PUBLIC SESSION

Bernard K. Jarvis Hall of Learning
Association of American Medical Colleges
655 K Street NW, Suite 100
Washington, DC 20001

Thursday, September 19, 2024
9:01 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:00 a.m.]

VICE CHAIR DUNCAN: Good morning. Welcome, and today we're kicking off our '24-'25 new analytical cycle.

I want to welcome two new Commissioners that are joining us today to MACPAC, Mike Nardone and Doug Brown. For those in the audience that would like to learn more about our new Commissioners or the other Commissioners on the panel, please feel free to visit our website at macpac.gov.

I would also like to recognize Verlon Johnson, our fellow Commissioner, as MACPAC's new chair. Verlon was extremely excited to be here today to lead us through this inaugural meeting of the meeting cycle. Unfortunately, she has extenuating circumstances that prevent her from being here. So Verlon will join us in October for that meeting.

With that, I'm excited to introduce our panel today, Chris, Kirstin, and Joanne to lead us through the overview of the recent CMS final rules. With that, I'll turn it over to this distinguished group. Thank you.

OVERVIEW OF RECENTLY PUBLISHED FINAL RULES

* MS. JEE: Okay. Good morning, Commissioners.

During this session, Chris, Kirstin, and I will be providing a fairly high-level overview of recent regulations, final regulations that CMS has issued. You probably know that they've issued rules on eligibility and enrollment -- let's see here -- eligibility and enrollment, access to services, managed care, and nursing facilities. So the agency has been busy and so have we reading those long rules.

I will note that the rules are final. So the purpose of this session is just to share some information with you all as just for your information and knowledge.

We will pause after the summaries of each of the rules in case there are any questions before we move forward to the next rule.

Okay. So we're going to start with the eligibility and enrollment rule. The Commission previously commented on this proposed rule, which CMS issued in September 2022. So that seems like a long time ago. Generally speaking, the Commission's letter expressed support for CMS's efforts to streamline the enrollment and renewal processes on balance with their program integrity obligations.

With respect to the implementation dates of the provisions within this rule, the Commission commented in support of establishing separate timelines for the effective date and the actual compliance dates, and that was to give states sort of a longer runway for implementation, given all of their many obligations.

CMS did finalize that phased implementation, and the compliance dates and the effective dates are in your meeting materials. But I won't be going through those specific dates this morning.

Oops. Hang on a second. Okay.

So the final rule included three provisions related to facilitating Medicaid enrollment. Those provisions were finalized as proposed. These provisions relate to facilitating enrollment for non-institutionalized individuals through the medically needy, eligibility pathway.

Secondly, the rule finalized requirements for electronic verification of eligibility and clarified that reasonable compatibility standards apply to verification of resources.

And thirdly, the final rule --

Oops, I think I'm on the wrong slide here. No, I'm not. Okay.

And thirdly, the final rule eliminated the requirement that individuals provide additional proof of identity when citizenship has been verified through certain specified avenues.

The Commission's comment letter addressed the second item on this slide, and you all supported clarifying states' responsibility to rely on electronic data sources for verifying eligibility when reasonably compatible, and in particular, the Commission noted the opportunity for states to gain efficiencies in doing so.

The final rule addressed a number of provisions related to enrollment and retention of eligible individuals, largely finalizing them as they had been proposed in the NPRM.

Specifically, the final rule took steps to align enrollment and renewal policies for the non-MAGI population with the policies for the MAGI population. Commissioners, you may recall that these policies for the MAGI population have been in place for quite a while but up until the final rule were not for the non-MAGI group.

So, for example, the final rule requires that states accept applications in all the modalities available and prohibit states from requiring in-person interviews. The rules also require that states send pre-populated renewal forms and addressed the frequency of redeterminations.

So this alignment in policies is really intended to reduce barriers to enrollment and renewal for individuals who have disabilities or who are aged, and as the Commission noted in the comment letter, it will hopefully promote equity for the non-MAGI population.

In addition, the rule finalized the NPRM provisions for acting on changes in beneficiary circumstance, including establishing time frames for certain actions.

The final rule also established time frames related to individual submission of additional information and for eligibility determinations. The rules previously had been silent in these areas. So the rule lays out a number of specific time frames, which really are too numerous to review in this short session this morning, but they are summarized in your memo. So I'll refer you to

that.

I wanted to note here that the NPRM proposal to give beneficiary 10 days to respond to requests for information was changed in the final rule and was changed from 10 days to 15 days, and that was an area that, Commissioners, you all commented on in your letter, stating that a longer period of time was needed.

The final rule describes steps that states must take to act on updated address information for beneficiaries, and this includes what states must do, for example, when mail is returned through the U.S. Postal Service or when updated eligibility -- excuse me -- address information is provided from a third party. I must have eligibility on the mind.

The rule also requires states to take certain steps based on the type of address change, which are listed towards the bottom of the slide here.

So the Commission's comment letter generally expressed support for CMS's efforts to address missing contact information, especially given the implications for retention of coverage, and this is a dynamic, Commissioners, that you know has been playing out for many,

many years and, in particular, in the last few years with the PHE-unwinding.

Okay. The rule also addresses provisions to prevent gaps in coverage and improve transitions, particularly between the Medicaid and CHIP programs. Specific requirements include that state Medicaid and CHIP agencies are to make determinations of eligibility for the other program and are to accept the eligibility determination from the other program.

The rule requires that states transition individuals to programs for which they are eligible based on the information that is available and that states coordinate a single notice to those determined ineligible for one program but potentially eligible for another.

Again, here the Commission was supportive of these efforts to streamline and -- but raised concerns about the burden associated with a combined letter, and that would be a burden obviously on states. And that was because of, you know, states' limited ability and the challenge that states have experienced in improving notices. However, as I mentioned, CMS did finalize that provision as proposed.

Okay. The rule finalizes provisions to eliminate certain barriers to access in Medicaid. Specifically, states may no longer limit the number of reasonable opportunity periods to provide documentation for citizenship but does not change the 90-day reasonable opportunity period.

The rule also eliminates the requirement that individuals as a condition of their eligibility for Medicaid apply for other benefits for which they might be eligible.

And lastly, the rule included provisions related to the access barriers in CHIP and the basic health program. I just want to point to a couple of provisions here because they are areas that the Commission has worked in in the past. Namely, the rule establishes a prohibition on premium lockout periods for those who are disenrolled from CHIP or BHPs for failure to pay their premiums, and the rule also prohibits waiting periods in the CHIP program.

Okay. So the next section is on MSP. So I'm going to hand that over to Kirstin.

* MS. BLOM: Thanks, Joanne.

So the -- hang on one second. Oops. Sorry.

VICE CHAIR DUNCAN: Heidi, you have a question?

COMMISSIONER ALLEN: Well, I feel like I should have taken a week off work to digest all of this stuff.

But I have a question related to these kind of transitions of coverage and determining eligibility in the context of now but also in the context of how things will change, and it's specific to pregnancy Medicaid.

I was recently looking at data from postpartum people in six states and noting that people on Medicaid were reporting a lot of out-of-pocket spending related to childbirth and also out-of-pocket spending related to postpartum care. And, you know, the federal regulation is that there's no cost sharing related to pregnancy services, and so I was trying to understand that.

And then it occurred to me that there could be a significant number of people who are on ACA Medicaid who get pregnant, and it isn't clear to me if they're required to notify the state of their pregnancy to be entered into pregnancy Medicaid or how the state figures that out.

And the implications for cost sharing are one thing, but I think that those are small compared to the

implications for not being eligible for continuous enrollment, because if you don't transition to pregnancy Medicaid, then you don't get that 12 months. And so, no, is that not -- can -- yes, please enlighten me.

COMMISSIONER BROOKS: So it doesn't matter what category a woman is in if she was pregnant. She gets the 12 months' postpartum. But I do think that if she were going to go over income, say, in adult expansion, she would then have to be transferred to the pregnancy group because she's no longer eligible. But there's not a requirement during the pregnancy, at the end of the pregnancy, to go into the pregnancy category. You can still qualify if you're enrolled in another category.

VICE CHAIR DUNCAN: Microphone, please.

COMMISSIONER ALLEN: So it just doesn't matter. All claims that are pregnancy-related should be subject to the rules of pregnancy Medicaid because they're pregnancy claims, and the person who is postpartum should get the 12 months, regardless of what category?

COMMISSIONER BROOKS: Right. I mean, how that's being implemented, I think, remains to be seen. But there's no requirement for states to move a pregnant woman

into the pregnancy category.

COMMISSIONER ALLEN: Doesn't that change, though, the FMAP?

COMMISSIONER BROOKS: It could if they moved them, but --

COMMISSIONER ALLEN: Well, that's what I'm wondering. So they stay in this -- they stay in the ACA FMAP? They get the 90 percent --

COMMISSIONER BROOKS: Yes.

COMMISSIONER ALLEN: -- versus if they change, they would go to the 50 percent?

COMMISSIONER BROOKS: Yep. We should probably take this offline. We're getting a little astray.

COMMISSIONER ALLEN: Yeah. I'm sorry. I was just trying to understand the transitions. Thank you.

VICE CHAIR DUNCAN: Thank you. Appreciate that, Heidi. And, Trish, thanks for weighing in.

Patti's got her hand --

COMMISSIONER KILLINGSWORTH: Yeah. Just a quick question on slide 5 and the provision to allow individuals to deduct prospective medical expenses. I looked at the rule. I could not tell. It speaks specifically about

those expenses being included in a plan of care developed under Section 1915(c) authority -- or 1915 authority. Sorry. And what that seems to include -- or exclude -- I'm sorry -- is services that might be provided pursuant to an 1115 demonstration.

There are a number of states who operate their HCBS programs exclusively under 1115 and not under 1915, and I would hope that there is provision to not exclude individuals in those states from this flexibility simply because they have -- by virtue of the authority that the state has chosen to operate their programs under. But it's not clear to me. Maybe you have additional insight. If not, I would love for us to just look into that a little bit more.

MS. JEE: Yeah. Thanks for that question. I don't actually have additional insight that I can offer you now, but I'd be happy to go back and take a look at that, because that's an important nuance, I think.

COMMISSIONER KILLINGSWORTH: Thank you, Joanne.

VICE CHAIR DUNCAN: And, Kirstin, before we go back to you, I'd like to tell the Commissioners, because we have four different rules, what we're going to do is go

through each of the rules and then ask questions at the end of each rule versus trying to get through all four and compiling those questions. So there will be time after Kirstin's presentation for more questions, input, and thoughts. So thank you.

Kirstin?

MS. BLOM: Thank you. Let's go back. Oops. Okay.

So just one note. So this slide is meant to capture the sections of the NPRM that are focused on the Medicare savings programs. So for your information, the NPRM was finalized by CMS in two parts. So there's actually two separate final rules to look at. So this one is the MSP rule.

This is about simplifying eligibility and enrollment determination, and MSPs was finalized last year. And it's designed to require that states basically use the application data, the "leads" data that they receive from the Social Security Administration as part of the SSA's work to determine eligibility for the Medicare Part D low-income subsidy program.

The LIS program, as you guys know, is a very

similar program to the MSPs in that it provides subsidized coverage of Medicare Part D costs to a similar population. So because of those similarities between the two populations and the two programs, there's been kind of an ongoing effort by CMS -- and it's also tied to things that we've said about the MSPs -- to work towards improving participation and beneficiary awareness of these programs by aligning the eligibility policies between the two programs.

So one of those was defining family size. The states tend to define family size differently than the LIS program does, which leads to bumps in transferring an eligibility application from LIS to the MSPs. So, in this rule, that's one of the things that CMS has made a change to define, to require that states define family size for the MSPs to at least include people who are part of that definition for purposes of LIS.

Other provisions of note are CMS is now requiring that people who are Medicare beneficiaries who are -- or sorry -- people who are SSI and beneficiaries who are eligible for Medicare, that they be enrolled in the QMB program, the QMB group. The qualified Medicare beneficiary

group is the largest of the four MSPs and provides the most benefits. So this is seen as a way of kind of reducing disparities between some of the lowest-income Medicare beneficiaries and others in the program.

One change over the NPRM was that CMS extended the time frame that states have to comply with the rule from 12 months after enactment out to April 1st of 2026, with one exception, which is the SSI provision. That's actually going into effect in October of this year.

These changes broadly align with recommendations that MACPAC made in 2020 and we referenced in our comment letter on the NPRM when this was at the NPRM stage, which were all sort of designed to improve participation in the MSPs.

Okay. So, with that, I think we're ready for any questions on this rule broadly, whether it's the MSPs or the stuff that Joanne walked through, or if there aren't any more questions, we can continue to the next rule.

VICE CHAIR DUNCAN: So, Joanne, Kirstin, thank you for the review. It was nice, as you pointed out, Joanne, to hear some of the recommendations that MACPAC had made and incorporated into the policies.

With that, Commissioners, any comments? Questions?

Tricia?

COMMISSIONER BROOKS: Sorry. I just need to amend what I said earlier.

There's no renewal due. Postpartum coverage is continuous eligibility, so people stay in the same eligibility category they were in when they were pregnant, but prior guidance has said you don't have to move anyone from the category they're in. So I think it still is a challenge for states to identify that that person was pregnant. So if that person has an income increase, would go over expansion, they still need to know somehow that they were pregnant and are in that 12-month category, and I don't know what states are doing about that.

VICE CHAIR DUNCAN: Heidi?

COMMISSIONER ALLEN: Yeah. I'd be really interested to try to understand that better, because it does seem like a place where people could lose coverage when they shouldn't, and it fits with this rule in a way that I know that the rule is intended to try to help these transitions, but without transitioning to pregnancy

Medicaid, you don't get that extra income. And then you wouldn't -- yeah.

Or I'm also just thinking of like when you renew, right? If your renewal was February, it automatically extends from the date of --

COMMISSIONER BROOKS: Yeah.

COMMISSIONER ALLEN: And so states are using T-MSIS, or, like, how are they identifying that? How do you go from a claim for a childbirth for somebody who is in ACA Medicaid, and then take that to the eligibility system to extend it? It just seems to me a little -- I'm sure there's an answer. I just would love -- I don't know it, and I would love to hear it.

MS. JEE: There was a lot of guidance several years ago and a lot of confusion around these particular issues that you raised, Heidi. I'll admit it's been a while since I've thought about it, but maybe we can go back and sort of refresh memories and take a look at what the state of play is.

VICE CHAIR DUNCAN: Thank you, Joanne.

Any other comments?

[No response.]

VICE CHAIR DUNCAN: All right. Well, let's move to the next one, access to services.

MS. BLOM: Okay, great. Thank you, guys. All right.

So this rule, the access rule, finalized May of this year, largely as proposed with a couple of changes. It's very much focused on increasing payment transparency, standardizing reporting, and promoting beneficiary engagement. And MACPAC submitted comments on the NPRM, expressing general support for certain provisions in the rule where we had prior work.

So related to beneficiary engagement, the final rule restructures an existing requirement that states establish Medical Care Advisory Committees, which the final rule is renaming as Medicaid Advisory Committees, or MACs.

The rule also expands the scope of topics to be addressed by those -- I hope I'm saying that right, or maybe it's MACs. I don't know. -- to include policy development and program administration.

The rule is also requiring states to establish a corresponding Beneficiary Advisory Council to be comprised of beneficiaries, their families, and caregivers.

According to CMS, these two entities are intended to provide bidirectional feedback between the state and interested parties in the Medicaid program.

We, MACPAC, recommended in March of this year that CMS address concerns related to beneficiary engagement, strategies to facilitate meaningful beneficiary engagement, and also clarify how states can provide financial arrangements to beneficiary participation.

And in the final rule, CMS addressed sort of that third element of the Commission's recommendation, which was to clarify how states can provide financial arrangements. For example, because stipends are accountable income for Medicaid purposes, CMS notes in the rule that states could submit a state plan amendment to disregard those stipends received for participation.

The final rule also includes a number of provisions related to HCBS. It requires that states establish written policies and procedures for beneficiaries to submit grievances for services received under a 1915(c) waiver that was delivered through fee-for-service. This requirement already exists for services received through managed care, and the Commission commented in support of

this provision.

Also, the rule requires that at least 80 percent of all Medicaid payments, including base and supplemental payments for these following services -- homemaker services, home health aide, and personal care -- be spent on compensation to direct care workers.

Under the final rule, there are three exemptions to that payment adequacy provision, which are small providers, providers that would experience a significant hardship under an 80 percent minimum, and the Indian Health Service or Tribal health programs.

Certain costs are also excluded. Those are expenses for DCWs related to training, travel, and personal protective equipment.

MACPAC commented in support of bolstering the direct care workforce. We encouraged CMS in our comments to work with other federal agencies and stakeholders to consider the implications of defining DCWs. We also -- defining DCWs in the rule, and CMS highlighted their continued commitment to work with other agencies and stakeholders in addressing the shortage and also noted that there are some factors affecting the workforce outside of

their purview as well as the scope of the rule.

Oh, and -- sorry -- one note on that last slide. We do have related work on this topic of HCBS payments and the direct care workforce. We've, in the past cycle, released a compendium and sort of did a phase one of looking at how HCBS rate setting occurs in relation to the workforce, and in this coming cycle, we are doing a second phase. We're convening a technical expert panel to consider issues around rate setting, including payment principles that are critical to establishing HCBS payment rates. So you can look forward to that in this coming cycle.

Okay. So the final rule also includes a requirement that states report every other year on HCBS quality measure set and establish performance targets for mandatory metrics. States are also required to describe the strategies that they're going to use to meet those targets.

In the Commission's comment letter, we highlighted concerns on a lack of coordination on quality metrics across programs, which the rule addressed by applying the quality measure set to Sections 1915(j), (k),

and (i) state plan services.

The Commission also noted in our comments the challenge related to data limitations, especially around race and ethnicity, which continue to pose challenges for states.

So related to fee-for-service, the final rule rescinds the prior state requirements to submit an access monitoring review plan and replaces those with payment transparency requirements. States must publish all Medicaid fee-for-service payment rates for the services listed on this slide. This must be done by July 1, 2026, for rates in effect as of that date.

For primary care, obstetrics and gynecology, and outpatient BH, states must also conduct a comparative payment rate analysis relative to Medicare and publish the initial analysis by July 1 of 2026. After that, the update should occur no less frequently than every two years.

In our comments, MACPAC supported payment transparency and raised several concerns about how supplemental payments would be factored in, guidance on calculating payment based on site of care, and disaggregating bundled payments, particularly for

institutional providers. CMS addressed this by noting that the agency is going to issue some sub-regulatory guidance on disaggregating payments, in particular, before the effective date of the final rule, and clarified that a number of payment types are not included, such as prospective payment rates for FQHCs and rural health services or centers, as well as DSH and supplemental payments.

MACPAC also raised some concerns about measuring provider payment rates without considering all factors, such as provider type or geographic area, and suggested it would be helpful to report payment data at the provider level or use some common groupings of sites of service, such as office-based. CMS addressed this in the rule by requiring reporting by population, provider type, and geographic location.

Lastly, in the rule, CMS is requiring states to have ongoing mechanisms in place for beneficiary and provider input on access to care, such as hotlines or surveys. States must also establish an interested parties advisory group to consult on fee-for-service payment rates for DCWs, for self-directed and agency-directed care. That

group, that advisory group must include DCWs and beneficiaries with the first meeting occurring by July of 2026 and then subsequent meetings with the state occurring every two years.

In our June 2022 report to Congress, the Commission urged CMS to implement a new system to monitor access that would specifically incorporate beneficiary input. The Commission also recommended that CMS field a federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care. In the final rule, CMS did not mandate a beneficiary survey but permitted it as an option to collect and respond to beneficiary and provider input.

Okay. So, with that, we'll be monitoring developments and implementation of this rule, including the issuance of sub-regulatory guidance, which we're expecting, as well as state experience. As we had said earlier, no specific action is required at this point from you guys, but we are happy to take any questions.

