function. If I'm remembering your slide correctly, I
5 think what you heard was that oftentimes, case managers
6 don't -- aren't as knowledgeable as they need to be about
7 self-direction and the provision of information and
8 assistance.

9 As we talk about streamlining, from my
10 perspective, when it comes to the provision of long-term
11 care supports and services and HCBS services, case managers
12 are really at the center of the equation in terms of
13 supporting members, in defining their service needs, and in
14 partnering with them to ensure that the services that they
15 need are accessible to them.

16 So, for me, a piece of the equation really needs
17 to be -- and there are states, in fact, that use case
18 managers as a primary I&A resource -- there needs to be
19 some attention focused, rather, on ensuring that case
20 managers do have the necessary training to present self-
21 direction as an option, to help individuals understand
22 their rights and responsibilities under a self-directed

1 model, and to offer that information and assistance.

2 And I just wonder, as states are looking at
3 options to streamline things and to cut costs, if turning
4 to that case manager as that I&A resource might become an
5 option that more and more states are thinking about.

6 But I'm curious to know from my fellow
7 Commissioners, who I'm guessing have some experience with
8 that type of model, whether there are also challenges
9 associated with the case manager serving in that capacity.

10 CHAIR VERLON JOHNSON: Thank you.

11 Patti?

12 COMMISSIONER PATTI KILLINGSWORTH: I would
13 venture to say, Jami, that there's no model for which there
14 are not challenges, right? No matter how you do it.

15 just want to make a quick follow-up to Anne's
16 comment and to John's as well. Sort of the flip side of
17 the risk that a person who uses their own budget, if you
18 will, to purchase I&A supports has less money available to
19 buy the supports that they need.

20 The other side of that risk is that they're
21 saving all of their money to buy actual hours, and so they
22 choose not to avail themselves of the I&A benefit, which I

1 think we would all agree is an important benefit, but
2 they're sort of disincentivized to use it.

3 So, there's probably some value in just thinking
4 through, does everybody need this or not? And if everybody
5 does need it, then what's the right way to make sure that
6 it's available to them, that it's high quality, that the
7 roles and responsibilities are clearly defined?

8 And I would say, even if it is a service, which
9 we've talked about all the reasons that that may be
10 problematic, but even if it is, there should be a way for
11 all Medicaid providers to ensure the quality of the
12 services that are being delivered, not just sort of to say,
13 well, it's a provider; I can't really control that. But
14 yeah, I can. There are outcomes that I expect in order for
15 Medicaid reimbursement to be appropriate, and I think we
16 could do that with those services. But it still doesn't
17 address the issue that we've talked about before, unless
18 you sort of carve that out of the budget, if you will.

19 CHAIR VERLON JOHNSON: Mike?

20 COMMISSIONER MICHAEL NARDONE: This is such a
21 complex topic, but I just wanted to raise a couple of
22 questions that might be helpful.

1 When I looked at the presentation, I said, is
2 that really the case? So one of the issues is around this
3 issue of the money coming out of the person's budget. Is
4 that only in cases where the person has control, has an
5 actual budget authority that they're controlling? So that
6 you could have -- and this is really technical, but you
7 could have a person-centered plan, right, that included
8 information and assistance as a service included in the
9 person-centered plan that was separate from the budget
10 authority? Is that -- so there are ways -- so I wanted to
11 be clear about that. It's very technical, but it's come up
12 a couple of times. So I think we should understand that a
13 little bit better.

14 And then the other issue around you have no
15 control over the quality of providers when you use the
16 system, I mean, there are ways to set standards for
17 providers. I mean, if you wanted to, you could do
18 preferred providers, right, and get a waiver of who could
19 be used as a provider. So, I mean, there are ways, I
20 think, and at least in some of the providers in the LTSS
21 system, the office -- the actual OLTL office -- or office
22 of long-term care will actually authorize a limited number

1 of providers that can provide the service, and they have to
2 be approved providers, and that's set in the waiver. I
3 just want to make sure that I'm understanding, you know,
4 the way the rules -- you know, kind of the way the program
5 works.

6 There are ways of doing it, which is one of the
7 reasons also where I kind of got away from, you know, maybe
8 this one option isn't the way of doing it. And, as Patti
9 says, there's always a problem with any model, right?

10 I think one of the issues for case managers is
11 when -- you know, just to your point, I just want to
12 respond. Maybe Patti has some perspective on this or
13 others too. -- is that some of the issues that you're
14 hoping that they're helping with are actually nitty-gritty
15 issues like when people don't show up, you know, like, or
16 you need to find workers. It's like a really detailed
17 level of assistance I think you're frequently providing.