VICE CHAIR DUNCAN: Thank you, Kirstin, and again, I appreciate you pointing out some of the recommendations we made, particularly around the direct

care workforce, as well as one of my favorite topics, transparency. It was also nice to see some of the interaction between some of the work we have in our pipeline around payment adequacy coming up. So thank you for that.

With that, Commissioners, any comments? Questions?

All right. John?

COMMISSIONER McCARTHY: I was wondering. We talked about this at a meeting -- I don't know -- two meetings ago. There was some confusion at some point around the 80-20 for IDD providers, and did that apply to them or not. I know Patti and I have talked about that at some of their association meetings.

They were told it didn't apply to IDD providers, and then others have said, no, it does apply. I didn't know if you had seen anything about that, whether or not it does apply. Or, Patti, if you've heard anything about that?

MS. BLOM: I can go through my notes, but if Patti has an answer, happy to take that.

VICE CHAIR DUNCAN: All right. So, Patti, you're

up next anyway.

COMMISSIONER KILLINGSWORTH: So I'm not the expert, but I will say that from my reading of the rule, what they've done is really bifurcate by service, and so personal care services, home health services, I think homemaker services are all included, whereas anything deemed to be habilitative in nature is not included. I think the complexities of trying to implement that in a workforce that in all likelihood probably delivers some combination of those will be interesting to see. So I would say that, by and large, IDD populations have been excluded except where they're receiving a service that falls under the sort of taxonomy of personal care.

My question really kind of relates to -- or comment, I think, really relates to the monitoring piece, and it is around this 80-20 requirement, because there was so much concern about whether the policy would have the intended effect of increasing access or whether it would actually have the opposite kind of effect.

And so it's one that I think because of its just significant implications, primarily for those populations that tend to receive more that sort of falls under that

umbrella impacted by this policy, I think we should watch it closely and look for -- really trying to understand the real challenges in both implementation and compliance with the requirement.

And then most importantly, as the access Commission, right, understanding how it's really impacting access, is it really improving access for people, or is it having unintended consequences? I think as a piece of that, I'd like to see the percentage of exempted agencies and exempted workers in those agencies, you know, just so that we can sort of understand who is really meeting the requirements of the rule and who is not.

I think -- I am so glad I'm not in a state anymore to try to implement this thing, because I think it will be really, really challenging.

VICE CHAIR DUNCAN: Thanks, Patti.

Kirstin, any comments, one on John, if you went back and looked at notes, and then any feedback back for Patti?

MS. BLOM: No. Just appreciate the questions. I think that my -- we'll go back and double check on the IDD, but I think Patti has -- you know, has good instincts on

that, and appreciate the specific flags from Patti around the percent of people exempted and watching the sub-reg guidance. That will be a good -- that's a good direction for us.

VICE CHAIR DUNCAN: Thanks, Kirstin.

All right. I'll go to Mike and then Dennis.

COMMISSIONER NARDONE: Hi. Just a point of clarification on the reporting requirements related to quality. Does the CMS regulation define what the format will be for reporting on that, or is that going to be sub-regulatory guidance following the -- in the near term?

MS. BLOM: Yeah. I think that will be part of the sub-regulatory guidance, and they have -- there are some whisperings about the timeline. I think they're planning to kind of start rolling that out, you know, sort of gradually. So there will be probably lots of bites at the apple.

COMMISSIONER NARDONE: So potentially could be part of the 372 process that's currently structured?

MS. BLOM: Perhaps. I don't know.

COMMISSIONER NARDONE: Okay. Thanks.

VICE CHAIR DUNCAN: Thank you, Mike.

Dennis?

COMMISSIONER HEAPHY: Thanks. I'll build on what Patti said. I'm excited about the 80-20 change but wondering what kind of workarounds different types of providers will try to put in place, and will states individually be trying to put in place different workarounds as well, so we don't have to do the 80-20 split. So will it actually lead to real change or not real change? So the follow-up is extremely important.

And then just very quick, on slide 17, who excludes -- it was like training -- the PPE thing just bothered me, that excluding, excluding a payment of PPE. Do I understand that correctly?

MS. BLOM: I think that the idea is to exclude those types of expenses that DCWs have, so they're not part of the minimum. Does that make sense?

COMMISSIONER HEAPHY: No.

MS. BLOM: So they're trying to set a minimum and throwing as much as they can into it, but I think they're trying to leave out certain things that they feel, you know, would maybe disadvantage DCWs.

COMMISSIONER HEAPHY: Thanks.

VICE CHAIR DUNCAN: Any other comments? Questions?

[No response.]

VICE CHAIR DUNCAN: All right. Thank you very much.

We'll now go on to Managed Care Access.

* MR. PARK: Thank you. So similar to the access rule, CMS issued a final rule of managed care in May of this year. The effective date of the rule was July 9, 2024, but you'll see that states have a lot of time to comply with some of these requirements. The rule was finalized largely as proposed and addressed a broad range of regulations regarding access, payment, and quality. So we'll walk through some of the key provisions in those broad topics.

We'll also highlight areas where MACPAC made comments. A lot of the comments were based on where the rule overlapped with our recommendations on access monitoring and state-directed payments made in our June 2022 report to Congress.

We also provided some technical comments based on prior work we have done on external quality review and

quality rating systems.

So the final rule changed CMS's approach to monitoring access to care in managed care by adding several new requirements to assess the beneficiary experience and new measures of access. Because implementation dates are not consistent across all of these provisions, we've put the year in parentheses by some of these things to give you a sense of when states and plans will need to comply with these requirements.

The rule requires states to develop and conduct an annual enrollee experience survey for each managed care program and plan as part of their monitoring system. We made comments on recommending that states conduct an enrollee experience survey annually. So CMS did implement that recommendation, but they did not adopt our recommendation that the survey should be either federally designed or at least creates like a standardized survey instrument tool to allow for comparability across states.

CMS declined to establish, like, a standard survey instrument or define minimum survey characteristics to give states maximum flexibility to design the surveys as they see would best serve their programs.

The rule also establishes new national maximum appointment wait time standards for routine services for three types of services. So those are 15 days for primary care and obstetric gynecological (OB/GYN) services and 10 business days for outpatient mental health and substance use disorder services. Additionally, states must establish an appointment wait time standard for a state-selected service.

In our June 2022 report, MACPAC did discuss the value of considering measures of appointment availability but did not make recommendations on specific benchmarks. Our research had highlighted the need for data to establish baseline measures that can inform appropriate benchmarks. CMS acknowledged the importance of our recommendation but also wanted to kind of implement this immediately and indicated that data collection and implementation could occur simultaneously, and that data would be able to inform any adjustments that were needed.

The rule requires states to validate managed care plans compliance with provider appointment wait time standards and the accuracy of certain information in the plan's electronic provider directories through secret

shopper surveys. The secret shopper survey must be conducted by entities independent of the state or contracted managed care plans, and plans will be deemed compliant with wait time standards if the secret shopper surveys reflect a rate of appointment availability within the standards of at least 90 percent.

The rule also requires states to report to CMS annually and make publicly available a payment analysis comparing states' managed care plans' payment rates for certain services. These are very similar to what was required on the fee-for-service side. For primary care, OB-GYN, and outpatient mental health and substance use disorder services, plans will need to compare the plans' payment rates for certain procedure codes as a percentage of Medicare's payment rates, and for home- and community-based services, the analysis will compare the plans' rates to the state plan rates.

States will be required to report to CMS on a lot of these access requirements in a network adequacy and access assurance report, or NAAAR. This NAAAR will be submitted on three occasions, in advance of contract approval, annually, and then anytime there's a significant

change in the managed care contract.

States must submit and implement a formal remedy plan when these monitoring activities identify the need for improvement in access. The remedy plan must be designed to address the issue and improve access within 12 months, and if it does not result in improvement, CMS may require changes to the plan or continuation of the plan for at least another year.

The provision of the final rules also add a lot of additional requirements and changes to the standards for state-directed payments, or SDPs. The rule exempts SDPs that establish minimum fee schedules at 100 percent of the Medicare payment rates from prior written approval. This approach is consistent with the exemption they put into place for minimum fee schedules that were established at the state plan rates.

CMS mentioned also several provisions were intended to make SDPs more consistent with the risk-based nature of managed care. So the rule requires states to submit all documentation for each SDP for which prior approval is needed before the specified start date of the SDP.

In the proposed rule, CMS initially set this date as 90 days in advance of the ending of the rating period but changed this due to concerns that retroactive contract and rate adjustments may create more administrative burden.

The final rule requires fee schedule and rate increase SDPs to be tied to the utilization and delivery of services for the applicable rating year, effectively prohibiting SDP payment solely based on historical utilization or requiring post-payment reconciliation processes. And CMS believes that this is required because, you know, tying payments to historical utilization or using post-payment reconciliation suggests an intent to ensure payment of a specific aggregate amount to certain providers and are inconsistent with the risk-based nature of managed care.

The final rule also prohibits the use of separate payment terms, and all subsequent SDP arrangements must be included as adjustments to the basic capitation payment rates, and this is a significant change from the proposed rule which had codified the use of separate payment terms but established more requirements on them.

CMS noted they're finalizing the prohibition on

separate payment terms due to concerns that the use of these arrangements result in little to no risk for managed care plans and are often driven by the underlying financing of the non-federal share.

The final rule establishes a total payment rate limit at the average commercial rate for four types of services: inpatient hospital services, outpatient hospital, qualified practitioners at an academic medical center, and nursing facility services. CMS had previously used the ACR as an internal benchmark for all SDPs, and so the rule just effectively codifies that internal practice for those four services.

CMS declined to establish a payment rate ceiling for other services but mentioned that they would continue to use ACR as their internal benchmark for all other services as well.

MACPAC had previously raised considerations for upper payment limits on directed payments in the June 2022 report and comment letter. CMS acknowledged these concerns by us and other oversight agencies that the ACR limit could incentivize states to raise total payment rates up to ACR based on the source of non-federal share rather than, you

know, actual access or quality goals. And so to mitigate this concern, CMS is proposing additional changes related to financing of the non-federal share that we'll talk about in the next slide.

CMS adds an additional evaluation plan requirement for state-directed payments that require prior written approval. Evaluation plans must identify at least two metrics, under the quality strategy, to measure the effectiveness of the SDP and meeting those identified goals. And at least one of those metrics must be a performance-based metric.

For SDPs that exceed 1.5 percent of the total cost of the capitation payment, states are also required to submit an evaluation report using the evaluation plan outlined in the approval process. And states are required to publish that evaluation online.

These requirements address MACPAC's concerns about the lack of information that's publicly available on SDP evaluations, and our recommendation to require more rigorous evaluations on SDPs.

To address financing concerns, the final rule explicitly requires that an SDP comply with all the federal

and legal requirements for financing of the non-federal share. Additionally, states are required to collect attestations from participating providers, indicating that the providers did not participate in any hold-harmless arrangements, for like a provider tax.

Just to note, in a concurrent informational bulletin released in April, CMS announced that it will not enforce the statutory and regulatory requirements with respect to some of these impermissible, hold-harmless arrangements involving provider redistributions until January 1, 2028. And they also noted in the rule that there is an ongoing injunction in Texas, enjoining the Secretary from enforcing recent guidance about these redistribution arrangements. So the outcome of that particular case could ultimately affect these provisions, and in the preamble, CMS signaled that these financing provisions are distinct and severable from the rest of the rule.

Additionally, states are required to submit provider-lever SDP amounts to T-MSIS. CMS will specify the effective date through reporting requirement guidance. This reporting requirement also aligns with MACPAC's

recommendation that we need provider-level data on directed payment amount in a publicly available method and in a standard format.

Directed payments have been a large part of our managed care work over the past few years, and certainly these regulations will influence the work we do in the future. For example, tomorrow you'll hear about our hospital payment work and the steps we'll need to take to estimate state-directed payment amounts because they are not currently reported at the provider level. So these new requirements will certainly help future work to determine provider payment amounts, but unfortunately, we may have to wait a while for that to happen.

The rule also aligns medical loss ratio standards with those established for Medicare Advantage and private market plans. So it puts into place some more definitions around provider incentives to have clearly defined performance period metrics and specified payment amounts. It only allows expenses directly related to health care quality improvement activities to be included in MLR calculation, and it clarifies that states must report the MLRs for each managed care plan.

The rule also codifies recent guidance on in lieu of services, or ILOS. It adds a more detailed definition of ILOS into regulations. It limits spending on ILOS to 5 percent of total capitation payments. It establishes enrollee rights and protections and requires documentation under the criteria under which ILOS may be offered. And for states with a cost percentage above 1.5 percent of the capitation payments, states must conduct a retrospective evaluation.

On the quality side, the final rules add some new requirements to managed care quality strategies, external quality review or EQR, and finalizes a framework for the quality rating system. CMS will now require states to make their quality strategies available for public comment, and publicly post the results of its three-year review on the quality strategy.

On the EQR side, CMS will now require that the EQR annual technical reports include outcomes data and results from quantitative assessments of performance improvement plans, performance measures, and network adequacy, as you will hear tomorrow, as we go into a little bit more of our EQR work. These changes address findings

that we noted from stakeholders who desire a greater emphasis on performance outcomes and comparability.

CMS also added new optional EQR activities for the evaluation of quality strategies, SDPs, and ILOS. This new optional task would give states an option to get the enhanced 75 percent match when using a qualified external quality review organization to conducts its evaluations. And CMS has also removed primary care case management from the scope of mandatory EQR activities.

CMS also finalized its framework for the quality rating system. It finalized standards for a mandatory measure set with a list of criteria as to how measures may ultimately be considered for inclusion. In our comment letter, MACPAC had highlighted our findings from stakeholder interviews, who generally agreed that a uniformed set of measures was important for monitoring the performance of Medicaid programs across states. A quality rating will include data for all enrollees receiving coverage of that service for a managed care plan and be issued, at the managed care program level and plan level. States must prominently display and make accessible the QRS on its website and include certain information such as

standardized information so users can compare managed care plans and programs and also interactive features that allow users to tailor specific information based on their inputs.

And so with that we'll welcome any questions or feedback that you would like us to monitor going forward.

VICE CHAIR DUNCAN: Thank you, Chris. I appreciate that. Again, excited to hear some of the recommendations we had particularly around the annual survey, the provider data, the transparency, and as we'll talk about tomorrow, the EQR, and also payments, how will that continuation work.

I will express I am disappointed and I understand the flexibility that we need to allow the states, but I'm disappointed in the non-standardized recommendation, because it makes it more difficult as we look for data to collect when it's non-standardized, to try to decipher. But thank you for that report.

Any other comments or questions from fellow Commissioners? Heidi.

COMMISSIONER ALLEN: So overall I want to commend CMS on doing a ton of work. You know, like this has clearly been a very ambitious effort across a wide spectrum

of issues and concerns related to Medicaid, to make substantive changes. And there are a lot of stakeholders and they had a lot of feedback, and I felt like the process showed that they were really trying to strike the balance between getting it done and also doing it in a way that stakeholders felt was reasonable.

I also want to publicly lament, to get this far and to still not have the ability to understand beneficiary experience for the Medicaid program as a whole and across states. I think that is, for a vulnerable population, to not be able to compare them to outcomes for like Medicare or people with private insurance, to not be able to look at all the Section 1115 waivers and other types of waivers and understand how they impact access, affordability, quality, even just the ability to collect demographic information that the application doesn't capture, to understand health disparities.

And so I'm wondering, one thing I think would be really important is that as MACPAC developed our Access Monitoring Strategy, and we made recommendations from it, and now there's going to be these profound changes, I would like us to revisit that and think about what is missing

from that and then what we have that we didn't have before and how we can implement that into our workplan to continue to examine access. And then I'm also wondering if we can issue recommendations for sub-regulatory guidance on ways within the new rules to try to harmonize data across states. And that could be having CMS develop a question bank that states draw from, so that even if not every managed care company is asking the same questions as another managed care company in that area or any other state, you would still have clusters. If they're all drawing from the same question bank you will still be able to do comparisons.

Would it be possible to link the survey data with T-MSIS, and have it anonymous to the managed care company but to be able to aggregate it at some level so that researchers can actually use this to understand how Medicaid is serving its patients. Can it be linked to cancer SEER registries? Like are there ways that we can make this data, that every managed care organization is going to have to collect, truly give bang for the buck and understanding of the Medicaid program at large.

And so I think that there is really substantial

body of work that we could dig into here to try to make a positive impact on the access monitoring and to continue our work in developing that framework from the past.

VICE CHAIR DUNCAN: Thank you, Heidi. We have Jami, Michael, and then Dennis.

COMMISSIONER SNYDER: Bob, do you mind if I go back and ask Kirstin a question on the access rule?

VICE CHAIR DUNCAN: I don't mind at all.

COMMISSIONER SNYDER: Okay. Thank you. So Kirstin, and my apologies if you spoke to this and I missed it. But just curious, does the rule speak to, under the 80/20 provision, how much discretion states are going to have in determining whether or not providers fall into one of those three exemption categories? Or do you anticipate that in sub-regulatory guidance?

MS. BLOM: Yeah, I would anticipate that being discussed in the sub-reg guidance. I think there was some mention of that in the rule, but I don't think there was a lot of detail. I mean, I can go back and double check that, but my guess is that would be a component of the guidance that's coming out.

COMMISSIONER SNYDER: Okay. And Patti may have

mentioned this earlier, but I do think that's something we should continue to monitor how that plays out at a state level and whether there's variability that might impact what it looks like on the state-to-state basis.

VICE CHAIR DUNCAN: Thank you, Jami. Mike?

COMMISSIONER NARDONE: Chris, I was wondering on the question about payment analyses for the various service categories, OB/GYN and primary care, does the program analysis anticipate the value-based purchasing arrangements that managed care companies might be using to reimburse those providers? I just know in my home state there are several payment models related to primary care as well as maternal care, and I'm wondering if that is anticipated to be factored into that analysis.

MR. PARK: Yeah, there were certainly a lot of comments regarding potentially some of the challenges with alternative payment models, and I think CMS did indicate that all of those payments should be included, but there was not clear, specific direction within the regs about how that should be done. Maybe that's something CMS will release guidance on, how states may want to either allocate certain payments, incentives, and things like that across

particular services. But certainly that was acknowledged by a lot of commenters about the potential challenges with value-based purchasing or other alternative payment models that kind of factor into some of these analyses and comparisons.

COMMISSIONER NARDONE: And ideally, we'd be looking at what impact those payment processes have on quality of services for beneficiaries.

I have another question.

VICE CHAIR DUNCAN: Go ahead. You have the mic.

COMMISSIONER NARDONE: I have another question related to state-directed payments and the provisions related to having to have the SDPs approved before implementation. Does the reg speak to, at all, the timing on the CMS side in terms of approval? Because I know that's something that states would be concerned about in terms of how quickly CMS will be able to review those.

MR. PARK: Yeah, I can go and double check, but I'm fairly certain that CMS does not need to fully approve the preprint. The implementation date provided in the preprint, they need to submit the preprint and have the implementation date listed there, say like it's April 1,

2025, before they can actually make the state-directed payments to the plans. So I don't think it's necessarily tied to the approval date from CMS, but they just need a clearly defined period and nothing that's retroactively applied.

VICE CHAIR DUNCAN: Any other questions, Michael? Hearing none we'll go to Dennis.

COMMISSIONER HEAPHY: Thank you. First, I am also excited all these changes taking place and I want to congratulate CMS on that. But like Bob I'm disappointed about the lack of a base set of questions in surveys that states will be using, and my hope would be that after these surveys are going out that after four, five, or six years CMS will look at those surveys closely and come up with a baseline set of standard questions they do want states to use, based on what the best questions are that they're being asked.

And then I also hope that with the MACs and the BACs, that that information will feed up to CMS, and then that basically can be used to better understand what's going on across the country. So get a baseline understanding of how well states are performing and plans

are performing in different states, so it's not the states alone that are collecting information. And see which states are actually implementing meaningful MACs and meaningful BACs, and which ones are not.