18 So, you know, I think that is a level of -- you
19 know, you can provide training around, you know, what is
20 self-direction all about, but I think it's really the
21 interventions on a real-time basis that, you know, are what
22 you need to know as an employer.

1 Like when we heard from the folks in the panel
2 last year about the folks who were doing the support broker
3 and she was talking about how -- well, my son has a lot of
4 difficulty getting, finding good helpers, and I really had
5 to spend a lot of time finding and doing -- like, that's
6 something that I don't know that a case -- like, I don't
7 know. I mean, I think there's a question as to whether or
8 not you could kind of build that in.

9 CHAIR VERLON JOHNSON: John.

10 COMMISSIONER JOHN MCCARTHY: As I was sitting
11 here thinking about this and why we're all kind of
12 struggling with different pieces, what popped in my head is
13 -- and I don't know if we can do this, but we've done it in
14 some other places. What I'm struggling and grasping for
15 is, when I was Medicaid director, we make decisions that
16 would be based on data, right? And so far, we haven't
17 gotten any numerical data.

18 We've gotten data around different things. But
19 what would be helpful is if you could do it by, say, how
20 much is being spent on administrative services for self-
21 direction, you know, broken out by those different pieces
22 so we could see, well, maybe this model is working better

1 or not, because if everyone's saying so far today about
2 changes because H.R. 1 is going to cost -- is going to make
3 things tighter budgets and states aren't going to have as
4 much money, well, then we should -- need to look at what
5 does it look like for it being less expensive.

6 However, you can't just go by less expensive,
7 right? And somebody said earlier, what are the quality
8 outcomes tied to it?

9 So, again, on incident reporting, while it's not
10 perfect, you know, is there a way to see is there more
11 incidents or less incidents by state? So, to me, going
12 forward, if there was any way for you all to gather that
13 data and be able to present it to us, be able to look at it
14 to make some of those decisions, I think would be helpful
15 around some of the different pieces that were discussed.

16 CHAIR VERLON JOHNSON: Okay. Any other
17 Commissioners?

18 [No response.]

19 CHAIR VERLON JOHNSON: Well, this is a very good
20 conversation. It really got us thinking about this issue
21 even more.

22 So I just want to say that I am supportive of the

1 direction of the policy option and what we're trying to
2 achieve, but agree with many of the Commissioners, too,
3 with some of the concerns they have. And I'm always afraid
4 of having one single point of failure for anything.

5 And so I guess from this perspective, it sounds
6 like we could do a little more research around some of the
7 questions that you heard, and let's figure out what is the
8 best way to go with this one. That would be helpful.

9 But do you need anything else from us, though?

10 GABBY BALLWEG: I don't think so. This was
11 really helpful. Thank you, everyone.

12 CHAIR VERLON JOHNSON: All right. Thank you so
13 much.

14 We are moving into our next session.

15 [Pause.]

16 CHAIR VERLON JOHNSON: All right. We're going to
17 have Maddie and Caroline and Kirstin join us on Medicaid
18 coverage of assistive technology for adults. So we'll let
19 them get situated, and then we'll get started.

20 [Pause.]

21 CHAIR VERLON JOHNSON: All right. The floor is
22 yours. Thank you.

1 **### MEDICAID COVERAGE OF ASSISTIVE TECHNOLOGY FOR**
2 **ADULTS: DATA ANALYSIS AND STAKEHOLDER INTERVIEWS**

3 * MADDIE MUSTAINE: Hello, Commissioners. Today we
4 will be discussing Medicaid coverage of assistive
5 technology for adults. Specifically, we will be reviewing
6 findings from our data analysis and our stakeholder
7 interviews.

8 We will start by reviewing our purpose and a
9 brief background on AT. Then we will present findings from
10 our data analysis and stakeholder interviews. We will end
11 by discussing next steps for this work.

12 MACPAC's work on AT aims to identify the
13 statutory and regulatory framework that governs how states
14 cover AT and to assess whether there are barriers to
15 coverage of and access to AT. MACPAC is focusing on adults
16 to manage our scope and because they may experience less
17 robust coverage of AT than children. Since our last
18 presentation on AT, MACPAC has analyzed claims data and
19 interviewed key stakeholders. This will be the focus of
20 today's presentation.

21 AT refers to a wide range of items that can help
22 individuals increase, maintain, or improve their functional

1 capabilities. In Medicaid, there is no statutory or
2 regulatory definition of AT. For adults, states often
3 provide AT through HCBS programs under Section 1915(c) of
4 the Social Security Act.