VICE CHAIR DUNCAN: Thank you, Dennis. Patti.

COMMISSIONER KILLINGSWORTH: I just wanted to make a general comment on the record about my concerns that as we want to see continued transparency, and I think it's really important, and even consistency can be really important, the tradeoff that we are making is flexibility. And you really see that in these sets of regulations, especially in the managed care regulation. I think a part of the value that managed care brings to Medicaid -- and I will say especially in the long-term services and supports arena, but really the program broadly -- is some flexibilities that aren't available kind of under the typical Medicaid program.

So when we think about things like in lieu of services, which is a flexibility that I think health plans have used really well to be able to meet very unique beneficiary needs, begins to be at risk with some of the regulatory requirements that are being put into place. I

think the same is true with regard to state-directed payments.

And there's a balance, right. I completely agree there's a balance that we need to strike between transparency and flexibility. But I fear that we've maybe swung the pendulum so far that there will be unintended negative consequences.

So as a part of our monitoring I would love, as these things sort of play out, for us to go back to states and health plans and beneficiaries and really understand have they had the expected or intended positive consequences or have there, in fact, been some negative consequences, and do we maybe need to swing the pendulum back just a little bit on some of these things where we've really gone very far and being very prescriptive about how things can be done.

VICE CHAIR DUNCAN: Thank you. Jami.

COMMISSIONER SNYDER: Chris, I really appreciated your overview of some of the new expectations for states around their quality rating system, and I think the development of a measure set that states will have to report out on in terms of plan performance could be really

impactful. But I think ultimately at least a piece of the underlying intent of that provision was to ensure that beneficiaries have a tool to use, that they can go to, to look at plan performance, and that tool will allow them, ultimately, to select a plan that they feel would best meet their needs.

I think the intent is great. My concern is that ultimately -- and kind of tying back to the point that Patti just made -- my concerns is that ultimately the value of this tool will be contingent upon state efforts to educate beneficiaries about the availability of the information that they have to post on their websites.

So I think that's just something that we need to keep in mind as they move forward with the posting of their QRS kind of report cards is that it's going to be equally important that states make a proactive effort to educate members about the availability of the information that's online.

VICE CHAIR DUNCAN: Thank you, Jami.

Dennis?

COMMISSIONER HEAPHY: Thanks for making those points, because I echo what Patti said as well in terms of

rural services specifically. Is that going to harm the creativity of the plans to provide services that people need? And then the point that Jami just made as well is extremely important.

And what are states doing, states specifically, to measure or provide transparent information to members about the quality of the plans in the state with data that's not captured by CMS? I'm thinking specifically about HCBS services and other services that may not be captured in the federal service.

VICE CHAIR DUNCAN: Thank you, Dennis.

Tricia?

COMMISSIONER BROOKS: I want to piggyback on Jami's comment. I think it was ACA regs that established the beneficiary support system that's supposed to be there to help beneficiaries select managed care plans, and the QRS, the Quality Rating System, is supposed to integrate -- be integrated into that. And I'm not sure that we've taken a look at what states are doing for their beneficiary support systems and how well they're working, and that might be a new area to try to get into the work plan at some point.

VICE CHAIR DUNCAN: Thank you, Tricia.

Any other comments or questions?

[No response.]

VICE CHAIR DUNCAN: If not, we'll move to the final rule of nursing faculty or facility staffing and payment.

MS. BLOM: Great. So yes, our last rule for today.

As you guys know, this one was proposed in September of last year, finalized this year in May. It sets new federal minimum staffing requirements for nursing facilities. It also creates new reporting requirements for long-term care facilities, which also apply to nursing facilities and intermediate care facilities for people with intellectual disabilities.

MACPAC commented on this proposed rule to highlight technical considerations, as well as the Commission's nursing facility payment transparency recommendations from the March 2023 report.

The final rule adds a new minimum staffing standard over what was in the -- sorry. The final rule also adds, just to clarify, a new standard over what was in

the proposed rule for all staff, which is 3.48 hours per resident day in response to public comments that indicated a total staffing standard promotes safety and high-quality care. This standard may be met with the use of registered nurses or nurses aides. It also finalized new minimum standards for registered nurses and for nurses aides that were proposed in the NPRM.

The regulations are revised to also require a registered nurse onsite 24/7. Previously, the requirement was for eight consecutive hours.

Okay. So it also clarifies the required components of the facility assessment and how facilities must use those assessment results to inform staffing decisions and then includes several hardship exemptions from the minimum staffing requirements, taking into account workplace safety and workforce shortages, but with several changes over what was in the NPRM.

The CMS did not finalize a distance requirement that was included in the NPRM. It added a public transparency requirement for nursing facilities that receive an exemption and then also added an exemption to the registered nurse onsite requirements, which is that

they -- rather than having to have a person -- an in-person registered nurse 24/7, they could have someone available by phone 24/7.

So facilities must comply with the new facility assessment requirements, and that's a requirement for a facility-wide assessment of all nursing facilities to determine what resources they need to provide care for their residents. So that's beginning 90 days after publication of the final rule, which is an increase over 60 days, which is what was included in the NPRM.

You can see here that there's different time frames for urban versus rural facilities. So urban facilities must comply with the onsite RN requirements and the total staffing standard within two years and with the other standards within three. And then rural facilities have a slightly longer window complying with the onsite RN requirement and the total staffing standard within three years and with the other standards within five.

However, of course, the elephant in the room on this one is that this is under -- there's legal challenges underway on the nursing facility minimum staffing standards, which I'm sure everyone has heard of, and so

that could affect the timelines that have, of course, been laid out in this final rule.

So the final rule also requires states to report annually on the share of Medicaid payments to long-term care facilities that is spent on compensation for direct care workers and support staff. The payment provisions in the final rule stop short of any minimum reimbursement or payment standard for states, and these federal minimum -- and the federal minimum staffing standards don't apply to ICF-IID.

The final rule excludes some Medicaid payments from state calculations where Medicaid is not the primary payer, such as Medicaid payments for Medicare cost sharing for dually eligible beneficiaries, and states have about four years to implement these requirements.

In the final rule, CMS directly acknowledged MACPAC's 2023 recommendation that CMS require nursing facilities to report on a broader array of payment information. MACPAC suggested that CMS make nursing facility payments publicly available beyond what is spent on staffing. MACPAC also suggested that states should compare payments to all costs of care for Medicaid-covered

nursing facility residents, not just staffing costs.

However, in the final rules, CMS deferred to states on whether to make the information available and disagreed with other commenters who argued that the high-level aggregated data required in the NPRM would not yield useful information. CMS stated that the reporting requirements as finalized will provide data that may not be entirely captured in the data elements recommended by MACPAC.

So CMS did not fully implement MACPAC's recommendations for nursing facility payments, but these new institutional payment transparency reporting requirements will provide access to some of the data elements that the Commission considers necessary for evaluating nursing facility payments relative to costs.

Oh, man, I sped through that. Okay. Sorry. I guess I was talking fast.

So, with that, we are happy to take any questions. This is one, obviously, we are continuing to watch, especially because of, you know, sort of the legal challenges and what that might mean for some of the most controversial parts of this rule. You know, a little bit

tough to speak on that now with those legal challenges underway but happy to take questions more broadly.

VICE CHAIR DUNCAN: Thank you, Kirstin. And again, I do think the legal challenges will dictate which direction where we can go, but it's nice to see we're chipping away at understanding and, again, by keyword transparency of how payments are directed in nursing facilities.

MS. BLOM: Mm-hmm.

VICE CHAIR DUNCAN: Any questions or comments, fellow Commissioners?

[No response.]

VICE CHAIR DUNCAN: Seeing and hearing none -- oh, Heidi comes in at the last second.

COMMISSIONER ALLEN: I had made notes in my readings to ask about the incident management systems and changes. What is considered an incident?

MS. BLOM: So we didn't include -- I didn't include that in here because we didn't really comment on that. We were trying to stay focused on areas of our prior work. So let me see if I can quickly -- and it looks like I can't. So let me go back and get some more information

for you on that, Heidi.

VICE CHAIR DUNCAN: Thank you, Kirstin. Thank you, Heidi.

Any other questions or comments?

[No response.]

VICE CHAIR DUNCAN: Hearing none. Joanne, Kirstin, Chris, again, thank you for a thorough review of the policies and the new rules and regulations. We look to our work to continue to impact those.

MS. BLOM: Thank you.

VICE CHAIR DUNCAN: Next, we go to the overview of timely access to home- and community-based services.

Tamara.

[Pause.]

VICE CHAIR DUNCAN: Thank you, Tamara, for joining us. Okay.

TIMELY ACCESS TO HOME- AND COMMUNITY-BASED SERVICES (HCBS): USE OF PRESUMPTIVE ELIGIBILITY AND EXPEDITED FOR NON-MODIFIED ADJUSTED GROSS INCOME (MAGI) POPULATIONS

* MS. HUSON: Okay. Good morning, everyone.

So I'm here today to share with you the

preliminary findings from our stakeholder interviews on the use of presumptive eligibility and expedited eligibility for non-MAGI populations.

Okay. So I want to start with a little bit of background on the eligibility process for individuals who are seeking Medicaid HCBS as well as some definitions for presumptive and expedited eligibility.

In our stakeholder interviews, we actually found that no two interviewees defined "presumptive eligibility" and "expedited eligibility" in quite the same way. So in order to discuss these terms and states use of these flexibilities, we've developed the following definitions. And I'd like to note that our definitions align closely with those used by CMS and, where possible, statutory and regulatory language and sub-regulatory guidance.

So this slide shows at a high level the eligibility process for non-MAGI populations, which includes individuals who are determined on the basis of age and disability. And in order to be able to receive Medicaid HCBS, individuals must meet both financial and functional eligibility criteria. Financial eligibility includes both income and assets, and functional eligibility is determined

using an assessment tool. And generally, individuals must be found to require an institutional level of care.

Then once determined eligible, designated staff, such as case managers, work with the individual on a person-centered service plan, or -- abbreviated to -- PCSP. And this is a document that describes the services and supports that individuals require to meet the needs and individual preferences identified in their functional assessment. And I would like to note that beneficiaries are required to have a PCSP in place before they can receive HCBS.

For non-MAGI groups, states have up to 90 days to make an eligibility determination, and while most states take between one and two months on average, some states do take longer.

So with that in mind and in line with the Commission's focus on access to HCBS, we've been working to understand states' eligibility and enrollment processes, particularly ways in which states streamline the process to enable more timely receipt of services, and so that's why today's presentation focuses on the use of presumptive eligibility and expedited eligibility.

Okay. So to start with presumptive eligibility, this allows individuals who have not yet been determined eligible for Medicaid to receive Medicaid-covered services while completing the full application process. The presumptive eligibility period typically lasts up to 60 days, at which time the full eligibility determination must be completed for coverage to continue.

And while PE is used most often for MAGI populations, states can allow qualified entities to make the presumptive eligibility determination for both MAGI-based eligibility groups and certain other populations.

Hospitals may elect to be qualified entities and conduct presumptive eligibility determinations for Medicaid, regardless of whether the state has adopted any of the options for specific populations. And the Affordable Care Act gave states the option to expand hospital presumptive eligibility to non-MAGI populations, but only one state has done so.

And so there are really two options for states to use presumptive eligibility for non-MAGI populations. So one is what I just mentioned, using a state plan amendment to expand a hospital presumptive eligibility program to

include non-MAGI populations, and then the other option is to use a Section 1115 demonstration.

Regardless of pathway, however, providers, such as a home health care agency, furnishing HCBS during the period in which a beneficiary is deemed presumptively eligible are reimbursed by Medicaid. However, again, services during this time must be rendered after a plan of care is established.

So next, to talk about expedited eligibility, this is when an individual's Medicaid application is processed in an accelerated manner for the purposes of making that Medicaid eligibility determination, but services are not rendered until the determination has been made, and so this is a key distinction between presumptive and expedited eligibility.

And there really isn't a uniform definition of expedited eligibility. Instead, states can speed up the process within certain parameters, such as setting specific timeline requirements for Medicaid eligibility approvals.

And CMS officials that we spoke with described expedited eligibility really as the expeditious processing of an application but caveated that "expedited eligibility"

is not a term used at the federal level. They acknowledge that some states use the term, and it can be used generally to describe a number of state actions to streamline eligibility, such as accepting self-attestation of information needed to determine Medicaid eligibility.

So I want to give an example from a state that we spoke with. So one state that we interviewed described a program in which an individual's level of care assessment is completed first, followed by the financial eligibility determination. And typically in a state, both the level of care and financial eligibility determinations are made before a PCSP is developed. But in this state's program, the PCSP development begins while the financial eligibility determination is happening. So this expedites the process because with the PCSP being completed at the same time as the full Medicaid LTSS eligibility determination, the individual can then immediately begin receiving HCBS once enrolled.

So you'll remember at our April meeting, we presented the results of an environmental scan that we contracted with The Lewin Group. That scan gave us an initial understanding of state uptake of different

flexibilities and policies around the use of presumptive eligibility, expedited eligibility, as well as level of care determinations and person-centered planning processes. And so for that scan, Lewin reviewed all Section 1915(c) waivers, Sections 1915(i) and (k) state plan amendments, and 1115 demonstrations for all 50 states and D.C., as well as a variety of other publicly available documents.

And so that scan found that as of February of this year, nine states were using presumptive eligibility and six states were currently at that time or were planning to use expedited eligibility for non-MAGI populations. And I would just like to note that both the compendium and an accompanying policy in brief are available on our website as a resource.

Okay. So today we're going to talk about the findings of stakeholder interviews that we conducted over the summer to really gain a better understanding of states' use of these flexibilities.

We used the environmental scan to identify states for interviews, choosing states based on authority used, populations served, geography, and implementation stage to get a mix of states with both newer and more established

use of these flexibilities, among other factors.

And so we spoke with six states as well as four national organizations and some CMS officials. And of the six states that we spoke with, based on the definitions that I just talked through, five states are using presumptive eligibility and one state is using expedited eligibility.

Okay. So to talk about our findings from those interviews. The first is that states generally use 1115 demonstrations as the vehicle to streamline eligibility. So of the six states we spoke with, four are using Section 1115 demonstrations. One state expanded their hospital presumptive eligibility program during the public health emergency using a disaster relief SPA and has since submitted a regular SPA to make that policy permanent. And then one other state used different flexibilities provided during the PHE for one of its Section 1915(c) waivers but did not elect to make it permanent.

And so that state that did not make their program permanent, they allowed self-attestation of financial eligibility and citizenship during the PHE but decided to return to their normal process at the end of the PHE. The

state explained that they have a large number of beneficiaries enrolled in the waiver and that the standard pre-PHE process to determine eligibility for applicants ensures that resources are being used appropriately, and then they also noted some workforce considerations.

And so we heard from many interviewees that states choose 1115 demonstrations to provide presumptive eligibility primarily because the state does not have to assume financial risk for federal financial participation associated with someone who was found presumptively eligible and then later deemed ineligible.

Section 1115 demonstrations also allow states to use entities other than hospitals such as a case management agency to make the presumptive eligibility determination.

And then finally, we heard that 1115 demonstrations give states the ability to innovate, design policies to meet their specific state needs, and waive certain elements of federal Medicaid authority, thus, making this authority an attractive option for states.

We also heard a number of common characteristics from state programs. First is that states are generally using presumptive and expedited eligibility for older

adults and individuals with disabilities, with a focus on helping individuals transition from hospitals back to the community.

So four states that we spoke with currently include hospitalized individuals, and one state was exploring how to expand their population to hospitalized individuals.

Three national experts also expanded on how important it is to disrupt the hospital to nursing facility pipeline, and they were hopeful that state efforts to use these flexibilities would be effective in ensuring that individuals are able to receive care in the setting of their choice.

We also found that states using these flexibilities generally accelerate eligibility determinations by relying on self-attestation, using shortened versions of their level of care assessments, and a limited benefit package.

So in one state, for example, that accepts self-attestation for purposes of financial eligibility, they also use a shortened version of their level of care assessment, and then the applicant can receive a subset of

home- and community-based services during the PE period while their full financial and functional determinations are being completed. And that state explained to us that they chose what services by identifying the most commonly used services in their Community First Choice program, as well as their Section 1915(c) waivers, as well as looking at what services could be accessed the fastest to determine what that limited benefit package would be.

A number of interviewees also suggested that offering a limited set of services can respond to beneficiary short-term needs and prevent institutionalization.

A few interviewees expressed concern about a state's financial risk for services provided to individuals found presumptively eligible for HCBS and then later found ineligible, despite CMS policy to the contrary.

CMS and experts said that states are under no obligation to repay services provided during a period of presumptive eligibility for either Section 1115 demonstrations or hospital presumptive eligibility through a state plan amendment, and interviewees also noted that error rates are typically very low.

A few states also expressed the importance of educating providers that there is no financial recruitment for Medicaid services provided during a presumptive eligibility period.

Okay. We also found that there was not consensus among interviewees about the need for additional CMS guidance. So of the state officials we spoke with, one state strongly supported the need for guidance, while two other states did not see an additional need. The other states that we spoke with really talked about the important role of CMS technical assistance in applying for and implementing these flexibilities.

And among experts, there was kind of a general feeling that additional guidance is usually helpful for states, with one expert noting that since much of this work is done through Section 1115 demonstration authority, which relies heavily on that back-and-forth discussion with CMS and the ability for states to tailor programs to their specific needs, that what we're essentially seeing is policymaking through waiver approvals.

And then in our conversations with CMS, they did not indicate plans to issue guidance to states on how to

incorporate presumptive eligibility into their 1115 waivers, but CMS did note that there's ample guidance on the use of hospital presumptive eligibility, in particular, pointing to a set of FAQs from 2014.

We also heard a number of other considerations. So the first one is that implementing presumptive eligibility requires training providers to make these determinations for non-MAGI populations. So three states and the CMS officials we spoke with talked about how implementation requires training for making those determinations and whether it's hospitals, case management agencies, or state workers. And so this was an operational concern for states when they stand up new flexibilities.

And the states that we spoke with were mixed in terms of who conducted the eligibility determination, with about half contracting out to case management agencies and the other half using state staff.

A couple other considerations. One was about how the complexity of non-MAGI eligibility determinations does not necessarily lend itself to a speedy determination. So a number of interviewees noted that the more complex and time-consuming portion of the determination is the

financial eligibility criteria, and so to reiterate, non-MAGI populations are subject to other criteria beyond what MAGI populations must meet, such as asset tests. And those can take additional time to complete.

CMS also noted that disability determinations are complex and can be difficult to do quickly and could pose barriers for states trying to figure out how to approach presumptive eligibility for non-MAGI individuals.

And then lastly, a few interviewees noted concerns about a benefit cliff for individuals who receive services during the presumptive eligibility period but are ultimately found ineligible, and so interviewees were concerned that people might not understand they were able to receive services only to subsequently receive a denial notice and then be cut off from services. Many interviewees, however, noted that this happens very rarely, and one state actually told us about a case where one individual received services during a PE period after being discharged from a hospital, and although the individual ultimately was found ineligible, by the time the determination came through, they had recuperated enough that the loss of coverage did not pose a hardship. And so

the services provided during the PE period responded to the beneficiary's short-term needs and allowed them to return home to the community.

Okay. So, to summarize, interviewees expressed strong support for the use of presumptive eligibility for non-MAGI populations and other expedited eligibility flexibilities that can reduce the amount of time it takes for an applicant to receive HCBS.

Interviewees agreed that timely access to services is critical, particularly when an individual may be in an emergency situation, citing particular concerns around individuals discharging from hospitals as to prevent institutionalization. Experts also reiterated that these policy tools support consumer preferences to remain in the community.

Okay. So to go over our next steps, for this meeting, we're seeking Commissioner feedback specifically on the use of presumptive eligibility and expedited eligibility for non-MAGI populations.