5 AT is an optional benefit and the Section 1915(c)
6 Technical Guide, which is a tool states use to design their
7 HCBS programs, defines AT.

8 States have flexibility in how they cover AT, and
9 our findings from the data analysis and stakeholder
10 interviews are specific to AT covered through Section
11 1915(c) waivers, Section 1915(i) and Section 1915(k) state
12 plan amendments, and Section 1115 demonstrations.

13 Now we will review our findings from our data
14 analysis.

15 MACPAC analyzed Medicaid claims data from T-MSIS.
16 We restricted our analysis to adult HCBS enrollees in
17 accordance with our project scope, and due to data
18 limitations, we selected specific types of AT for this
19 analysis, AT and specialized medical equipment and
20 supplies, personal emergency response systems, home
21 accessibility adaptations and vehicle modifications, and
22 electronic and remote monitoring. We further segmented

1 data by age, geographic location, dually eligible status,
2 HCBS subpopulation and HCBS authority, and by fee-for-
3 service and managed care.

4 This table shows the percent of HCBS enrollees
5 receiving select types of AT and its related percent of
6 HCBS spending in 2024. Among HCBS participants, about 6
7 percent received AT and specialized medical equipment and
8 supplies, which accounted for about 0.3 percent of HCBS
9 spending.

10 Almost 8 percent received PERS, which accounted
11 for 0.1 percent of spending, and 1.4 percent received home
12 accessibility adaptations and vehicle modifications, which
13 accounted for 0.1 percent of HCBS spending.

14 Use of and spending on electronic and remote
15 monitoring was low, so this data is excluded from this
16 table.

17 Across most types of AT, individuals who were
18 older, lived in rural areas, and were dually eligible
19 beneficiaries represented larger shares of AT users than
20 individuals who were younger, lived in urban areas, and
21 were Medicaid-only beneficiaries.

22 Among HCBS subpopulations, individuals with brain

1 injuries represented the highest share of AT users, and
2 individuals in HCBS programs established through Section
3 1915(c) waivers represented a higher share of AT users than
4 individuals in other HCBS programs.

5 We further analyzed AT users and spending in fee-
6 for-service and managed care, and we found that across all
7 types of AT, a larger share of HCBS users received AT in
8 fee-for-service than managed care. Spending also similarly
9 followed this pattern, with higher spending in fee-for-
10 service than managed care.

11 Now we will move on to our interview findings.
12 We conducted stakeholder interviews with federal and state
13 officials, national associations, subject-matter experts,
14 and advocates, managed care organizations, and providers.

15 Stakeholders highlighted that AT may permit
16 greater independence for beneficiaries to successfully live
17 at home and engage in the community, and some stakeholders
18 mentioned that AT may help support caregivers as well.

19 States have flexibility to cover a range of AT in
20 their HCBS programs, and states noted that adoption of
21 their AT benefits was lower than expected.

22 Interviewees also identified opportunities and

1 challenges that may influence AT's ability to achieve the
2 intended impacts.

3 We summarized our findings from interviews in
4 three sections. The first section describes how states
5 cover AT in their HCBS programs, the second section
6 describes the process for obtaining AT, and the final
7 section describes how beneficiaries use AT.

8 First, we will present findings on how states
9 cover AT in their HCBS programs, including expenditure
10 caps, reimbursement, and coverage of new technologies.

11 All states reported covering AT primarily through
12 HCBS programs, particularly Section 1915(c) waivers, which
13 aligns with findings from our data analysis.

14 Some states reported that they appreciate the
15 broadness and flexibility of the AT definition in the
16 Section 1915(c) Technical Guide and noted that it permits
17 customization and innovation in their HCBS programs.

18 One national association explained that case
19 managers are more likely to discuss AT in person-centered
20 planning processes for intellectual and developmental
21 disability HCBS programs compared to programs for aging and
22 individuals who have physical disabilities.

1 Some states reported that the definitions and
2 decision-making processes for AT are more developed in
3 these I/DD programs than aging and disability programs.

4 States can set expenditure caps for HCBS services
5 as a cost containment strategy. Some HCBS programs have
6 caps for a specific service or a group of services, and one
7 state that we talked with does not have a cap on AT.
8 States reported that even with expenditure caps, they
9 approve most AT requests. However, caps can limit some AT,
10 such as high-cost items like stairlifts or items that need
11 periodic replacement.

12 Providers reported that Medicaid reimbursement
13 for AT is low and that HCBS programs do not adequately
14 cover the full range of services needed to provide AT, such
15 as assessments, fittings, installations, training, and
16 follow-up.