In October, we plan to return with some information on the use of provisional plans of care as well as some additional information on the use of presumptive

and expedited eligibility.

The descriptive chapter in the March 2025 report to Congress can act as a resource for policymakers about state approaches to eligibility for HCBS. And then we also have some future work on level of care assessments and person-centered planning processes for non-MAGI groups, and we plan to return in the spring and in the next cycle with findings on those.

So, with that, I will turn it over to Commissioners for questions and comments. Thank you.

VICE CHAIR DUNCAN: Thank you, Tamara.

And I see Doug's got his hand.

COMMISSIONER BROWN: Thank you. Thank you for the presentation.

If we can go back to slide 13 for a minute, where we have CMS saying that states are not under obligation to repay services provided during the period where presumptive eligibility occurs, and then notifying -- the idea that you have to notify or make sure that providers understand that there's no financial recruitment or recoupment of the payments. And then your example where one state talks about a hospital is treated, they don't qualify. Is there

then no payment that goes back to the hospital for the service during that time?

MS. HUSON: It was really states expressing concern -- [audio drop] -- by the government, and so CMS clarified that that is not what happens. But providers are -- [audio drop].

COMMISSIONER BROWN: Okay. Thank you.

VICE CHAIR DUNCAN: Sonja?

COMMISSIONER BJORK: Thank you. What a great presentation. I appreciate it.

So presumptive eligibility sounds great, doesn't it? It's low risk. Hardly anybody makes a mistake. You said there was low errors, and it's a really good way to get people the services they need before it's too late. So you can get them in the moment instead of going on that pathway to a long-term care facility and then trying to activate all the services that could keep them in their community. But my goodness, only nine states are using it. So I'm really looking forward to us identifying how to address that particular issue.

So I know CMS said there's already FAQs. There's great information out there. But for some reason, it's

hard for the states to operationalize this. So it could be education. It could be encouragement. It could be -- you know, how do we get the message out that this is great? For one thing, the states won't be on the hook for those very low instances of errors where the person turns out not to be eligible. On the other hand, there's not one single stakeholder I can think of that will be upset if a person is able to get the services they need quickly. So it's one of those really great win-win situations, but we have to be able to help the states make it happen.

So it sounds like some of them feel mistrust about allowing hospitals or other entities to handle the eligibility, and so maybe there's some best practices that could be shared, or maybe there's a big campaign that could happen or some ways to make this easier. But I'm really excited about PE.

Expedited eligibility sounds great and all, but it sure is wide open. Like, some entities consider expedited that they got it done, you know, in a couple of weeks, and some considered expedited that they got it done before the whole 90 days. And so that one didn't seem as powerful to me, but I'm really, really interested in

presumptive eligibility and how to promote it on behalf of consumers.

Thank you.

VICE CHAIR DUNCAN: Sonja, thank you.

I'd like to acknowledge we had some technical difficulties during that time frame, and we'd lost you for about probably the wisest comments you were going to make during the session.

COMMISSIONER BJORK: Oh, probably so, yeah. Thanks, Bob. You can just fill in something that sounds really smart. Thanks.

VICE CHAIR DUNCAN: Okay.

[Laughter.]

VICE CHAIR DUNCAN: We captured the first part and got the last part, but I don't know if there's anything else during that middle, because you had a lot of good comments to make.

COMMISSIONER BJORK: Yeah, I just really -- I want us to focus on how to help states take advantage of presumptive eligibility. What are our approaches, or what can we recommend? How can we help them? Because it's such a great option and it's a win-win for everybody. Thanks.

VICE CHAIR DUNCAN: Thank you, Sonja.

All right, Tricia, then Patti, Heidi.

COMMISSIONER BROOKS: Yeah, Sonja, not to burst your bubble, there were a lot of states that were not happy with hospital presumptive eligibility because it's different than regular presumptive eligibility. You state that hospitals have the prerogative to raise their hand and say I'm going to do this, and the state has to provide the training and the process for that to happen.

And so what CMS put into either the rules or guidance -- I can't remember -- is the ability to set standards, and what states did was set standards that were discouraging for providers. So they would say, generally, the standards are X percent of the people you determine to be eligible PE, need to be determined eligible or need to apply, and then of those who apply, X number need to be determined eligible. And states were setting those at 95 percent, and it really was a barrier.

So I don't know if we've looked at those standards. I think they're in the SPAS for hospital PE, would need to be in the waiver language, I assume as well for states doing it for non-MAGI.

But that is, I think, Sonja, part of the reason why you see nine states moving in this direction.

VICE CHAIR DUNCAN: Thank you, Tricia.

Patti?

COMMISSIONER KILLINGSWORTH: So I agree with Sonja completely that this is really important, in particular, as a way to help people stay in the community and not be unnecessarily institutionalized.

As a state official who has tried to implement both presumptive and expedited eligibility in the home- and community-based services world -- now, it was decades ago, right? So some of the flexibilities are available now, like you're not on the hook for the cost if they turn out to not be eligible or not available then.

But nonetheless, I think your Slides 15 and 16 are just so critically important. It is finding the who is actually going to make those determinations. It is the complexities of non-MAGI eligibility, the need to think about things like assets, the need to think about things like disability determinations, which, oh, by the way, cause us to give state agencies 90 days to determine eligibility kind of in real life, if you will, recognizing

the complexity of those determinations. It's just so much harder.

And then there is this very real implication of a benefit cliff. You know, most of the time when hospitals are determining presumptive eligibility, it's to pay for your hospital stay, and when you go kind of home with home- and community-based services and you receive those for a period of time, and then all of a sudden, oh, you don't get them anymore, it's kind of just a really big deal for people.

And so I do think it's important that we do it, but I think states really do need a lot of help, guidance, best practice, success stories, if you will, in terms of really how to make this work for this particular population so that we would see more of it. And I do think it's needed.

[Pause.]

VICE CHAIR DUNCAN: Apologize again. We had technical difficulty here. We'll look at -- everything is being transcribed. So what the comments being made are being here in the room, we may have lost the sound for a brief moment. It is still being captured and -- [audio

drop] -- and input.

With that, we'll go to Heidi.

COMMISSIONER ALLEN: It seems like -- [audio drop] -- Tricia, for the comments about why so few states allow hospitals to do presumptive eligibility.

It used to be, like, the most critical -- [audio drop] -- be helpful -- [audio drop] -- and efforts that people have to start engaging with to -- [audio drop] -- benefits -- [audio drop] -- and those and simplify so that -- [audio drop] -- even with their providers on -- [audio drop].

The last thing I wanted, I was so intrigued by that state -- [audio drop] -- received a home- and community-based services following a hospitalization and then was determined not to be eligible, but -- [audio drop] -- services enabled the person to return home and not go into institutional care. And that is, like, very different from everything that -- [audio drop] -- who's not eligible for Medicaid -- [audio drop] -- to me wonder about the appetite for having home and community versus available through some form of -- [audio drop] -- you know, prevent a cascading series of -- [audio drop] -- public programs.

And is there any -- you know, like, would there be potentially -- [audio drop] -- medical crisis and if -- [audio drop] -- or institutionalized and then requiring Medicaid? It just -- I wanted to call that out because that is very different from the overall conversation we're having about people who mostly are Medicaid eligible.

VICE CHAIR DUNCAN: Thank you, Heidi.

Any feedback or comments?

MS. HUSON: Sure. So to your second point about kind of aligning with other federal programs and disability determinations, that really was kind of the comments we heard from CMS as far as a barrier to more states not using particularly the hospital presumptive eligibility piece.

And then your last comment about, you know, kind of that temporary Medicaid eligibility, that makes me think a little bit about one state that we talked with who -- you know, states like to kind of have flexibility, and they were very adamant that their program was temporary eligibility and not presumptive eligibility or expedited eligibility. And so this again is where states sometimes call these things by different terms, and we, for the purposes of this presentation, wanted to make it

streamlined to be able to talk about.

And so their program is a little bit what you're talking about as far as it was like a temporary eligibility. However, they still -- because it is a Medicaid program, they still wanted the person for an HCBS program. So I think I would need to think a little bit more about kind of the specifics of what you thought might work, since typically our Medicaid programs are bound by the eligibility criteria that are in place.

VICE CHAIR DUNCAN: All right. John, Dennis, then Mike.

[Audio drop.]

[Pause with no audio.]

VICE CHAIR DUNCAN: I apologize for the audio difficulties. We are going to break for lunch and pick this up again when we return. Hopefully, we can do that without the technical issues.

* [Whereupon, at 11:52 a.m., the meeting was recessed, to reconvene at 2:00 p.m., this same day.]

AFTERNOON SESSION

[2:01 p.m.]

VICE CHAIR DUNCAN: Good afternoon. I'd like to welcome everyone back. For those that are participating via Zoom, again I'd like to apologize for technical difficulties. We think we have those finished.

So what we'll be doing now is going back to finish our discussion on timely access to home- and community-based services. We'll pick up with Commissioner John McCarthy's comments, and then take it from there. I would like the participants that are on to understand that we're going to forego the public comments until the final end. So we'll be taking public comments on all sessions that we've had today at around the 2:45 p.m. mark.

So for those that may be joining this afternoon that didn't join us this morning, I'd like to welcome two new Commissioners, Mike Nardone and Doug Brown. And for those in the audience who want to learn more can go to the MACPAC website. Also again we'd like to recognize Verlon Johnson, our fellow Commissioner, is our new MACPAC Chair.

Verlon is excited to be here today. Unfortunately, there were some circumstances that prevented her from being here, and she'll be joining us in October.

So with that, Commissioner McCarthy, would you please give us your comments.

COMMISSIONER McCARTHY: Thanks, Bob. I'm under a lot of pressure here to remember exactly what I said last time. But it was something to the effect of the fact that what I would like us to look at is instead of focusing totally on presumptive eligibility for HCBS, 1915 waivers, that we really look at the fundamental problem behind it, which is why does it take so long to complete the applications in the first place, especially when you're comparing it, MAGI to non-MAGI populations.

Part of that reason we talked about was level of care determinations. Some states have figured out how to do level of care pretty quickly, especially in the examples that we've been talking about. If somebody is in the hospital already and you're trying to figure out what it is, you can do an assessment fairly quickly. They're in there for a couple of days anyway.

But the second part is how do you do the

financial eligibility. The hard part of that is the asset test, and is there something we should be focusing on to be able to do those asset tests faster, quicker, so that they get done in a timely manner, meaning they get done in two or three days. And the example I had given before is when we all go apply for a loan it's literally minutes that we can apply for a loan, and then we get that back. So is there some way, something that we should be looking at differently, of how that part is done, and what is the role of both states and federal government to expedite those processes.

VICE CHAIR DUNCAN: Thank you, and you did a really nice job of recalling what you had said. I appreciate that. And Tricia, you were weighing in on those concepts.

COMMISSIONER BROOKS: Yes. I was just going to talk about the asset verification system, which is required. And we were huddling on an aside here about this, and Jamie may have more to say. But it's the five-year lookback that might be harder than your current assets. But still, as John points out, I can apply for a mortgage. They are going to look at my credit history for

three years. They're going to look at assets for the past three years. It's all there.

So maybe it's more, better understanding. You know, some states had to be kicked a little bit to get them using the AVS, and how well is that working. Are there areas to explore where there could be improvements made to that so that we can expedite.

And I think this concept of expediting coverage should be for every population. I mean, that's why we're trying to move to electronic verification across the board. And we need to really hold states accountable for improving those systems, because they're getting a 90 percent federal match to develop them.

So I'll get off my soapbox now. Thank you.

VICE CHAIR DUNCAN: Thank you, Tricia. All right, Dennis, I believe you were in the queue next.

COMMISSIONER HEAPHY: Thanks. I was just curious. How does presumptive eligibility impact folks who go into long-term care if they lose their presumptive eligible? Do they end up being kicked out of the nursing home? Is there any data there that shows what happens to these folks at all? Do they lose their house because, you

know, in those 60 days they make a decision to go to a nursing facility and they have to forfeit their home? Do we have any data on that?

MS. HUSON: So I believe your question is specific to institutional settings, like a nursing home?

COMMISSIONER HEAPHY: Yes, and I bring that up because if folks don't really understand their options for home- and community-based services and they're moved in the direction of skilled nursing facilities because of institutional bias, how do we protect folks from going into nursing facilities rather than getting HCBS services, like in terms of them being told what their options are and explained how presumptive eligibility works.

I know there are folks who now, if I'm going to get a service, I have to sign a document saying that if MassHealth does not pay for it then I have to pay the cost of that, or DME, whatever that may be. So people are signing documents saying they are going to be financially responsible for something, if what the service, then it's not going to be covered.

MS. HUSON: So I don't think I have the best answer for you since our work was focused on HCBS. We

didn't necessarily ask about what happens if somebody goes into a nursing facility. I mean, generally speaking, individuals should be made aware of all the things you just talked about when they are applying, and the potential outcomes that could happen.

You know, if an individual goes through a PE process and is put in a nursing facility and then later found ineligible, again, we didn't ask specifically about this. You know, it would depend on their circumstance, whether they can private pay or not, maybe they're put in like a Medicaid spend-down population.

So again, I don't think I have the best answer for you, because to my knowledge we don't really have great data on that.

COMMISSIONER HEAPHY: [Audio drop] -- options are, and also, realistically, what can be provided within the 60 or 90 days, to the person receiving Medicaid services under presumptive eligibility? So let's say someone orders a wheelchair. That wheelchair is not going to get there for 120 days. They're expecting that wheelchair to get to their home, and it's not going to be covered because 60 days into it or 90 days into it they

find out they're not eligible.

MS. HUSON: Yes. So in most of the states that we spoke with they offer a limited set of services during the PE period. There was only one state that we talked with that allowed the full set of waiver services. So I think you're right that some of those types of things might not be covered during the PE period for HCBS.

You know, again, for individuals in institutional settings, like nursing homes, there is the ability to have retroactive coverage. So individuals may be able to receive more services in a nursing facility and have that retroactive Medicaid coverage. That's a possibility.

COMMISSIONER HEAPHY: Okay. I have one last question, and that is regarding all the best practices in the counseling services, make sure that people get those services. And across the different states, how variable are the services folks are provided within that presumptive time period? Can you provide us a list of here are the most common services provided to folks under the presumptive payment period?

MS. HUSON: I don't remember that off the top of my head but I could come back in October, the states that

did tell us exactly what services they offer. So I could provide you that information at our next meeting. I just don't remember everything off the top of my head.

COMMISSIONER HEAPHY: Thank you.

VICE CHAIR DUNCAN: Thank you, Tamara. We're just trying to remember what we said two hours ago.

All right. Jami.

COMMISSIONER SNYDER: Thanks so much, Tamara, for your really in-depth exploration of this issue. I think it's an incredibly important topic.

The thing I just wanted to go back to, and Tricia touched on it earlier in our conversation, are some of the operational considerations related to a presumptive eligibility program. Tricia specifically talked about making sure that the requirements that states set for participation in the PE program not be too cumbersome. I think that's really critical.

I also think -- and this is based on my experience in a couple of states -- it's really important that the state do sufficient education to make sure that providers that can participate in the program are aware of that opportunity.

And then I would say, in particular, when we're talking about PE for non-MAGI populations and extending the PE determination opportunity to entities outside of hospitals, I just think that training component is really, really critical. And I know that came up in one of your interviews, as well, but I just wanted to make sure, as we think about where we're headed in terms of making any recommendations regarding presumptive eligibility that we're taking those operational considerations into account.

VICE CHAIR DUNCAN: Thank you, Jami. Mike?

COMMISSIONER NARDONE: I was going to just say that I think John's points are well taken, and maybe some of the work that's in the compendium around expedited eligibility can help lead to some of those refinements in the process that could be implemented.

But just the thing that was really striking to me in your excellent presentation was the fact that there was confusion around whether or not the services were covered or not, were eligible for FFP under the presumptive eligibility stream.

And it did seem to me, given the desire to really kind of figure out a way to streamline the processes for

people to get into home- and community-based services that some sort of guidance around that, even just to clarify some of those basic points, could be very helpful in this process, because it is so critical to making sure that people can get into HCBS, and it seems consistent with kind of the overall goal of streamlining processes for folks who are non-MAGI to be made eligible for services.

VICE CHAIR DUNCAN: Thank you, sir. Any other questions or comments?

Seeing none, Tamara, thanks for enduring a long period of reflecting back on that.

We'll move straight now into -- you just stay at the table, and Kirstin has joined you -- and we'll move straight into our Section 1915, Home and Community-Based Services Authorities.

SECTION 1915 MEDICAID HOME- AND COMMUNITY-BASED SERVICES AUTHORITIES: REVISITING POLICY OPTIONS

* MS. HUSON: Okay. Thank you. Happy to be here again to talk about another HCBS topic.

So Kirstin and I during this session are going to revisit two of the policy options for our work on addressing administrative requirements for Section 1915

HCBS authorities, and as you will recall, we first brought these policy options to you in March.

Okay. So I want to start with just a brief background, before I turn it over to Kirstin to recap our findings and policy options.

So, as a reminder, we developed this framework for HCBS access in our June 2023 report to Congress, and there are four domains, as you can see. And this project focuses on the last domain of administrative complexity.

There are four Section 1915 authorities that states can use to deliver HCBS Sections 1915(c), (i), (j), and (k). And there are additional authorities that states may use, such as Section 1115 demonstrations, but our work for this project focuses just on these four 1915 authorities.

The policy options that we're discussing today target Sections 1915(c) and (i). So I want to spend just a minute on those two.

So first, Section 1915(c) is a waiver authority that allows states to offer a broad array of HCBS to individuals who meet an institutional level of care, which is the typical standard for Medicaid coverage of HCBS.

It's the most widely used authority, with over 250 waivers operated in 47 states.

And then Section 1915(i) allows states to offer HCBS to people who need less than an institutional level of care. Individuals must be eligible for Medicaid under the state plan with income levels up to 150 percent of the federal poverty level, and states can also establish other specific criteria for people to receive services through 1915(i). And there are 17 states that use Section 1915(i).

States consider a number of factors when selecting which HCBS authorities they will operate, including design flexibilities allowed under each authority and the ability to waive various Medicaid requirements found in Section 1902. And this includes statewideness, comparability of services, and community income rules, and definitions for each of these are provided on the slide.

Okay. So, as you recall, we contracted with Mathematica to better understand the administrative requirements for each Section 1915 authority. We presented the findings from that contracted work back in November. And again, just to recap, Mathematica reviewed the requirements for each Section 1915 authority and grouped

them into the five categories that are on this slide. They developed a background report for us comparing the five categories of requirements by authority, and this included a review of federal statute, regulations, sub-regulatory guidance, and other CMS resources. Mathematica then conducted 17 interviews with state and federal officials as well as policy experts.

Following our November meeting, we conducted additional interviews with CMS and some other policy experts to dive deeper into the three specific areas of technical guides, renewal requirements, and cost neutrality to better understand the implications of potential policy changes around each of those areas, and we presented that work back in March.

In order to be responsive to the feedback that we received in March, we've conducted additional outreach, such as to state associations, to further understand the implications of the proposed policy options.

So we're returning today with two of those policy options, and I'm going to turn it over to Kirstin now to walk you through the evidence and the options.

MS. BLOM: Great. Thanks, Tamara.

So just a quick recap before we move into these findings. So Tamara mentioned our June 2023 chapter, which was a review, or an initial review, of barriers to access in HCBS, and that effort led us to kind of focus in on administrative complexities, when in the interviews we were doing we're hearing a lot about that issue both in terms of complexity in the authorities, complexity from state to state, just it kept coming up.

So that is why we then started down the path -- and Tamara flagged that in the framework -- of focusing in on that particular topic.

And when we talked to you in March, we were bringing back three policy options, three ideas related to streamlining, making things more straightforward for beneficiaries, sort of in that contract with Mathematica. That's what we had sort of set out to do.

So those three options were a technical guide, they were an extension of the renewal period for 1915(i) and 1915(c), because those are the two authorities, as Tamara mentioned, that we're focused on, the two that are subject to renewal, and then a third option around cost neutrality and the complexity of that effort.

So when we talked with you guys in March, we kind of decided that the first -- you guys decided -- that the first option was maybe not -- there just wasn't really a lot there. There's other technical guides that are sort of comparable to the one that we would have asked for, for 1915(i), and it felt like we were at a point where we were going to table that. And so then that option is not really part of our conversation today. And the other two -- but the other two are still. So the renewal one is back as well as the cost neutrality one.

But what we've done since we talked to you last is we've done some -- a little bit of sort of additional conversations with experts. We've talked to a couple of associations, things like that, to try to flesh that out a little bit. So some of what we're going to go through in these findings is a little bit repetitive but just wanting to kind of set that up that we've -- this has been sort of a long path starting with the chapter in 2023.

So we're focusing in, first of all, on the application/approval renewal process to get at sort of the complexity within that, that is then tied to the option around extending the renewal, and then we'll move to cost

neutrality.

So, of course, with everything in Medicaid, there's differences that exist between these two authorities that we're focusing on today. We are, like I said, focusing on (i) and (c) because they are the ones subject to renewals.

In our work, Section 1915(c) waivers have the most complex and time-intensive requirements. States on average spend around 160 hours completing an application, for example. As part of that application, there is a demonstration of cost neutrality, which occurs in Appendix J. There's an effort through that piece of the application to demonstrate that institutional spending is more expensive than HCBS.

As part of that application and then as part of renewals that occur later, CMS can ask questions at any time around -- whenever a state's annual reporting shows a difference from what was included in the application -- this is just an example of, you know, some of the complexities. So states do spend a lot of back-and-forth is what we heard with CMS explaining, you know, changes, even perhaps that are not related to cost neutrality.

And we have this table, which we showed you last time, but just for you to see, you know, sort of the differences in the amount of time that is spent and the amount of pages, et cetera, related to these applications.

Okay. So we also reviewed the approval and renewal process requirements under both authorities. So Section 1915(c) waivers have an initial approval period, as you guys know, of three or five years, and then they can be renewed every five years. And Section 1915(i) is approved indefinitely unless the state is restricting eligibility to specific populations, in which case it also must be renewed every five years.

So in our interviews, we heard kind of across the board that renewals are really important for oversight, for evaluation of program performance, and they also provide an opportunity for the public to have input on the entire waiver.

But, of course, these processes are labor intensive, both for federal officials, state officials, as well as experts talked to us about the -- sort of the use of resources, the expenditure of resources on these processes that could, you know, be spent elsewhere,

including things like, you know, focusing more on quality or more on the experience of care for beneficiaries.

States tell us that this process can involve kind of months of back-and-forth with CMS, which is burdensome and also creates uncertainty around when they will get approval from the agency.

Some states told us that the questions they receive, you know, even during that process from CMS sort of across the multiple waivers they might be operating, can be pretty duplicative. Really just, you know, we heard repeatedly around the -- sort of the time burden here.

So given that we kept hearing that, that kind of led us in the direction of, you know, changing the renewal requirements, primarily increasing the renewal period as a way of reducing burden. We heard support for this. Again, you know, federal officials really focused in on how the renewals are important. So, you know, to the extent that eliminating renewal periods came up, there was some pushback on that.

But where we kind of landed in terms of what we were hearing from interviewees was increasing the renewal period above five years but not beyond ten years. So

that's what you'll see when we get to the policy options section.

Okay. And then quickly on cost neutrality. So again, you know, we did talk about this in March, but I -- we wanted -- obviously, that was a long time ago for all of us. So wanted to kind of do a quick recap.

So Section 1915(c) is unique; that is the only waiver authority for which states must demonstrate cost neutrality, which means that average per-person costs for waiver services cannot be -- it cannot exceed the average cost in institutional services that an individual would have otherwise received if they weren't getting HCBS.

So states demonstrate cost neutrality using the 372 reports, and this occurs for each waiver they administer.

The people that we talked with generally agreed that states don't have difficulty meeting the cost neutrality requirement. They pointed to the fact that institutional costs are generally higher than HCBS waiver services. But we heard mixed feedback from interviewees around the question of getting rid of cost neutrality.

CMS talked with us about how the data can be

useful in demonstrating that HCBS results in lower spending relative to institutional care, and others indicated that eliminating it could actually perhaps increase spending to the extent that some states were choosing to spend -- or would choose to spend more if they were no longer required to spend below that ceiling.

Some interviewees, on the other hand, expressed support for eliminating it, citing that the original purpose of the test was no longer relevant insofar as it related to concerns about like a woodwork effect leading to big potential increases in spending as well as using this as a way of managing state spending.

There was a perception that at the time that this was enacted, there was a lack of data about HCBS relative -- - HCBS costs relative to institutional care.

Some experts also noted that there was a tension between cost neutrality and the Olmstead Act. We heard that in one state, a new waiver had to be put in place for a beneficiary with high HCBS costs because the waivers available in the state at the time would have exceeded the cost neutrality limit if that beneficiary had enrolled in them.

To get a better sense of where states were falling in the cost neutrality threshold relative to it, we did an analysis of the 372 data for Section 1915(c) waiver spending as a share of institutional spending.

So after the cleaning the data that we had to do, we were able to analyze 169 waivers in 37 states plus D.C., and we analyzed them over a three-year period from 2019 to 2021. We found that almost all waivers, really all waivers except for one, met the cost neutrality requirements. One waiver in 2021 did not meet the test.

This table shows you the waiver costs relative to institutional costs, and if you focus on the last row in the table, you can see that in each year, 60 percent or more of waivers had estimated annual average per capita spending that was 50 percent less than the estimated average annual per capita for institutional care. So in the second column, for example, for 2019 it was 60 percent, 2020 it was 63, and 63 as well in 2021.

So this analysis demonstrates that states were generally meeting the requirement in that study period and often had waiver spending that was significantly lower than institutional spending.

Okay. So moving to our policy options. So the first option is about the renewal period. So this option would increase the renewal period beyond five years, as we talked about, but we did make one change. So after our conversation with Commissioners at the March meeting, we heard a preference for specifying the increase, so specifying ten years. So we changed the policy option to tie this to make it go from five years to ten years. Ten years aligns with some of what we heard from interviews. It aligns with several or a few prior Section 1115 demonstrations under the Trump administration that were approved for ten years, and it ties into the standard ten-year budget window that the Congressional Budget process relies on for their budget projections and cost estimating.

We also talked with the Congressional Budget Office about this policy option as we typically do with policy options like this, and they indicated that while this option could decrease state administrative burden, they were not able to estimate changes in direct spending without additional data around sort of what the changes, how the changes would be implemented and what the regulatory changes might look like.

And then our second policy option is about cost neutrality. So under this option, the cost neutrality test would be removed, but states would continue collecting data on waiver costs and utilization.

In addition, following our discussion in March, staff heard Commissioner concerns about wanting a credible source for states to use to demonstrate HCBS cost effectiveness relative to institutional care. So we added a requirement here that the Secretary publish an annual report that states could use for that purpose. So states could rely on that. They'd still have a sort of a document from the federal government that would indicate that this -- that there is a threshold -- that the HCBS costs are lower than institutional spending.

I want to make clear too that, like, we are maintaining the reporting requirements for states. What we're not keeping is the Appendix J portion where they would have to demonstrate cost neutrality, so just to be very clear about that.

Okay. And then the only other thing on this slide is the consultation with the Congressional Budget Office. So in speaking with them, they estimated that this

option would increase federal spending by about a billion over a ten-year period, because some states who are near the top of the cost neutrality ceiling, they, in their estimation, would likely increase spending if that threshold was removed.

Okay. And then just a couple more items to recap on here in terms of our findings that I think I actually went over, but the cost neutrality requirement and our -- there was general agreement around the cost neutrality requirement and support -- sorry -- around the idea that states are meeting that requirement, and the 372 analysis supported that. But we did definitely hear mixed responses about, you know, sort of eliminating it or not. So it was not -- it was not, I would say, a slam dunk in terms of the interviews that we did.

So I'll stop there. I'm happy to sort of hear from you guys about next steps. We do have a few questions here, and I want to, before we get to those questions, point out, you don't have to move these forward as a package. So each of these is independent of the other, fine to, you know, decide you want to advance one of them or both of them or none of them. We are able to

accommodate any of those options. If you do choose to advance one of them, the plan would be to return at a future meeting with recommendation language that we would then vote on, and then our goal is to put the findings from this work into a chapter in our March 2025 report.

So I wanted to stop with these questions, just kind of leave this up here for your discussion. But basically, what we could use from you is whether there are any outstanding questions about these options that we could answer, and then if you guys, you know, in your assessment, do you think the evidence that we've shared supports either or both of these options moving to a vote during a future meeting?

VICE CHAIR DUNCAN: Thank you, Kirstin.

All right. The hands are up. So let's go. Patti, you're up first, then Jami, Heidi, and Tricia.

COMMISSIONER KILLINGSWORTH: I would like to start with just a clarifying question, which I think can help frame a little bit of my comments.

So I think I heard you say that the recommendation is to keep the annual 372 reporting requirements, but only eliminate the Appendix J cost

neutrality demonstration? Is that correct?

MS. BLOM: Yes, that's right.

COMMISSIONER KILLINGSWORTH: Okay, super helpful. So thank you both so much for this work. Clearly a complicated topic, but really important in terms of thinking about state capacity to manage these programs.

I will say that I would love to see recommendations on Policy Option 1 and would support extending that renewal period.

By the way, the only time you actually do a full Appendix J is at the application and renewal period. So you don't actually do those annually. You just do those.

So in that, I guess, light, if we extended the renewal period to every ten years instead of five, you'd only be doing that full cost neutrality projection, if you will, every ten years, then, instead of every five.

I will say having spent decades filling out these waiver applications and completing these annual reports, the vast majority of those 160 hours is really spent on the programmatic information that's in the waiver application. I don't want to minimize that it is -- it does take work to actually project the cost of expenditures in a home- and

community-based services program, but the work is not really in projecting the institutional costs. That's really coming directly out of your MMIS system. You're looking at what you're currently spending on average.

I would bet you that any state in the country could tell you what they're spending on institutional costs on average, but it's a fairly simple calculation. The real challenge is in sort of thinking forward, how many people do I think will use the service, and how many units of the service do I think they'll use, and what is the average cost per unit of that service so that you can sort of project, which is important from a state budget perspective, whether or not you are comparing it, then, to the cost of institutional care.

So I'm not sure that it changes a whole lot for states in terms of really needing to think through and understand what their financial obligations are expected to be under a new program or a continued HCBS program.

I think one of the things that was mentioned is that only 1915(c) waivers have a cost neutrality component. That's true, but all waivers have some sort of a cost demonstration, whether it's cost effectiveness for 1915(b)s

or cost neutrality for 1115s. There's always just kind of this expectation that we are looking at what the cost of services would be absent that kind of waiver authority being utilized, and I don't think we should be surprised that states are meeting what is a federal requirement, right? So it's a requirement to have a waiver. It's a requirement to keep the waiver. I'm not surprised to see that most states meet it.

I think part of my concern is that the scope of the recommendation seems to go beyond the scope of our policy goal, which is to reduce administrative burden and not to change the federal requirement. So I think we could look more in a more targeted way at reducing the administrative burden associated with cost neutrality without eliminating the requirement or expectation that home- and community-based services are at least as cost effective as care in an institution.

If the 372 reporting is continuing, really the only thing that's going to sort of change the administrative burden would be extending the waiver renewal period, since that's the only time that the Appendix J is actually completed.

The other thing I'll say is from a state perspective, again, having run these programs for decades, is that that cost neutrality component can actually be really important for states. It can be really important in terms of working with state legislatures to help them understand and feel good about funding these programs, because they know there's a federal requirement for them to be at least as cost effective as institutional care. And I think they do worry about the woodwork effect and beyond.

And I also think it becomes important for states in terms of being able, in some cases, to defend themselves, whether that's in litigation or in other kinds of programmatic questions. I think having some federal law to stand on in terms of managing the cost of these programs is really, really important.

So I would not be able to support any sort of a recommendation to do away with cost neutrality requirements but would like to see us maybe get -- work a little bit more in detail on how we could really reduce the administrative burden associated with it.

VICE CHAIR DUNCAN: Thank you, Patti. Jami?

COMMISSIONER SNYDER: Thanks so much, Kirstin and

Tamara, for this important work. I'll start by saying that I fully support the policy recommendation around extending the renewal period to 10 years, and being definitive about that 10-year renewal period, based on some of the information that you provided.

I'm still a little bit on the fence in terms of the recommendation around cost neutrality, and my question is very much related to some of the information that Patti just presented. Having worked in a state where our program sat underneath an 1115 waiver, I'm not as familiar with the administrative burden associated with the cost neutrality calculation versus the administrative burden associated with the 372 report.

Were you able to gather any insight into that during your interview process or just your research?

MS. BLOM: I mean, we definitely heard from states that this was a burden, involved a lot of back-and-forth with CMS. We kind of focused in on the Appendix J of the application because of its direct tie to the cost neutrality demonstration. But it came up a lot in our conversations, so that's sort of where we're coming from. Tamara, I don't know if you have anything to add.

MS. HUSON: Maybe just to add a little bit of context around that. I think that's right. I think there were a couple of states who maybe shared similar experiences to Patti, where they didn't find the annual reporting for cost neutrality overly burdensome. They had kind of gotten the hang of it once they figured out how to do it. So I think, as with many things, it was kind of a mix.

COMMISSIONER SNYDER: Yeah. I think in that case, you know, I sort of agree with Patti that maybe we need to think a little bit more about sort of the objective of this exercise, which is really around relieving states of some of the administrative burden, and if the recommendation, as stated, gets us there, I guess. And again, it's a little bit of unknown to me, just because I haven't worked in a 1915(c) space. But I think that's an important thing to be thinking about as we move forward.

VICE CHAIR DUNCAN: Thanks, Patti. We've got Heidi, Tricia, Mike, Doug, and Dennis.

COMMISSIONER ALLEN: Thank you. This has been a really interesting topic, and I feel like I learn so much from my fellow Commissioners. A very quick clarification

question. Is cost neutrality always only applied at the aggregate level and not at the individual level, and is it applied at the individual level too?

MS. HUSON: It can be either.

COMMISSIONER ALLEN: So I guess my question would be, actually, I would send to Patti, because Patti, I've learned so much from you over the last year on this issue. And one of the things you frequently talk about is institutional bias, the institutional bias of sending people to institutions rather than using home- and community-based services. And it feels to me like benchmarking home- and community-based services to institutional care will always reinforce that institutional bias. And that you're saying it's okay for institutional care to cost more, but it's never okay for home- and community-based services to cost more.

And yet, you know, when I ask people what I should do with my 91-year-old grandmother, who is not doing well, you know, is starting to need more support, people tell me, well, if you move her to a nursing home she'll probably just die really quickly. And I'm like, well, that's awful, like that's really scary. And then I

remember during the pandemic that institutions were among the most dangerous places for people to be.

And so I think do we want to continue to support this bias of home- and community-based services to never cost more than institutional care, when institutional care may not be the best for health outcomes.

VICE CHAIR DUNCAN: Thank you, Heidi. Tricia.

COMMISSIONER BROOKS: I think my comments follow both Jami and Heidi. I'm having trouble reconciling that home- and community-based services are about 50 percent of the cost of institutional care, and yet OMB says it's going to cost $1 billion. And so does that get to what Patti was saying, that more people will take advantage, and that's why OMB got there.

So let me let you comment on that, and then I have a follow-up.

MS. BLOM: Well, CBO --

COMMISSIONER BROOKS: Yeah, CBO. Sorry.

MS. BLOM: Yeah, so it's a range. That is not really a point estimate. But I think they're trying to think about a 10-year window. They're trying to think about multiple states, and they're trying to think about

states not feeling the constraint of the threshold. So I don't know if we could say a lot more about the math there.

MS. HUSON: Yeah, I can't comment on the math. Maybe just to add a quick point, though. You know, kind of getting back to Heidi's comment, institutional settings are paying for room and board, whereas home- and community-based services are not, so that is a large part of the differential in the spending. And then again going back to CBO's score, that this could increase costs, again I can't speak directly to the math involved. But I do just want to reiterate that there are other cost containment tools that states have outside of the cost neutrality test. So, of course, states have to work within their own state budgets, and then specifically in the waivers, states can set enrollment caps, they can set individual budget caps. So there are other ways for states to ensure that costs are contained.

COMMISSIONER BROOKS: Well, I think that brings me to where I originally was with Jami, sort of on the fence. But when I think about, even if we're bringing more people in, because they're saying, "I am not going in a nursing home," but they need a level of care, we're

contributing to population health in a better way, a more efficient way, and eliminating that institutional bias, which is so stubborn to get rid of. I don't know. When we take a vote, I'll let you know where I land.

VICE CHAIR DUNCAN: Thanks, Tricia. Michael.

COMMISSIONER NARDONE: I was going to say, I'm supportive of the proposal around extending the time frame around the renewals. I'm still struggling a little bit with the cost neutrality recommendation. If the goal is to streamline the administrative processes, I'm not sure how this recommendation really accomplishes that, because you're still reporting on the 372s. It sounds like the time-consuming nature of this is the back-and-forth between CMS around whether or not the numbers, the projections are off from where the numbers that they're reporting on an annual basis are off from the projections of two or three years ago, or whenever the initial period was.

So I think you're still going to have that back-and-forth because you're reporting. And I assume that although maybe you could clarify this a little bit for me, that if the Secretary has to do a report, an annual report, he's going to have to get some information from states.

Now maybe that's just all coming from the 372s, but I could also see that potentially putting more burden on states, where we're helping produce that report.

But I guess the thing is, so I'm not sure that it gets to kind of, at least what I thought was one of the key components of what we were trying to accomplish, which was streamlining the process for states. I kind of agree with -- I agree with Patti on all things. No. I agree with Patti around maybe there's an opportunity at looking at the 372 process in terms of how that can be made more streamlined for states. And, you know, it does seem, we heard earlier about the presentation on the HCBS rules, where we'll be looking at quality metrics and kind of making the move to more of a focus on those quality metrics as the measure of how well states are doing. I mean, I think that provides potentially an opportunity, because I would think that the reporting of the 372 would have to feed into that, although the guidance isn't really available. We're still waiting for guidance.

But I think it is a natural to kind of look at that process, to also look at ways to maybe streamline this requirement so that it works better for states. Because my

recollection of when I was reviewing 372s in my prior role was that so much of the effort around 372s was also around the quality indicators, less so the cost neutrality piece of the 372.

So perhaps that's the way to go with kind of marrying Patti's comments as well as trying to reduce the burden on states.

VICE CHAIR DUNCAN: Thank you, sir. Doug, and Dennis, Patti, and then John.

COMMISSIONER BROWN: Thank you both for your presentation. Excellent job.

Relative to the extension from 5 to potentially 10 years for the renewals, my question is are there policy or program changes that would be delayed because of extending the renewal period? And I guess the former Medicaid directors, thinking about those renewals in 5 years. If you have 10 years to do it, do you just keep the program kind of the same and not make those major changes until the renewal period, and does that delay somehow impact patient care or improvements to the program or process improvements?

MS. HUSON: I can answer that. States can submit

amendments at any time, so they would be able to change essentially anything in their waiver at any time during that 10-year period. We heard from many states that during the current 5-year period there is almost always at least one amendment to the waiver. And depending on what that change is, many times an amendment will also include a public comment period and will kind of include some of the other requirements that are part of the process.

So for instance, public input was something that we heard as a potential consideration for extending the renewal. But again, any amendment can kickstart that process, and then you have states also talked about other avenues they have to get beneficiary and advocacy input into their programs, as well.

COMMISSIONER BROWN: Okay. Thank you.