17 In accordance with the Section 1915(c) Technical
18 Guide, Medicaid cannot reimburse for utilities or services
19 that are not rendered. This includes upfront or prepaid
20 subscriptions.

21 For example, if a state pays for an annual
22 subscription for a Medicaid beneficiary and the beneficiary

1 becomes disenrolled during that year, the remaining portion
2 of the payment would be an unallowable cost for services
3 not provided.

4 All states expressed interest in keeping pace
5 with changing technologies and covering new technologies,
6 such as wearables and smart home options in their HCBS
7 programs. States also expressed challenges in doing so.

8 Some stakeholders explained that the federal
9 requirement for AT to address a functional need may limit
10 the new technologies that HCBS programs can cover.

11 Some technologies may be considered dual-use
12 devices because they can meet a functional need and can
13 also be used for other purposes. However, HCBS programs
14 can only cover devices or parts of devices that address a
15 functional need.

16 Additionally, some new technologies may also
17 primarily support independence and may not address a
18 specific functional need.

19 Stakeholders also noticed that the state
20 definitions of AT can become outdated as technology
21 evolves, especially since states may choose to only revise
22 these definitions every five years during waiver renewals.

1 States have the flexibility to develop new
2 services and definitions subject to approval by CMS, and
3 some states have created new services to cover new
4 technologies. A federal official noted that new services
5 generally follow the same guidelines as other services
6 defined in the Section 1915(c) Technical Guide.

7 Now I'll hand it over to Caroline to discuss the
8 rest of our findings.

9 * CAROLINE O'NEIL: Thanks, Maddie.

10 Next, we will discuss the process for obtaining
11 AT through Medicaid HCBS. Obtaining AT involves multiple
12 steps, and this process varies across states.

13 Generally, the processes are as follows. First,
14 a beneficiary's care team identifies an AT-related need and
15 incorporates it into the beneficiary's person-centered
16 service plan, or PCSP. Then an AT professional conducts an
17 assessment to determine what item is appropriate to meet
18 the beneficiary's needs. The case manager then identifies
19 an AT vendor to supply the item. Then the state confirms
20 that Medicaid is the payer of last resort, and finally, the
21 state or health plan issues prior authorization. This
22 process can take months, and delays can occur at each step.

1 The PCSP describes the services and supports,
2 such as AT, that an individual requires to meet the needs
3 identified in a state's functional assessment. AT must be
4 identified in the PCSP. So, if case managers are unaware
5 of or lack knowledge of AT, beneficiaries may be limited in
6 what AT they can receive.

7 States reported various ways they assist case
8 managers with identifying AT, including incorporating AT-
9 specific questions in their PCSP to encourage case managers
10 to discuss AT with beneficiaries.

11 After identifying AT as a needed service in the
12 PCSP, states may require an AT assessment to identify the
13 item that best meets the beneficiary's needs. Getting an
14 AT assessment can take time for various reasons, including
15 waitlists or lack of providers to conduct these
16 assessments.

17 Once an AT device has been prescribed, it can be
18 difficult to find a vendor that will supply the AT.
19 Stakeholders reported that AT vendors may be reluctant to
20 enroll as Medicaid providers since the process can be
21 complicated and may bring relatively few clients.

22 Finally, case managers are often responsible for

1 finding AT vendors, which can be difficult given their
2 competing responsibilities and large caseloads.

3 By law, all other sources of coverage must pay
4 claims before Medicaid will pay for the care of an eligible
5 individual. Thus, it is often necessary to coordinate
6 across multiple payers when providing AT, including AT Act
7 programs and Medicare, which can be complicated.

8 Prior authorization can make it difficult for
9 beneficiaries and providers to access and provide AT due to
10 administrative burden and long wait times for approvals.
11 In emergency situations and for low-cost items or repairs,
12 some states do make exceptions to prior authorization.

13 We will now present findings related to how
14 beneficiaries use AT.

15 We heard from stakeholders that adoption of AT is
16 relatively low, even though most Section 1915(c) waivers
17 cover some AT. Stakeholders suggested these relatively low
18 use rates could be due to a lack of beneficiary awareness
19 of the availability of AT, a lack of training in how to use
20 the devices, and limited access to repairs.

21 Stakeholders emphasized that beneficiaries need
22 additional education about the availability of AT, noting

1 that it is uncommon knowledge that coverage of AT is
2 available for beneficiaries enrolled in HCBS. Stakeholders
3 reported that making beneficiaries aware of their AT
4 options may increase awareness and adoption of AT. Some
5 beneficiaries may be hesitant to adopt technologies that
6 could replace human support, such as remote supports and
7 smart home options. This could be due to a lack of comfort
8 with relying on technology versus in-person assistance.