VICE CHAIR DUNCAN: Thank you. Dennis?

COMMISSIONER HEAPHY: Dennis. Thank you. I think cost neutrality really goes against the spirit of the ADA and also Olmstead. And as other folks have said, we saw from COVID that the last place you should be during a time of pandemic is in a nursing facility. When we look at quality of service in nursing facilities around the

country, I think we have to demonstrate that their value is worth the cost.

And I think, just shifting the conversation a little bit, I'd like to look at cost neutrality from the perspective of what states are spending considerably less than the cost neutrality cap on home- and community-based services. How much are states appropriating at a fixed annual budget for their state, for the Medicaid expenditures, which do not provide adequate funding to fill all of the approved waiver slots.

And then are states hesitant to authorize coverage amounts that would bring the average per capital spending of home- and community-based services up to the maximum amount because they are concerned that, under cost neutrality, because they're afraid that folks in the community will start using more health services and utilization services will increase.

And so I think really just looking at this from what are states doing now that are far below the cost neutral requirements, and so reframe it a little bit and say is it necessary, since states have really implemented, and someone else mentioned implementing these efforts to

reduce costs, and is that valid or is that going against really what states should be doing, which is investing more in home- and community-based services up against the institutional bias.

So I think really taking the deeper dive and looking hard into what states are doing that are denying folks access to home- and community-based services is something that would be really helpful if you could do that.

MS. BLOM: We can definitely think about that. We didn't really dig into which states were doing what that were under that threshold.

VICE CHAIR DUNCAN: Thank you, Dennis. Patti.

COMMISSIONER KILLINGSWORTH: I'll make this really quick because I've already sort of had my turn. So just kind of thinking about institutional bias and really what that means. Institutional bias is really about policy that favors institutional care over home- and community-based services. So institutional care being a mandatory Medicaid service and HCBS being an optional benefit, freedom of choice default to care in an institution rather than to care in the community, paying for room and board,

using Medicaid dollars in an institution but not allowing any kind of room and board assistance to people living in the community, even if they're living below the federal poverty level.

Eligibility processes, which have typically strongly favored people who are seeking institutional care I think will be mitigated some by allowing projected HCBS costs to now be included, going forward. But there has been this sort of long-standing institutional bias in eligibility policy.

And so just to be really clear, I don't think that cost neutrality constitutes a bias in the regulation at all. I think if anything it levels the playing field in terms of the amount of funding that can be spent to provide services, regardless of which setting that you want to receive them in. So if you want to receive services in the community, all it says is your field is level, right. You can get up to the cost of institutional care, depending on how that state structures its programs.

I think for me, at least, one of the things that it really helped me do as a state official was to manage the appropriations that we had in ways that would allow me

to make home- and community-based services available to more of the people who needed them, so that there weren't these really long waiting lists in my state of people who didn't have access to any benefits. And I would hate to see that sort of mechanism go away that was really important in helping us do that.

The other thing I'll just say really quickly is Mike was absolutely correct that the primary burden of 372 reports is in the quality-related components. If you've done those reports before, what you know is that the data gets spit out of your MMIS. You design a report; the MMIS generates that report on an annual basis. Now, you have to validate it and make sure that it's correct. But it's coming. It's claims-based information that is coming directly out of your Medicaid management information. It's not that you're trying to cobble together all of these numbers sort of on your own.

So that really is sort of the primary source of burden is not the numbers themselves, which I would argue are important for states to know anyway. Thank you.

VICE CHAIR DUNCAN: Thanks, Patti. John?

COMMISSIONER McCARTHY: So as many of the people

who have worked with me know, lots of times when I come up with ideas it's to be somewhat provocative, to come up with people generating other ideas and thinking of some. And so as a person who has said maybe we should look at getting rid of budget neutrality, I feel like I need to speak to this.

And I want to go back to the point that -- I was going to make this point and Patti just, of course, jumped in right before me and made the point right before me. The whole purpose of what we were trying to do when we originally started talking about this, way back when, was how do we reduce the burden on states. And we were throwing out different ideas. You went and looked at some things. I agree with some of the comments that were said, is even if we go from 5 years to 10 years, how much of a burden reduction is it?

The real issue we're running into, and what Patti was saying, institutional bias, is that for nursing homes you don't have to do a 372 report. There's nothing like that. There's nothing that goes along with that. So maybe -- this would be the opposite of it, more burden on states -- maybe we should do 372 reports for nursing homes. Like

is that the direction we need to go to get people to start thinking of things in a different direction.

Or if we were talking about saving money, keep cost neutrality but to save money, should our recommendation be stop paying for room and board in institutional settings? That would level the playing field too. And I want to bring that up, as it's a huge piece that Patti brought up because of this issue that we keep running into with HCBS services, in places where housing markets and facilities are super expensive, people are only using their Social Security income that they get to pay for their rent. So that is a burden that happens in there. So those are the biases that we're talking about that are built in.

So coming full circle to where I started, I know I was the one who said hey, maybe we should look at dropping budget neutrality; after talking about it and everyone looking at it probably would not vote to drop it. But I do think that we should continue to look at these things and come up with other recommendations around -- I know we have a couple here -- but what is it? How could we really reduce the burden on states, if that's what we

really want to do, or is it going in some other direction? So a continual thought process on these and thinking through some of these things.

It is really, really hard to say drop quality reports. I mean, you can't do that. But you can't. There's a lot of good stuff in there, probably some stuff that, I agree with you, Mike, maybe that's the direction we go as we look at the 372s, and is that something that needs to be reformed or changed or something different done in there, and that would be a better direction to go.

VICE CHAIR DUNCAN: Thanks for always being provocative, John. Let's go to Tricia.

COMMISSIONER BROOKS: And I'll be quick too because I already had my turn. I don't recall that this conversation was solely about eliminating administrative burden for states. And I always want us to be reminded to look at it from the lens of the beneficiary, and if people are served better in their communities, we need to do whatever we can to make sure that we can get them there.

VICE CHAIR DUNCAN: Thank you, Tricia. Jami.

COMMISSIONER SNYDER: Yeah, and sort of tagging onto that, you know, again, I'm still on the fence in terms

of whether the proposal would effectively reduce administrative burden for states. But in the words of a former CMCS administrator who will remain nameless, I think it is incumbent upon us to continue to have a conversation around whether this cost neutrality test is meaningful -- that's the word that our former administrator used in talking about budget neutrality. And I would argue that we have 43 years, right, of data now, using this cost neutrality test, and it really has demonstrated that the vast majority of states, in fact, are easily meeting the expectations around cost neutrality.

So while I think we probably have to give some more thought to whether the proposal addresses the issue of administrative burden, I wouldn't want us to lose sight of the discussion around the cost neutrality test, more generally, and whether it's truly meaningful.

VICE CHAIR DUNCAN: Thank you, Jami. Dennis?

COMMISSIONER HEAPHY: Just following up on what John was saying, it does seem somewhat untenable that we're looking at cost neutrality alone, without looking at quality and the impact on people's lives. So is the investment of dollars into long-term nursing facilities

equal to the investment of dollars into home- and community-based services. So if you're not looking at the quality of those services, you're really not comparing apples to apples.

And also just using average cost, that doesn't seem like an adequate way to capture the total cost of services.

VICE CHAIR DUNCAN: Thank you, Dennis. Jenny.

COMMISSIONER GERSTORFF: So I am surprised by the upper bound on the CBO score, the $1 billion. But to help with the context on that, do we know what annual spending is for 1915(c) waiver services?

MS. HUSON: CMS contracts with Mathematica to put out yearly reports, so there is data out there. I don't know it off the top of my head, but there is data out there.

COMMISSIONER KILLINGSWORTH: I want to say it's around 160, but I wouldn't swear to that. But I think it's in the neighborhood. That may be high. I know that the total was over $200 billion across institutional and HCBS. I need to go back and look at the breakdown on that. Maybe it's 116 and I've got my numbers a little mixed up. But

it's substantial.

VICE CHAIR DUNCAN: Okay, Heidi, you get the last question. We have to move to public comment and then our panel.

COMMISSIONER ALLEN: Okay. Well, my question was just trying to understand what Patti was saying about Medicaid directors using it as a tool to manage wait lists and be inclusive of populations so that more people have eligibility. I assume that we're speaking to the ability to hold people to institutional care at the individual level, meaning that if you keep out high spenders then, therefore, you can serve more people on that limited budget.

And I just wanted to make sure if that was the case, would it be possible to maintain -- I'm just thinking like in eliminating cost neutrality could you -- I don't know. I'm just trying to think of the policy benefits and side effects of keeping cost neutrality at the program level but eliminating it at the individual level, or keeping it at the individual level but eliminating it at the aggregate level. Because it seems like if it's used in order to be able to serve more people then it makes sense

that you wouldn't want to lose -- like you wouldn't want one or two people taking all the money and then leaving a bunch of people out.

But at the same time there may be cases where for a person it makes a lot of sense for them to be able to be at home, and they might require a lot of services, but putting them in an institution would be really terrible for them. And I don't know how this intersects with children or what populations, but it seems like there are some populations that it might be a lot more expensive to have them at home, but it's still the right thing to do.

So I guess I'm just trying to understand that, and maybe the next time we come together if you guys have anything that you could help me think through that issue, that would be helpful.

VICE CHAIR DUNCAN: Thank you, Heidi, and I want to again thank Tamara and Kirstin on the work. I think you heard unanimous support for Policy 1, the 10 years, and a lot of questions and comments on the second option. So we look forward to coming back with that.

So now with that, we'll open for public comment. We invite the audience to raise your hand if you'd like to

offer comment. Please introduce yourself, the organization you represent, and we ask that you keep your comments to three minutes or less. Anyone in the audience with a comment?

PUBLIC COMMENT

* [No response.]

VICE CHAIR DUNCAN: Going once, twice, sold. Appreciate that.

We'll now prepare for our panel. We have Brian and Drew joining us. Brian, I believe this is your first time to be part of us up here.

UNDERSTANDING THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) MODEL

* MR. GERBER: All right. Well, good afternoon, commissioners. Welcome to our premiere session on the Program of All-Inclusive Care for the Elderly, or PACE model.

Today I'll be walking through some background on the PACE program, including some facts and figures around eligibility, enrollment, and service delivery, before passing it over to Brian to discuss the model's financing structure, evaluations of PACE, as well as some recent

trends in legislative interest in the program. We'll end with some next steps describing what the Commission can expect from our ongoing work examining PACE as well as solicit some suggestions from Commissioners on particular areas of focus to target in our upcoming interviews. We're going to try and breeze through this initial presentation pretty quickly to get to your questions, and then, of course, to our moderated panel later this afternoon.

So to start with some background, PACE is a home- and community-based care model that serves frail adults aged 55 and older. Those enrolled in PACE must have a nursing facility level of care need but can live safely in the community. Unlike other integrated care options for dually eligible individuals, PACE is provider-led.

The model first originated in California in 1971 with the On Lok Senior Health Services program. CMS supported this model as a demonstration program in the '80s before Congress permanently authorized PACE in 1997.

Notably, PACE is a Medicare program as well as a Medicaid state plan option, and provisions defining the model sit in both Medicare's Title 18 and Medicaid's Title 19.

Relative to some of the other integrated options that we've discussed before the Commission, PACE is small. As of August 2024, more than 63,000 Medicare beneficiaries were enrolled across 179 programs in 33 states and the District of Columbia. The actual number of individuals enrolled in PACE is actually a bit higher when counting Medicaid-only beneficiaries, but data on that is a bit less readily available.

The majority of PACE enrollees are dually eligible for both programs, and the National PACE Association estimates that about 84 percent of enrollees are dual eligibles.

I touched on some of the eligibility criteria on the previous slide, such as the nursing facility level of care need. However, states and PACE organizations may include additional eligibility criteria. However, at this point, the extent to which this flexibility is used is unclear.

To talk about enrollment, once a beneficiary elects to enroll in PACE, enrollment is effective the following month, and it continues until death, regardless of changes in the beneficiary's health while enrolled.

Those enrolled may voluntarily disenroll at any time. For example, selecting to receive fee-for-service waiver services outside of PACE would count as voluntary disenrollment. They may also be involuntarily disenrolled for a few reasons, such as if they no longer meet the state nursing facility level of care need requirement.

States must evaluate enrollees annually for that requirement, though there may be a few select situations where states are able to waive or deem individuals eligible without assessment.

Finally, on service delivery, PACE enrollees are served by an interdisciplinary team, or an IDT, that develops care plans and then provides the care. Federal statute mandates that 11 different provider types are included on this team at a minimum. More may be included. The IDT also may include a mix of directly employed providers as well as providers that the PACE organization contracts with.

PACE organizations are required to operate what's known as a PACE center, from which the IDT provides most services, but whether an enrollee actually attends the center and how often is subject to the care plan that is

individually tailored for each enrollee.

PACE organizations may also provide services in the home or alternative community settings, and the National PACE Association estimates that 95 percent of PACE enrollees live in the home.

The characteristics of PACE organizations themselves vary, and we have some details on that, I believe, in the materials we provided, but many are part of a larger health care system, such as a hospital network or federally qualified health center.

Currently, the largest PACE organization is a for-profit company, following CMS changes in 2019 that allowed for-profit organizations to operate the model.

We included a list of common services included through PACE in your materials, but some examples are adult daycare, dentistry, meals, primary care, of course, and transportation, among others.

However, in fact, PACE programs must provide any items and services that the IDT deems necessary for enrollees' care plan, with few exceptions, and the services are not subject to the typical benefit limitations, conditions, cost sharing, et cetera, that apply for other

Medicare and Medicaid benefit packages.

So now that I've gone through some of that basic background of how the model functions, I'll pass it over to Brian to understand better how the model is paid for.

MR. O'GARA: All right. Let's see how fast we can get through this.

All right. Rate setting. So PACE organizations receive a blend of monthly capitated payments from different programs, depending on which programs the beneficiary is eligible for, but these are usually capitated payments from Medicare Parts A, B, and D, and state Medicaid agencies, and in very rare cases, the participant will also pay premiums for some of the services.

Medicare and Medicaid capitation rates are structured differently under PACE than other models of managed care and have some of their own unique requirements, and they're listed here. The rates from Medicaid must account for the frailty of PACE enrollees compared to the general Medicare or Medicaid population.

The rate must be a fixed amount. It doesn't fluctuate with changes in the participant's health status.

States can renew and renegotiate Medicaid rates annually, but within that year, they cannot change the rates month to month.

The Medicaid rate must represent full reimbursement, meaning that providers can't charge participants who are eligible for Medicaid any deductibles, copayments, coinsurance, or other cost-sharing schemes, and the rate that states pay to PACE must be less than the amount that would have otherwise been paid, or -- I'm going to pioneer and call this the AWOP. I don't know if that's real, but these rates must be less than what would have been paid if the participant was not enrolled in the PACE model.

Some more details on Medicaid rates. I think I'm changing my pages early. States base the capitation amount for each Medicaid participant on a blend of the cost of nursing home care and institutional care for a similar population in a similar service area, and this is to account for the frailty of the PACE population that's required under Medicaid regulations.

State Medicaid rates, unlike other managed care entities, do not have to be actuarially sound to be

approved, but they are subject to an upper payment limit, which is the amount that would have otherwise been paid. So those two acronyms are used interchangeably, and I apologize for the confusion.

Most states do calculate their upper payment limits first and then set the PACE capitation rates as a fixed percentage of that limit, so for example, 95 percent of the upper payment limit or the cost that would have otherwise been paid. And states can create multiple rate cells based on the participant's age, gender, geographic region, or other factors to better target the capitation rates. However, unlike some other state payments to Medicaid managed care organizations, PACE capitation rates can't utilize separate institutional and community-based rate cells.

And so I just included these screenshots from the Kansas State website just to demonstrate how states may use a combination of these elements to develop their Medicaid PACE capitation rates. So, as you can see, these are three separate PACE providers in Kansas, and since they serve different areas, they have slightly different rates to begin with.

All of the state Medicaid rates are set at 90 percent of that amount that would have otherwise been paid. That's the percentage that Kansas was going with here, and you can see the three separate rate cells that Kansas elected to utilize for their PACE: dually eligible individuals ages 74 and below, dually eligible individuals ages 75 and above, and then the non-dually eligible population enrolled in the model.

And so some quick information on total Medicaid spending on PACE. So over the past two decades, spending has grown substantially as both the federal and state governments have moved to rebalance LTSS spending. At 2003, it was just under $44 million, and this past year, or fiscal year 2023, it was almost $4 billion.

The majority of that spending, 56 percent last -- sorry -- in fiscal year 2023, came from the federal share of Medicaid costs. That was about $2.2 billion. Five percent, or about $180 million, came from federal relief associated with the COVID-19 pandemic, public health emergency. And then the remaining 40 percent, or about $1.5 billion, came from state Medicaid spending in the 32 states and the District of Columbia that operated PACE

during this time.

So state Medicaid spending specifically. So state Medicaid rates can vary widely, because these rates are specific to local factors such as health care costs, living costs, and most states do not provide publicly available information on their capitation rates or how they develop those rates.

One recent analysis from the Urban Institute of seven states with publicly available data over the past few years found that rates ranged from a low of about $2,700 for a full benefit dually eligible beneficiary in Oklahoma to a high of just over $8,000 per member per month for a full benefit dually eligible beneficiary in California. And so that shows the wide range that states can utilize when creating their Medicaid capitations.

And even the data that is publicly available from these limited states remains difficult to compare simply because, again, the rates are very specific to time and place, as well as local policies, budgetary constraints, and negotiated agreements between state Medicaid agencies and PACE providers.

So now we'll quickly run through some of the

model evaluations that have been conducted on the PACE program. So there is a small but hearty body of literature on the health and financial outcomes associated with this model. The research largely supports claims that PACE does help improve health outcomes for beneficiaries and preserve independence, but it is less clear about the impact of the PACE program on state Medicaid expenditures.

So generally, PACE participants do experience lower mortality rates; reduced nursing facility use, hospitalizations; and potentially avoidable hospitalizations when compared to similar populations.

And one recent study from HHS found that despite being the oldest, having the greatest number of comorbidities, and having the highest mortality rates on average, PACE enrollees were less likely to be hospitalized, less likely to visit the emergency department, and less likely to use institutional care than comparable enrollees in FIDE SNPs, D-SNPs, and non-integrated MA plans.

One limitation that should be noted with this research on health outcomes is that in many of the studies, comparable populations or control groups include people who

would not normally be eligible for PACE, such as 1915(I) waiver enrollees who don't have to meet state nursing facility level of care criteria or recent nursing home entrants who, of course, were not deemed to be able to remain safely in the community.

There are mixed results on PACE's impact on Medicaid spending. Despite the design requirement that state Medicaid capitation rates have to be less than what would have otherwise been paid, it's not clear if this design requirement yields savings to state Medicaid programs.

Oklahoma, for example, has found savings with one of their programs. Wyoming estimated savings from cutting their only state program, and the literature on this also reveals mixed results.

Studies recognize that estimating the cost impacts of PACE largely depend on the assumptions made about alternative placements, and the body of research really is in agreement that if you assume a PACE participant would otherwise enroll in an HCBS waiver, PACE does not save the state Medicaid program money. If you assume that the PACE participant were to otherwise enroll

in a nursing facility or institutional care, then PACE may save the state Medicaid program money.

It's also important to note that existing studies on financial impact all utilize data, claims and administrative data from before the introduction of T-MSIS.

All right. Wow. We got there. So next steps for this work. So we're just beginning the work, and this is going to be kind of a foundational level-setting resource on the PACE model.

Our research so far has revealed significant gaps in publicly available data on the model. Despite being a permanent model for over 25 years, significant questions do remain about how it operates and whether it meets the goals that were originally laid out by Congress and CMS.