9 Some stakeholders explained that when human
10 support can be provided alongside these devices, it may
11 make beneficiaries more comfortable with the technology.
12 Engaging with aging and disability resource centers and AT
13 Act programs may increase beneficiary awareness and
14 adoption of AT.

15 Some HCBS programs cover training on how to use
16 AT for beneficiaries, their families, and caregivers. We
17 heard that a lack of available training for beneficiaries
18 on how to use their AT device can lead to device
19 abandonment. Stakeholders emphasized that caregivers and
20 beneficiaries can be hesitant about using AT when they have
21 not had much exposure. Additionally, stakeholders noted
22 that incentives for caregivers to learn how to use a device

1 and train the beneficiary are not always aligned, because
2 some services could lead to reduced hours for in-person
3 caregivers if the beneficiary is able to use a device in
4 lieu of a caregiver.

5 AT often requires repairs and maintenance to be
6 beneficial to users, and many waivers cover repairs. These
7 repairs may require prior authorization, which can further
8 add time that it takes to receive repairs.

9 Additionally, stakeholders noted that repairs can
10 take additional time due to a lack of designated skilled
11 providers who can repair a device, and stakeholders raised
12 concerns about potential negative effects on beneficiary
13 health and independence while they're waiting for a repair.

14 Finally, we will discuss the next steps for this
15 work.

16 We will return in December with policy options.
17 To inform this work, we are curious about any opportunities
18 and challenges raised in our data analysis or stakeholder
19 interviews that stood out to you. Did the findings from
20 the data analysis on HCBS subpopulations align with or
21 differ from your expectations? And given our findings on
22 limited awareness of the AT benefit in Medicaid, what ways

1 would you identify to increase awareness? And, finally,
2 how might the PCSP be used to identify beneficiary needs
3 that could be addressed by AT?

4 CHAIR VERLON JOHNSON: Okay. We have some great
5 questions in for us, so I will open the floor up.

6 Patti?

7 COMMISSIONER PATTI KILLINGSWORTH: I love this
8 topic. It has such tremendous potential to improve the
9 lives of people who use long-term services and supports.

10 If I look at your data across all of the
11 different types or definitions of AT that you looked at, it
12 was a half a percent of total spending in those programs.
13 If I look at the population that you identified as the
14 heaviest utilizer, which was individuals with traumatic
15 brain injury, it came to a whopping 1.1 percent of the
16 total home- and community-based services expenditures.

17 And if we compare that to the percentage of
18 spending that goes toward in-person supports, whether those
19 are personal care or respite or residential services, that
20 is going to hit more like 80, 85, in some states 90, 95
21 percent of the total expenditures are going for those in-
22 person supports.

1 At a time when we are struggling, continuing to
2 struggle, I think we will struggle for as long as I can see
3 into the future with having enough workers to be able to
4 deliver all of the supports that individuals need. If you
5 just look at the demographics of our country, the
6 populations of people who will need supports are increasing
7 at much faster paces than the working-age individuals that
8 we might expect would be employed to deliver those
9 services. And so there's this ever-widening, it feels
10 like, gap of the needs and the supply of workforce.

11 There are things that technology will never
12 replace in terms of in-person supports. But, as a
13 practical matter, there are many, many opportunities for
14 people to experience greater independence in their daily
15 lives and to have more reliable assistance available to
16 them because in the home health world or the HCBS world,
17 there's a standard now of if you can cover about 80 percent
18 of the hours, that's good. Well, that's not good for the
19 other 20 percent that somebody needed help and nobody
20 showed up to help them. And so where we can equip people
21 with technology that will allow them to have consistent
22 access to the support they need to live their daily lives,

1 we should do that.

2 Part of the issue starts really in the Medicaid
3 statute itself, which has never anticipated that a part of
4 the role of Medicaid home- and community-based services
5 should be to support the independence of people who receive
6 those services, to support their integration into community
7 and their equal access to all of the benefits of daily life
8 that we all enjoy. We've left that sit separately in the
9 ADA and in other civil rights legislation, and we have
10 failed in Medicaid to address the longstanding
11 institutional bias that has prioritized institutional care
12 over home- and community-based living for this population,
13 let alone said that we should actually deliver supports in
14 a way that maximizes their opportunities for independence.

15 There are also longstanding ways of assessing the
16 needs of people who receive home- and community-based
17 services that are very deficit-focused. Let's identify all
18 of the functional areas that they need support with.