So our next steps on this work, we are working with the Center for Health Care Strategies to schedule interviews in five states with Medicaid officials, PACE providers, and consumer advocates, as well as CMS officials and other national stakeholders. These interviews hopefully will enhance our understanding of the model, identify successes and challenges related to the model's objective of providing comprehensive community-based

integrated care, and will hopefully help us better understand elements of the model for which publicly available data is lacking, such as Medicaid capitation rate setting, data reporting requirements, state-specific evaluations, et cetera. And we hope to present findings from these interviews at a future Commission meeting.

So what we need from all of you today, what we would love to hear from all of you, is what questions you have about the PACE model's policy and regulatory framework or any questions about the model in general and what areas you would also like us to highlight and bring out in our upcoming stakeholder interviews.

VICE CHAIR DUNCAN: Thank you very much, Brian and Drew.

Comments? Okay. First, I've got Tim.

COMMISSIONER HILL: Thank you. This is a great presentation.

I'm not going to articulate this well, but sort of my experience, both in Medicare and Medicaid, thinking about PACE and its approach, it's as much community-based as it is clinically or policy-based, right? All of our analysis is around spending and enrollment and eligibility,

but so much of what I've seen that makes a site successful is kind of the people that are there and the community that it creates and sort of how the beneficiaries feel in that setting. And so finding a way to get that beneficiary input and user experience that is different in a PACE relative to -- certainly relative to a nursing home and certainly relative to an HCBS setting, it's just a different -- the model is so different in terms of how the beneficiary experiences it. And I feel like we have no good way of measuring that, right? And I think it's important to have some sort of measurement of the beneficiary experience and kind of what it felt like to be in PACE versus another setting.

VICE CHAIR DUNCAN: Thank you.

Adrienne?

COMMISSIONER McFADDEN: I would agree with Tim's comments, and actually, the basis of my comments are sort of along the lines of the experience of the beneficiaries who are enrolled in PACE by my limited me-search of the limited knowledge that I have of folks who are enrolled in PACE programs.

But is there any idea why there's been such a

depressed amount of growth in the number of beneficiaries who are enrolled in PACE programs? It looks like the spending has gone up quite a bit over the last 20 years, but it doesn't sound like there's a large number of beneficiaries who are taking advantage of it. So I just would be curious as to what's contributing to that.

MR. O'GARA: Sure, I can start. I think one of the key reasons is that the model is designed to be, you know, a very intimate, close relationship, community-based model of care, and so I think scalability is just an inherent issue with that model design.

I also know that from past work, it can be very expensive to launch PACE programs and to staff up and to build a center before receiving approval from CMS and from the state.

Yeah, I'm going to stop there.

MR. GERBER: I would just add from our other work on integrated care, seeing the competition between traditional MA plans, D-SNPs, other integrated options, there's a large different number of models fighting over this group of people. So it's something we can explore, whether it's in this work or future work, but understanding

how beneficiaries are learning about these options and how they're making their choices, that could be something for future work.

VICE CHAIR DUNCAN: Thank you. Jenny, then Patti, John, and Doug.

COMMISSIONER GERSTOFF: I don't know how prevalent this model might be in a rural setting, given it's focused around a center, but if there are programs that are rural versus urban, understanding the outcomes of those differences would be interesting to me.

MR. O'GARA: Yeah, we'll certainly be looking into that.

I know North Dakota had a hub-and-spoke PACE model, and there has been a lot of research and thinking about how this applies. I know -- I'm forgetting the name, but the Commission that advises HHS on rural health came out with a report on PACE recently, and they had some thoughts about it too.

MR. GERBER: And I would just add that's a great question for our panel in a couple of minutes.

VICE CHAIR DUNCAN: Thank you, Jenny.

Patti?

COMMISSIONER KILLINGSWORTH: Thank you both. Glad to see this topic come into the forefront.

I will say this is probably the gold standard when we just think about integrated care. It's really the only model where you bring together all of the Medicaid payments and all of the Medicare payments and really, truly invest authority in a single entity to administer those benefits without having to carve them back out again into Medicare and Medicaid.

And my experience in visiting PACE sites has been that they're highly interdisciplinary, very coordinated, and that people tend to be very satisfied.

All of that said, so here's the struggle with PACE, and many of the things are things that you pointed out, right? It's just this lack of data and transparency around both the rate setting and also how the funding is then in turn spent.

For many years, there was no encounter data at all for PACE. I believe there are now encounter requirements for PACE, but they only include things that are purchased outside of sort of the PACE entity itself. And we really have very little insight into what people are

actually receiving through that contracted PACE entity.

So there's a lack of understanding about the dollars and what people are actually getting for those dollars which, as your presentation highlighted, can be a lot. The capitation payments are based on a blend of nursing home and home- and community-based services, and yet very few people in the PACE program receive nursing facility services. So there's probably a favorable rate-setting process when you take the cost of institutional care into account.

As we continue sort of our theme of transparency, I would like to see much more financial accountability in the rate-setting process and in terms of how the dollars are spent and some consistency to that rate-setting process.

And then I would also like us to look at and try to understand why the PACE program is exempt from so many other requirements that apply to other home- and community-based programs, exempt from the HCBS settings rule, exempt from I think many other requirements of the HCBS access rule, so just really understanding sort of why this one little program gets so much special flexibility, if you

will, and how that in turn then affects the people who are served by that program.

VICE CHAIR DUNCAN: Thanks, Patti.

All right, John, Doug, and then Dennis.

COMMISSIONER McCARTHY: See, there are times that it's helpful that Patti goes before you. She says a lot of the stuff you're going to say.

A couple of things on PACE that have brought up, and I agree with everything that Patti said. And I think one of the issues that I always had with PACE was some of the things that Patti was just saying about nursing homes, and that when I was Medicaid director, when we went in to investigate our PACE programs, because we had two in Ohio when it first started, what we found was them disenrolling people who had moved to nursing homes after a few months, not immediately, and so that was one of those issues of, like, where you're getting high rates, including nursing home services. That's one.

The second thing is I would like to see, now that we actually have better data to do comparisons on -- so, Brian and Drew, if you could go and look at the states that have PACE programs and have duals programs. So, you know,

California had those. Ohio had those. There's a number of states, right? And then if you could compare those capitation rates between the PACE program and the duals programs, because now we have them.

Like, we have, in both those programs, capitation rates that would be for similar services, and then that way, I think we would get a better idea then when it comes to costs of what -- how to compare programs, because it was back to what somebody said earlier is it is often difficult with PACE to compare costs. So we should be able to do that now. So I would ask if we could look at that going forward.

VICE CHAIR DUNCAN: Thank you, John.

Doug?

COMMISSIONER BROWN: John asked my question, but I just want to say, is there another way we can look at PMPM for the HCBS populations that we also have and compare that, just so we can see what the PMPM is on that also? Thanks.

VICE CHAIR DUNCAN: Thank you, Doug.

Dennis?

COMMISSIONER HEAPHY: I think the magic sauce for

the PACE program is they provide a lot of in-home care, and they reduce isolation and loneliness, which we know are killers. And so from my understanding, that's, of course, they're very -- the cultural affinity is really important in the development of PACE programs, and so really looking at it from a different, through a different lens, I think it's important.

Everything you said about financial transparency, I agree 100 percent. I'm also wondering -- concerned about the expansion of PACE programs to folks who are younger than 65 -- I mean younger than 55, and that's because the under-65 or under-55 population is very different from folks over 65. And we look at what the PACE programs actually provide to the beneficiaries, both to the members. What does transportation mean? Is it transportation solely to the center? You've been involved in the center, and solely medical transportation to and from medical appointments outside the center. So what does transportation actually mean as opposed to in a D-SNP? And I'm glad you raised it with the ideological programs, and so what is the comparison, particularly from -- now we need to expand and look at folks under 55 and say what types of

services are different than being provided to folks in D-SNPs that may not be provided by PACE programs, given the model of care? You know, it's going to draw people -- my understanding of PACE programs, it's really to keep folks healthy in their homes as opposed to D-SNPs. So for folks under 65 is to really support people's ability to live in the community, and that there's two very different ways of looking at provision of care.

VICE CHAIR DUNCAN: Thank you, Dennis.

In respect for the time of our panelists, Mike and Heidi, after our panelists, we'll come back to you for your questions or comments on the subject, but we're honored to have three distinguished panelists join us. And, Drew, I'll let you introduce them.

MR. GERBER: I'll actually pass it to Brian.

MR. O'GARA: Thank you. Are they here yet? Do we know?

VICE CHAIR DUNCAN: They're all here.

MR. O'GARA: Are they here? Okay, great. I can't see anyone. Hello, everyone.

Well, yes, I would love to welcome our three panelists for today's conversation on PACE and thank them

for taking time out of their busy schedules to be with us.

So today joining us, we have Kayla King, Sabrena Lea, and Cindy Proper, and I'll just do some brief introductions for them.

So Kayla King serves as the PACE and Senior Care Operations Program Manager at the MassHealth Office of Long-Term Services and Supports, and she works closely with the Commonwealth of Massachusetts' eight PACE programs with a focus on expanding PACE access and streamlining the enrollment process for eligible constituents.

Sabrena Lee serves as the Deputy Director for Long-Term Services and Supports in the North Carolina Department of Health and Human Services. She serves as the Senior Medicaid Administrator for the state's LTSS programs and associated contracts, totaling approximately $5 billion.

And finally, we have Cindy Proper, who is currently the PACE Technical Director with the Division of Health Homes, PACE, and Coordination of Benefits/Third-Party Liability in the Medicaid Benefits and Health Programs Group at CMS. And she has been with CMS since July 2010 and prior to that has more than 25 years of

experience in the Commonwealth of Pennsylvania's Department of Human Services, where she also worked on PACE.

So thank you all for joining us.

We're going to begin with a question for Kayla and Sabrena for the state perspective. So, Kayla and Sabrena, could you just both provide a brief overview to the Commission of what PACE looks like in your state and what you see as the value of PACE and how PACE fits into your state's long-term care strategies?

Kayla, we can start with you. So that way, there's no --

* MS. KING: Okay. No problem. Hi, everybody. I'm Kayla King.

So in Massachusetts, the PACE program, it sits in the Office of Long-Term Services and Support. This department, we manage several different programs, but PACE specifically is managed by the Integrated Care Team, which is a team that I'm a part of.

So on the team, we have three programs that have the similar goal of keeping enrollees in the community for as long as possible. So these three programs -- we have PACE One Care, which is a MMP demo for disabled individuals

ages 21 to 64. That's going to be transitioning into a D-SNP in 2026. SCO, where I'm also the program manager of Senior Care Options, which is currently a D-SNP for elders age 65 and up.

And so right now as a state, what we're trying to do is kind of align these three plans, especially from a policy standpoint, as much as possible in order to benefit enrollees across a wide spectrum of ages and level of care.

So PACE is our smallest program in Massachusetts. They have about 5,400 participants right now. 5,100 of those are dually eligible members, and about 300 of them are Medicaid only.

We have eight nonprofit PACE programs located throughout our state, and I'd say a lot of them, they're pretty unique. I'd say some of them are more out west in the state, which you could consider some of the areas there are more rural, and then some just in the city. We do allow for there to be overlapping territories for our plans.

And currently, which I'm sure we'll talk about a little bit more, we had allowed our plans to do expansion, zip code expansion. So in 2022, our PACE firms, they had

the opportunity to do that. So we were able to offer PACE to more people in the state.

And so to answer the question of how PACE is currently satisfying our goals for the long term, we definitely, as a department, like trying to keep people in the community for as long as possible. That is the goal, and we've been able to really work closely with our PACE programs on that and so whether it's just being as creative as possible as we can and really letting our PACE programs kind of drive the boat, so to speak, in terms of like the care that they think that these members need in order to help them to satisfy that goal. I would say we have a very, like, health collaborative relationship from that standpoint.

And I will turn it over to Sabrena.

* MS. LEA: Good afternoon, everyone, and thank you for the opportunity to contribute to this very, very important discussion.

North Carolina operates its PACE programs within our Medicaid Division of Health Services as a part of our LTSS service array that includes state plan, personal care services, as well as 1915(c) waivers, which serve about

11,000 individuals. In addition to our CAP waivers, we also offer for adults limited private duty nursing.

North Carolina administers 11 PACE contracts, delivering care in 12 locations. North Carolina has been a PACE state for 16 years, with our first PACE organization opening in 2008 in Wilmington, North Carolina.

We operate our PACE programs currently as an optional state plan service. Our PACE is available in 38 of our 100 counties, and we are currently working to expand our PACE over the next 24 months to encompass 49 of our 100 counties by the end of 2027. We will accomplish our current expansion using new PACE sites as well as deploying alternative care settings, primarily in rural areas. And while the 38 percent represents our geographic distribution, because we have PACE available in our metropolitan areas or our most populous areas of the state, we believe that our demographic utilization is somewhere around 50 percent.

The state has -- well, our method for expansion is through RFA. Our RFAs are open only to existing PACE organizations, and to date, all of our PACE organizations operate as not-for-profits.

PACE growth is accomplished through flexible monthly slot allocations to ensure budget predictability for us. To date, we have about 3,000 beneficiaries, which represents a 38 percent increase since fiscal year 2022, and our spend for 2023 was $114.4 million, which in addition to being a rate increase for our PACE programs, the first in ten years, represented a 47 percent increase compared to 2022.

PACE is obviously a model for delivering managed care, and as most of you are very, very likely aware, North Carolina launched our Medicaid managed care in 2021 using our 1115 waiver authority.

So to respond to the question about how does PACE fit into our state's infrastructure, interestingly, individuals who were required to enroll in our 2011 1115 managed care waiver expansion, of that group excluded from enrollment in that PACE health plan managed care program were individuals who are dually eligible, individuals who are participants in our 1915(c) waivers, and individuals who were long-stay in skilled nursing facilities.

So PACE in North Carolina, 90 percent, probably closer to 95 percent of our PACE enrollees are dually

eligible. Obviously, 100 percent of them need nursing home facility level of care. So PACE provides important data to us about how to deliver managed care to this tiny population.

At this time, it is really unclear as to how PACE will roll out in our service array, as we are beginning to discuss expansion of our 1115 waiver managed care to incorporate individuals who are dually eligible.

One of the things that we are doing at this time is that when individuals who are enrolled in standard plan managed care, because of our requirement that individuals who exceed a 90-day stay in nursing facilities must disenroll, one of the things that we are doing is looking to make a referral to PACE to determine whether or not that individual can be supported ideally in transitioning out of the skilled nursing facility to receive PACE services or if, in fact they are able to be served by PACE through a different structure.

Typically, we are finding minimal success, dependent upon the reason that the individual is enrolled in PACE, but that is one of the initiatives that we are doing to look at that.

We're also looking at how PACE might be utilized for -- or PACE or PACE-like models might be utilized to serve non-traditional populations who need that institutional level of care designation but have the resources to remain in the community-based service.

MR. GERBER: All right. Thank you, Sabrena. We do need to move on to the next question, I think.

MR. O'GARA: Thank you for all that lovely insight for our Commissioners.

So turning now to Cindy, Cindy, could you tell the Commissioners how PACE fits in with CMS's goals to integrate care for dually eligible individuals?

* MS. PROPER: Sure. Yeah. And it's interesting when you talk about how PACE fits in with our, you know, other models, because as kind of was mentioned, PACE was developed well before our current focus on integrating care or value-based purchasing or alternative payment models. And as you heard in the PACE overview before the discussion, you can trace its history back to the 1970s through the demonstration and ultimately when it became a permanent program.

So PACE was the first integrated and managed care

model that we used that focused on individuals who need nursing home level of care, and while it doesn't serve the quantity of individuals that was mentioned that we serve today in other programs, waiver programs, or state long-term care managed care programs, CMS still considers it a valuable delivery model. And it's an important vehicle for states, we think, in working toward that greater balance of community-based versus institutional care.

It's especially a good option for individuals who need and want that high level of day-to-day interaction that PACE provides, because there is a lot that happens with the PACE participant and the team as opposed to some of the other models. So it's not right for everyone, but for the people who need it, it can be a great model.

And while we do have other programs today that serve our dual eligibles, compared to PACE, one could argue that -- and I think this was kind of touched on one of the questions after the presentation -- was that no other CMS program or model kind of offers a more holistic person-centered approach to care, permits coverage of a broader range of non-traditional and non-medical services, or provides a greater degree of upside and downside financial

risk on the part of the organization that's operating the program.

In fact, aspects of the PACE model were often used to inform development of some of our other CMS models and tests, including the dual demonstrations.

One challenge I will note is that since PACE is truly integrated through Medicare and Medicaid, PACE doesn't always seem to fit perfectly into other buckets. As it was mentioned earlier, it's a provider and a plan, because most of the care is provided directly by the PACE staff. So it's not officially managed care. So it doesn't fit within those requirements and processes. It isn't a waiver program. It has what most would consider an adult day center, but even at the state level, it's more than that and doesn't often perfectly align with some of the adult day requirements that states have.

And even from my state days, PACE is kind of its own animal. So it never seemed to fit really nicely into any existing organizational structure that existed at the state or federal level, and so PACE can be resource-intensive at the state and federal level based on the number of people that are enrolled, which is, I think,

primarily due to the population that it serves as well as the provider-based nature of the program.

But still, PACE has a lot of supporters at CMS and on the Hill because of the great outcomes that you had talked about earlier and that it can provide and the feel-good nature of the program.

And I'll add that hands-on, that day-to-day touch that PACE provides did seem to be very successful during the pandemic. We had some really good outcomes for PACE participants during the pandemic because of that kind of day-to-day touch that PACE offers.

MR. GERBER: Thank you.

I think, actually, for our next round of questions, we'll stick with you, Cindy, because some of the synergy with the question. Can you describe some of the challenges that come from the unique three-way contract between CMS, states, and providers? And you did touch on a bit how the program or the model differs from other examples of managed care that we have, but maybe you can talk a bit more about how it differs in terms of managed care-type requirements that PACE may or may not be subject to.

MS. PROPER: Yeah, so obviously PACE is unique in that there is a three-way contract between the PACE provider at the state and CMS. So I would say that CMS is kind of much more involved in the day-to-day operations, kind of the policy oversight of PACE, as compared to some of the other models or even other authorities that serve this population.

The three-way partnership between the three parties is sometimes complicated by what I talked about earlier, the involvement of various components within CMS. Since PACE is a Medicare and Medicaid program there are a lot of different payers, even within CMS. Medicare PACE staff reside in the area that works on Medicare Advantage. They have primary oversight of the application and overall policy of PACE. There are Part D staff involved because PACE is required to be a Part D plan since they provide the all-inclusive package of services. There is another team that works on audits of PACE organizations and another working on if there's any enforcement activities.

The Office of Program Operations and Local Engagement, or OPAL, they're located around the country, and previously known as our regional offices, so they have

account management functions that work directly at the local level with states and PACE organizations through kind of regular communications.

And then the Duals Office, or the Medicare and Medicaid Coordination Office, is also involved in PACE discussions, while they don't have any specific regulatory work on PACE.

I sit on the Medicaid side, so there are certain things our team is solely responsible for, such as the oversight of the PACE Medicaid rate setting, the PACE state plan amendments, and we also work closely with our Medicare colleagues on application reviews, policy discussions, and enforcement actions.

So as a result of the all-inclusiveness, it touches so many different areas. And while I think we do a pretty good job of coordinating across our various silos, there are challenges associated with communications and staying on the same page sometimes.

And I guess I would say another challenge I see with PACE, more from a state perspective, would be because PACE is a Medicare and Medicaid program, and as you had mentioned has its own statute, very specific regulatory

requirements, it's very prescriptive, and there is a little opportunity for variation in how states or organizations could design the program. You know, there are clear parameters on who is eligible to enroll. States really don't have flexibility outside of that. The all-inclusive nature and full risk nature of the program. We have some managed care programs that carve out certain services so that organizations aren't at risk for those. States don't have that flexibility with PACE. And other requirements such as the PACE Center.

I would say many managed care programs are developed by the states, and they do have flexibility there. But with PACE they don't.