19 And then the care planning part of that, the
20 person-centered planning part is -- and now let me equate
21 that to minutes or hours of support for a person to come in
22 and do those things for them, without stopping first to

1 say, gosh, is there a thing that I could do, a support that
2 I could provide for you that would allow you to continue
3 being able to do those things for themselves? And there's
4 a growing body of literature that points to when people
5 maintain independence, their quality of life is better,
6 their health is better, their mental health is better, and
7 when they begin to lose that independence, then all of
8 those other things go down as well.

9 So there are so many reasons why we should flip
10 the way that we do planning on its head and really
11 prioritize those opportunities to support independence for
12 people.

13 It's really so disappointing to know that we're
14 spending such a small percentage of dollars on supports
15 that could have such an important impact, and so I think a
16 part of our work should be why and how. How do we remove
17 some of those barriers?

18 Some of the administrative hurdles that we put
19 around how to access these benefits are so penny-wise and
20 pound-foolish. We want to make sure that services are
21 prior authorized and that Medicaid is the payor of last
22 resort, and yet some of these things cost like 20 bucks and

1 could change a person's life in terms of their ability to
2 get up and get dressed in the morning instead of waiting
3 for someone else to show up and help them. Do we really
4 need to go through all of that for 20 bucks?

5 We need to rethink the processes for accessing
6 these benefits. We need to rethink the way that we pay for
7 Medicaid services right now. Providers are incentivized to
8 want to deliver more in-person care. It's the way they get
9 paid. We don't incentivize them to help people become more
10 independent. In fact, they're disincentivized to want to
11 do that, because then they have less opportunity to earn
12 revenues.

13 So just so many things from a quality perspective
14 we don't ever look at, did anybody who received home- and
15 community-based services actually become more independent
16 as a part of the supports that we provided? We don't
17 measure that, even though it would be hugely impactful.

18 There's so many things that I think we need to
19 change if we're really going to get from less than a
20 percent or less than half of 1 percent, not to any
21 particular number, but to a place where we can have greater
22 confidence that we're providing access to the array of

1 benefits that would afford people the greatest
2 opportunities for independence and meaningful community
3 life.

4 That's my --

5 CHAIR VERLON JOHNSON: Thank you so much, Patti.
6 Appreciate that.

7 COMMISSIONER PATTI KILLINGSWORTH: Off my
8 soapbox. Thank you.

9 CHAIR VERLON JOHNSON: No, your soapbox was
10 great. We appreciate it.

11 John and then Heidi.

12 COMMISSIONER JOHN MCCARTHY: First, on the data,
13 I think it's excellent you brought this up, and I agree
14 with Patti's points.

15 I think there's a couple things on here, though,
16 that skew it just a little bit, and that, so for instance,
17 on vehicle modifications, you do that once, and then that
18 vehicle modification stays, right? It's not like a
19 reoccurring cost. And so like the way we're looking at it
20 in a year, you're catching one year's worth of vehicle
21 modifications, but that doesn't mean -- and I'm going to
22 make up a number. It doesn't mean like 100 percent of the

1 people could have had their vehicles modified, but it's
2 just over that year, only that small percentage. I'm not
3 saying it's 100 percent, but just like that's one of the
4 issues with the data.

5 I think what I'm struggling with this one is --
6 and I normally -- it's important to keep things at the
7 state level, but in looking at this going forward, I do
8 wonder if there's more of a we need to be thinking of
9 policy measures at a federal level, because as leading a
10 state, it's hard to make the decision.

11 And I agree with Patti of like being penny-wise
12 and pound-foolish on some of these, but it's also just hard
13 to make a decision of what new technologies work. And as
14 technology is coming faster and faster, it's like, is there
15 a way with either the federal government and a commission
16 of states, a rolling commission of states to be able to
17 review some of these technologies to be able to say, yes,
18 this one works or that doesn't work?

19 I just saw an interview the other day with Chris
20 Johnson, a former NFL running back who's got ALS, and he
21 could speak. So he'd be independent, and he can only move
22 his eyes. And when they were doing the live interview, he

1 was just interacting with the interviewer. So that is an
2 amazing technology, and it's only going to get better.

3 I don't know how much that technology costs. I
4 remember when I was fighting with my staff over whether or
5 not a person should get a -- what was it called? A
6 speaking board, a communication device that a person -- we
7 were fighting over, like, should we pay \$2,000 for this
8 thing? And I was like, why wouldn't we? And they're like,
9 oh, it's so expensive, and you can have a person. So is
10 there a way for us to think of it a little bit differently
11 of how to evaluate the technologies, what works, what
12 doesn't work, and evaluate them the way Patti talked about,
13 that it leads to independence? And that's just on that
14 side, let alone all of the things we're going to be seeing
15 on the health side, health sector side of it.

16 And, Maddie, you brought up some really
17 interesting ones I hadn't thought about, which was like,
18 yes, a lot of these are subscription models, and it's
19 cheaper to do it by the year rather than paying by the
20 month. But if the person should become disenrolled, pass
21 away, then what do you do? So are there some of those
22 things, and is there a threshold that we cover for that?

1 And I just have to bring up, I get it on the flip
2 side, because the issue around vehicle modifications is
3 always like, okay, we're going to modify this vehicle for
4 the person's parent or partner, significant other, husband,
5 wife, whatever it is. And then people would have auditors
6 coming in or IG coming in saying, well, they're using the
7 van to go to the grocery store and the person's not in it.
8 And you're like, well, of course they are. That has
9 nothing to do with -- we're not charging mileage for that
10 period. But so it was modified. What does it matter? And
11 then it was like, well, what level, how many times do they
12 have to drive a person in it? So I think there is this,
13 like, where do we draw some of those lines and align some
14 of those different pieces in there, and are we okay with
15 some of that as a policy decision on those?

16 So kind of a little bit different type of what
17 you want is, how do we decide on how to do this going
18 forward? Especially with -- you know, we hear about AI so
19 much, and we've talked about AI so much around prior
20 authorizations and things like that. But AI in this area
21 is probably going to lead to even greater things.

22 And we haven't even talked about, for instance --

1 I know Xi was here today. Robotics in China are just
2 amazing of what those robots can do. They'll be coming to
3 the U.S. in a few years and be able to even leave the
4 further independence of being able to do things for people.
5 So I think that's something we could -- what does that look
6 like going forward? Thanks.

7 CHAIR VERLON JOHNSON: Thanks, John.
8 Heidi.

9 COMMISSIONER HEIDI ALLEN: So Patti and John both
10 said a lot of what I had written down, to say that I'm
11 remembering a couple of years ago when I went to Patti
12 about my grandmother who was 90 and who was living
13 independently but starting to forget to take her meds, was
14 starting to struggle. And I was thinking about, okay,
15 Patti, how do we take her to the next level, and Patti was
16 like, you do everything you can to keep her in the house
17 that she has been in for 15 years. She's like, you buy the
18 alarms. You go online, you know, all of these \$50 or \$20
19 or \$30 support systems to enable her to stay in her home.
20 And you were like a prophet in a way because my
21 mom went out of town for a few days and she got the flu and
22 there was nobody monitoring her. So by the time my mom

1 came home and found how sick she was she went into the
2 hospital and then she went from there into -- she became
3 extremely dementiad and didn't know where she was, didn't
4 know who anybody was, and never made it back home.

5 And I think, well, what if there had been remote
6 monitoring to show that she had spiked a fever and then
7 somebody would've went in and found out that she had the
8 flu and she could've started treatment.

9 So, it is these, you think of them as minor, but
10 they are attached to huge transitions that when we fail to
11 catch things early, when we fail to help people stay at
12 home that they end up going into the most expensive
13 systems. And it also has, in the case of my grandma, I
14 think it shortened her life.

15 So, understanding the technology, how quickly
16 it's adopting, thinking about how it can be helpful for
17 people, and then thinking big picture, how these very small
18 investments could be used to prevent really expensive
19 downstream costs is really important.

20 And I think it's ridiculous to require these
21 entities to become Medicaid vendors. I mean, the idea of
22 that is so ridiculous to me. There has to be a way to

1 purchase something that is useful without saying, okay,
2 company, I'm going to call your 1-800 number on your
3 website and ask you if you'd be willing to become a
4 Medicaid vendor in my state.

5 So, I would really love to see us come up with
6 some practical, no-nonsense -- I loved John's idea of a
7 technology review board. I think that would be useful for
8 everybody. You know, you think about people that aren't on
9 Medicaid, but if they end up going into needing more care
10 then they have to spend down and go onto Medicaid. For
11 every person that we can keep independent and keep at home
12 and hopefully keep them off of Medicaid, that's money well
13 spent. And yet these technologies, you really do need
14 expertise that an individual state Medicaid director or
15 even a small committee may not have over what's worth
16 buying versus what's not. So, I really appreciate those
17 comments.

18 CHAIR VERLON JOHNSON: Thank you, Heidi. Carolyn.

19 COMMISSIONER CAROLYN INGRAM: Thank you for doing
20 this work. I just want to add one more piece in about the
21 issues around fraud and abuse and just remind folks that
22 one of the reasons the federal government requires states

1 to have these folks licensed as vendors is because there's
2 a lot of fraud around DME equipment and assistive
3 technology, unfortunately. It doesn't have anything to do
4 with the people who we're actually trying to serve and the
5 people that are getting the products, that Patti, John, and
6 others are talking about.

7 It has to do with, unfortunately, entities who
8 run fake storefronts and just get people's information and
9 identification and bill. The person would never even know
10 that they were being bill against. Those institutions are
11 trying to collect that information.

12 And we have found, in one state in particular,
13 when we sent people out to go look at who was doing all the
14 billing for a certain assistive technology, the storefront
15 was a sporting goods store, and they didn't sell any of
16 those things at all. They sold sporting goods.

17 So just to keep in mind that's one of the reasons
18 that some of those protections are in place. So, while we
19 want to see the flexibilities, I think those are important.
20 We have just got to make sure that we allow states what
21 they have to do, and the federal government what they have
22 to do, to kind of cut out those bad actors. Thanks.

1 CHAIR VERLON JOHNSON: Thank you. Doug.

2 COMMISSIONER DOUG BROWN: Thank you. Great
3 presentation. I want to just take us up one level, just
4 for my background and understanding. Am I correct in
5 making the assumption that at the general Medicaid level,
6 that AT is covered for Medicaid recipients?

7 MADDIE MUSTAINE: You mean outside of HCBS
8 programs?

9 COMMISSIONER DOUG BROWN: Outside of HCBS.

10 MADDIE MUSTAINE: DME would be covered. So, items
11 that are specific for a medical necessity need versus like
12 a function need that would be covered in HCBS.

13 COMMISSIONER DOUG BROWN: Okay. And is there any
14 way that -- and I'm just thinking through this -- that
15 someone received their AT under Medicaid and then became
16 independent enough to be at home, and now they're in HCBS.
17 So maybe they got their AT prior to arriving in HCBS, which
18 may make the spend a little bit lower.

19 MADDIE MUSTAINE: Yes, correct. Certain devices
20 that might be more medical in nature are not reflected
21 necessarily in these numbers. So, something that's
22 traditionally DME would not be reflected here.

1 COMMISSIONER DOUG BROWN: Right. And are the
2 services in DME also for technology?

3 MADDIE MUSTAINE: Most states, the HCBS programs
4 cannot overlap with the DME benefit, so these AT devices
5 cannot be covered in the state plan DME benefit overall.
6 So, they would be different. An example of something more
7 traditionally DME would be a wheelchair.

8 COMMISSIONER DOUG BROWN: Right.

9 MADDIE MUSTAINE: And something more motorized or
10 any devices to go onto the wheelchair would be covered
11 here, as an AT device.

12 COMMISSIONER DOUG BROWN: I got it. Okay. That
13 helps. Thank you.

14 CHAIR VERLON JOHNSON: Thank you. Any other
15 questions?

16 All right. Another really good presentation. I
17 really love the data that you all put together for sure.
18 It really tells us a little bit more about who is on it,
19 who has assistive technology. But I also think it really
20 helps others who don't at some point, as well.

21 And going back to Patti and her opening
22 statement, I really like the idea of really thinking about

1 do we have the right people that actually have access to
2 this and -- hold on, someone is trying to call me. And
3 then also make sure that people are using it successfully
4 would be really important for this, right. And then also
5 making sure they can maintain it, which is an area that you
6 all brought up, and then ultimately make sure it gets to
7 the goal of experiencing greater independence as a result
8 of that.

9 So, if we keep all those things in mind as we go
10 through this we can really make sure that whatever we want
11 to do as a Commission kind of stands out a little bit more.
12 So, I appreciate all of your efforts on this, for sure.

13 MADDIE MUSTAINE: Thank you.

14 CHAIR VERLON JOHNSON: All right. With that we
15 are now at the public comment part of our session, so we
16 are inviting people in the audience to raise their hand if
17 they would like to offer a comment. Please introduce
18 yourself and the organization you represent, and we do ask
19 that you keep your comments at three minutes or less.

20 Let's see who we have.

21 **### PUBLIC COMMENT**

22 * [Pause.]

1 CHAIR VERLON JOHNSON: All right. Seeing no
2 comments I want to remind you that if you have comments
3 later you can feel free to submit those to our MACPAC
4 website. And other than that, we are at the end of our
5 meeting. I thought it was a very good two days. And I
6 wish all of you a great weekend, and we will see you all
7 next month.

8 * [Whereupon, at 11:29 a.m., the meeting was
9 adjourned.]

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