But that, I guess, just to the question about the three-way agreement, I will say it does, I feel like, result in a much closer collaborative relationship between the three parties than in some of our other models where regular communications with states and PACE organizations, especially when issues come up.

And from my days at the state Medicaid agency I really valued that collaboration and that hand-in-hand work through the application, the approval, implementation of

PACE, as well as the operational and audit enforcement process.

MR. GERBER: Thank you. And then turning to our state partners, and I think beginning with you, Sabrena, if that's okay, what would you identify as some of the primary barriers that you see for states and for providers in terms of establishing and operating a PACE site?

MS. LEA: Well, Cindy did a wonderful job saying many of the things that I would share, so I'll reflect on what she said related to the three-way agreement. That while it is a positive thing, it is somewhat complicated because you have to integrate and communicate with so many people in terms of doing the monitoring. And it is cumbersome for us as a state, and it is also cumbersome for the PACE organizations themselves.

The other barrier that I will talk about is the fact that PACE evolved as a community-based organization, and the rollout timeline for PACE is very, very immense and again, cumbersome. And as we are looking to stand up and roll out statewide health plans, the evolution of PACE is a much slower process, much more expensive process. And critically important is to fill the significant equity

partnerships at the local level that will help PACE do the same over that rollout process, because many PACE organizations, in their first two years, operate at a loss, and that then becomes risk for those individuals who are enrolled in PACE organizations.

Another barrier, as you mentioned, although it's a barrier and it's a benefit, is that PACE organizations operate as we stated, Cindy, as both payer and provider, and that makes the burden of administration much heavier, and enforcement often much heavier.

I have to say this is talking about barriers. I want to talk about a positive, and that positive is the benefit of PACE organizations for their beneficiaries and to the family caregivers that support them. And I'm not sure that we often quantify the benefits that PACE aligns to support families who are desperate to support individuals to live in the communities and their families. So I know we're talking about barriers, but we don't often state that there is an important benefit.

And I'll hand off to my colleagues.

MS. KING: So just to go off that, I would say that some other barriers that we have experienced with PACE

would definitely have to be around enrollment and eligibility. It does take at least, in Massachusetts, it does take a long time for when somebody raises their hand to say that they would like to be in a PACE program and when they can start receiving services. When we kind of looked at it, it was taking anywhere from three to six months for someone, and this may be if this person, they did want to be on Medicaid and go into PACE. If they were already on MassHealth, which is our Medicaid product, they would have to reenroll in MassHealth, and then apply for PACE.

So there were some practices that we realized that were kind of adding to this, and it was very, I'll echo the words "long" and "cumbersome" of having somebody enroll in PACE. So that has been something that we are really trying to navigate, to help get that number down. And even looking into some areas of where we may just let somebody be a part of PACE and on the back end be looking at their eligibility and then their enrollment, kind of more of like an auditing process from that.

And then second challenge, I'd say, is infrastructure. I would say a lot of our PACE plans,

they're not the same. They don't operate the same. So they may be very, very great on the clinical side but maybe on the reporting side, where we really want to start getting them to think about submitting encounters and different types of reports and things that we need from them, not all of them have the infrastructure that maybe some of our D-SNPs that we work with, that they have. And realize it's been a lot more hand-holding that we would have to give them in order to be able to get what we need, and a lot more just like education, working really closely with CMS in order for that to happen.

So those are the two areas that right off the bat, when I think of challenges, that we have kind of been evaluating and trying to help our programs get through.

MR. O'GARA: Wow, you're all on the money with transitions today, because we're going to talk about data and outcomes next. Kayla, we'll stick with you. Can you just tell us how Massachusetts monitors and conducts oversight of PACE, and, of course, if you have any data on PACE outcomes in your state that you could share with us.

MS. KING: So I don't have state outcomes that I can share right now, but that is something that I've been

working on to get, which kind of goes into what I was thinking about challenges and things, which is just the infrastructure and information that we need.

We have been partnering with a lot of our different departments and trying to get the PACE programs up to speed. So we look at our Quality Department. So having our PACE programs doing kind of looking at a subset of their enrollees. We'll have certain questions we want them to look at, whether it's how many admissions to nursing homes and some of the outcomes around that and then comparing them. But it's a very, very small subset of their group, so it's not really statistically significant at this point and kind of slowly trying to build that up, so that's something we could regularly ask from them.

So on our department, I'm the program manager. We have contract management that works really closely with the PACE program. But I'd say we are definitely at the infancy of trying to get our programs to really be thinking about how they can share certain end data with us, especially when we think about rate setting and how we can have that make a lot more sense. So encounters and just trying to look at more claims sort of things. It's

definitely a work in progress, for sure.

MR. O'GARA: All right. Sabrena, could you share with us how your state monitors and conducts oversight of PACE?

MS. LEA: Certain. I want to pick back up on the barrier conversation, because one of the barriers for us of the three-way of doing it is the requirements on the reporting. We find that those requirements are insufficient, and we are aware that many states have adopted, in addition to the three-way agreement, a two-way agreement with states to strengthen their ability to collect data and reporting. North Carolina has gone in that direction, but I see that as a barrier.

To mitigate that, North Carolina has a reporting system that we call e-PACE that captures basic information on enrollments, disenrollments, some quality outcome measures related to hospitalizations, ER visits, inpatient stays and admissions. We monitor our PACE programs remotely. We have access to their electronic medical records. We do a 100 percent review of all enrollments and disenrollments. We do random samples of grievances and appeals. We do randoms of their annual reporting

attestations, and obviously we would review the service plans randomly. But we also provide on-site visits on a quarterly basis in partnership with our Division of Aging, which is the state division that administers the Adult Day Health concept.

Answering the question around the value of PACE, or the way I like to frame it as what would happen if an individual who is enrolled in PACE didn't have access to PACE, has been challenging for us, due to the unique structure of PACE and the characteristics of the beneficiaries it serves. Because individuals voluntarily enroll in PACE, it is difficult to suggest or design a true comparison, even though they meet institutional levels of care of another cohort that is not enrolled in PACE to do what we believe to be a fair analysis. Truly defining what individuals and individuals would choose were they not enrolled in PACE, and, of course, the intangibles that are provided in that PACE subset make a meaningful analysis difficult. So defining the right alternatives for individuals if you weren't to have PACE is problematic.

We have looked at a comparison group. We have looked at our waiver group. We have looked at nursing home

individuals and other services. Because of these challenges, quantifying the cost-benefit for PACE has been elusive for us during the course of time that we have been a PACE state.

We do not have current outcome data. We did include PACE in our NCI-AD. We will repeat that survey in 2025. We think that that would give us some opportunity to do a meaningful analysis as we start to get at the heart of the true value of PACE, of our PACE program.

MR. O'GARA: Thank you so much. And now we'll turn to the Federal perspective. Cindy, could you tell us what data CMS collects from providers and states throughout the application and enrollment process, and what data gaps you see around the model?

MS. PROPER: Sure. And let me begin with full disclosure that PACE data collection is not really my subject area of expertise. But I can give you some general ideas about the PACE data that is collected, from a federal perspective.

And as was mentioned by the states, some states do have additional reporting requirements for PACE, which they certainly can do. Some require encounter data, more

detailed financial reports than CMS requests, as an example, as well as enrollment, disenrollment information. So that's something states can do over and above what CMS requires.

As far as the application, the application process is housed in our Health Plan Management System, and entities that want to develop PACE or expand their existing programs have to submit an application through this system. And while much of the application is attestation based, there are documents that have to be provided along with that. So we collect all of that. A lot of that is then used to feed into the three-way program agreement that is ultimately signed.

There are also some documents that come in with the application from the states, that includes their Medicaid rates, their enrollment and disenrollment processes for PACE, and some other assurances that they make that they're willing to enter into an agreement with this organization.

And then once operational there are, of course, other reporting requirements that occur. The states, of course, have to report their PACE Medicaid expenditures to

CMS. PACE organizations are required to submit specific financial reports to CMS, but they're really not detailed in a level based on service categories or anything like that. They're more just general. And one of the things that CMS looks at is to ensure compliance with requirements of the federal regulations that require that the organization be fiscally sound.

And then I know encounter data was touched on. Initially there was no encounter data required for PACE, and then in 2013, PACE organizations were required to begin to submit encounters for only Medicare-covered items and services for which they collect a claim form.

So CMS doesn't currently require submission of encounter data for all of those day-to-day services that are provided directly, although there is a long-term goal to do that, to be able to collect encounter data. My colleagues in Medicare are working on that, and you may be aware that just recently there was a place of service code established for the PACE Center. It's not being used yet, but it was just kind of one of the first steps to get to the place where organizations would be able to submit some level of encounter data for services that are provided at

the PACE Center.

And then finally I think what we call our PACE quality monitoring and reporting requirements, I don't know that that's an accurate description, but PACE organizations must report aggregate and individual PACE quality data to CMS. That's also submitted through the Health Plan Management System. There are 23 data elements that are required to be submitted.

But I would say where CMS is lacking, too, related to data collection, is the ability to compare PACE data and outcomes across other programs. This is actually something that I think I've heard since the inception of PACE, that both states and the industry, quite frankly, have expressed they would really like to do, to show on paper the value that PACE can bring.

MR. O'GARA: Thank you all so much for such wonderful insights. I'll turn it back to the Commissioners now for their questions.

VICE CHAIR DUNCAN: Thank you very much. Commissioners, any questions for Kayla, Sabrena, or Cindy? Mike?

COMMISSIONER NARDONE: Yes. Thanks for that

great presentation. I was wondering, Sabrena, you mentioned that you were collecting NCI data on beneficiary experience. I was wondering, you said 2025, but I didn't know if you had also collected that information earlier. So I was wondering if you have any reports out on that.

And I guess I wanted to ask Kayla if Massachusetts was also heading in that direction.

MS. LEA: The last time North Carolina conducted the NCI-AD study that included PACE was in 2010. And we had a small number of PACE organizations then, I think we [inaudible] now. So while I do have that data, it's not current.

MS. KING: And I'm not familiar with that specifically, but we do have the PACE programs, that they complete an I-SAT survey, which is a participant satisfaction survey. And then it compares across just our eight PACE programs of the experience there. So that is something that they do complete currently.

COMMISSIONER NARDONE: Can you comment on what are the results of that survey? I mean, are they generally positive about the experience?

MS. KING: Very positive about the experience.

And I think because we do have a close relationship, when we are hearing of something that may happen, we will usually know about it. But I think the last time I looked at it overall it's in the mid-90s for overall satisfaction, and that's pretty much what's been trending for the past maybe three or four years that we've been doing that.

COMMISSIONER NARDONE: That's helpful. And can I ask, in terms of the oversight, what's the extent of oversight that you have on disenrollments in terms of ensuring that people stay. I'm wondering what kind of lengths of stay you have in terms of the PACE program; how long people stay? Or do you oversee to ensure that disenrollments are appropriate?

MS. KING: Yes. They actually need to be approved in a lot of cases, especially if there is involuntary disenrollments. So it may be that something is going on with the participant where they may not be following the certain rules they need to be. Maybe rarely if there are issues of non-payment, if it's somebody who is self-pay, or just whatever reason, that may go into that involuntary disenrollment bucket, we have to approve that. We work with the PACE Centers to do that.

And then we do monitor very closely. We are now meeting with all of our PACE enrollers monthly, and disenrollments is something that we look at, and they give us the disenrollment reasons for each participant. And if we have to have some sort of case review to go over that and if there's anything that's trending, that's something that we handle in our oversight meetings with them.

COMMISSIONER NARDONE: Great. Thanks.

VICE CHAIR DUNCAN: Any other questions? Heidi.

COMMISSIONER ALLEN: Thank you so much for all of this really wonderful information. I guess I would just say if you had a parent or a grandparent that you could put in a PACE program versus like a D-SNP, HIDE-SNP, which would you want for your people?

MS. LEA: So I am a caregiver for a 92-year-old who has complex issues, including dementia, who is currently in a Medicare Advantage plan. She is not eligible for D-SNP. And yes, I am looking to enroll her in a PACE program. So I highly support and endorse PACE for those individuals who need it. Again, I cannot say enough for the incalculable value that PACE offers the families in that support.

MS. PROPER: I think I would second that. You know, obviously there are organizations that sometimes don't live up to the standard, and we have to address it. But I would say just the overall, generally, PACE is kind of the -- somebody had mentioned earlier -- the gold standard.

I actually had a mother -- she has now passed -- who was needing a level of care. We did not have PACE available in the area of the state that I live, and I was wishing that we did and that somebody would develop one there, because I would've definitely had her enroll in that program.

MS. LEA: I don't think the issue is the value of PACE. As a Medicaid administrator, to me it's the scalability.

VICE CHAIR DUNCAN: Thank you. Dennis.

COMMISSIONER HEAPHY: I remember when my mom was alive, we were looking and trying to get her enrolled in a PACE program because of the really heavy amounts of person-centered care coordination that was provided. Because she was on a lot of medications, had a lot of different types of providers, and PACE just provides a much more robust

care coordination, care team model.

But folks who are under 55, given all the restrictive or prescriptive nature of PACE programs, what do you envision to be the bumps in expanding the program to folks under 55, since the populations are radically different? I guess I'll ask that of Cindy first.

MS. PROPER: Yeah, that is definitely a challenge because the PACE Center is a big, integral part of the PACE model. And the population that's enrolled in PACE currently loves it. I just recall doing audits in Philadelphia, where they would come in dressed up. Like they would love the bus ride because they couldn't get out of the house usually, and they just didn't even care how long it took.

So the PACE Center is a place for them to not be isolated and to interact with their peers. But I know for a younger population that the PACE Center requirement would probably be a challenge, not something necessarily that that population would want.

You had talked, I think, earlier, I heard your question about transportation and that kind of thing. You know, most PACE participants use the PACE transportation,

where maybe a younger population would want to use something more public transportation. That would create some regulatory conflicts because of the regulations that say PACE is in charge of making sure everybody who is driving meets all of these requirements.

And then there's the cost variation, I think, as well. The 55 and over population is a very homogeneous population as far as their needs and their cost experiences. But when you get into a younger population who has disabilities or other needs, it's a little less predictable to cost out as far as capitation rates.

Those are just some of my initial thoughts.

COMMISSIONER HEAPHY: One follow-up question, and this is actually for Kayla. In terms of the care coordination, care team model that provided in SCO compared to PACE, is there a way to transfer some of that care coordination, care coordinator model from PACE over into SCO, so they do get that robust level of care coordination that's not necessarily provided right now in SCO, but is available in PACE.

MS. KING: Yeah, that's the goal, and when I first started talking about how we are trying to align

these, that's one of the areas, absolutely. And so as we are moving over to transition and we are re-procuring our SCO plans and rewriting our contracts, getting our SCO plans, our D-SNP plans, to kind of emulate the PACE model, especially with their care coordination and their care team, that is definitely one of our goals, for sure.

It's kind of difficult because it's not like it's contract language for PACE, and that's why they are so successful with the model, and that's why they carry it out. So it's kind of like trying to find those nuances and how we can bring that over to our SCO plans, and even with OneCare, as well. But that's an area that we're trying to get our D-SNPs to kind of follow that specific PACE model. So that's where I think a lot of the outcomes and the success, it's just a lot more hands-on. But I think it's difficult where we have 80,000 people in our SCO plan versus the 5,000 people, even spread out where we have some PACE programs that have 250 people. So, of course, it can be way more hands-on than we have huge plans that are handling 20,000, 30,000 people.

COMMISSIONER HEAPHY: I guess possibly by risk category would be a way to determine that. So we can have

a conversation.

MS. KING: Yes. It's good to see you, Dennis.

VICE CHAIR DUNCAN: Thank you, Dennis. Any other questions or comments for the panelists?

[No response.]

VICE CHAIR DUNCAN: Seeing none, Kayla, Sabrena, Cindy, thank you for your time, your expertise, and what you're doing both in Massachusetts as well as North Carolina. And Cindy, thank you for what you're doing for the country.

With that, back to Brian and Drew.

MR. GERBER: I think now we can kick it off for Commissioner-only discussion. I believe, to reiterate sort of what we had concluded at the end of our presentation, what would really help to hear from all of you are areas of focus for our future interviews with the various stakeholders that we're speaking with in the coming months, as well as just areas of the model that you'd like further explanation on in a future session.

VICE CHAIR DUNCAN: All right. And we broke away on our panelists' time. We have Mike and then Heidi.

COMMISSIONER NARDONE: Yes. I was trying to

remember what I was going to say. Anyway, the PACE model is one that, in Pennsylvania, when I was Medicaid director, we did a fair amount of work with, and expanded the model greatly during my time. And certainly see the huge value that it potentially plays as one of the tools in the toolbox of Medicaid directors to provide truly integrated care.

So I'm very supportive of this work overall. I think some of the things other have said I would just kind of go back to, like what Tim said around beneficiary experience and some of the comments, or the question I just had for the panelists.

But I also would like to, I think, understand a little bit better the role that the state plays in monitoring the PACE program. One of the panelists mentioned two-way agreements. So I'd be really interested and hope to understand a little bit better around how that works.

And I think also maybe understanding a little bit better kind of the disenrollment processes and the role that states play in ensuring that folks are not prematurely disenrolled as per, I think, the experience that John was

reflecting on what he hears sometimes. So I think understanding that a little bit better.

And then finally just the AWOP, as I recall from my time at CMS, is something that is specifically in statute. And I think understanding a little bit better around how states develop their AWOPs and what they use as the standard. Because I also understand that in addition to the states that do develop an AWOP and then do a percentage off of that, there are states that use actuarial standards, as I understand it, for setting PACE rates. So maybe understanding a little bit more around how that is done.

VICE CHAIR DUNCAN: Thank you. Heidi.

COMMISSIONER ALLEN: Thank you. So echoing what's been said multiple times, I'd really like to understand beneficiary voice, and if possible, how that compares to what beneficiaries say in other settings.

And this was alluded to. Ms. Lea mentioned this. But caregiver burden. You know, a day center allows people to go to work and know that their loved one is taken care of, which I think is really valuable for working-age primarily women and their ability to function and do well.

And I think especially for women who are caring for children and aging parents -- and I know that men do, as well, there's plenty of research to support that the real burden hits women harder -- I think is an important part of understanding the benefits.

And then I am very concerned that this kind of pairing, per member, per month, when you're not accounting for the time that they're spending in a day center as a service provided, because that means that the hours in the day center have to compete with the cost of like emergency departments or hospitalizations. And those represent such dramatically different cost expenditures in terms of what that means for the patient. And one, that means they're very sick and they're requiring intensive care, and the other, it means they're not lonely, they're being supported, they're being taken care of.

So just comparing those I think is really complicated. I know it's complicated, but I would rather be thinking about this AWOP kind of measure than just the per member, per month.

And then there's a bunch of states that don't offer PACE, and I'm curious as to why, and what could be

some policy efforts that would support scalability.

VICE CHAIR DUNCAN: Thank you, Heidi. Any other questions or comments? Dennis.

COMMISSIONER HEAPHY: Yeah. I'd like if we could find out more about the model itself and how it would impact access to -- [audio drop] -- under 55, -- [audio drop] -- and do those restrictions -- [audio drop] -- understand what the difference are in the populations and their needs. Cindy said that, as well.

VICE CHAIR DUNCAN: Thank you, Dennis. Tricia.

COMMISSIONER BROOKS: Just a quickie on getting the beneficiary voice. I want to make sure we're actually talking to beneficiaries and not their caretakers who are helping to enroll them.

VICE CHAIR DUNCAN: Thank you, Tricia. Anyone else?

[No response.]

VICE CHAIR DUNCAN: Drew, Brian, anything else you need from us?

MR. GERBER: I think you've given us plenty to think about. Thank you.

MR. O'GARA: Plenty to think about, and I'm

mortified to get an email from CMS that that's not an acronym or something.

VICE CHAIR DUNCAN: Don't worry about them. Dennis had something else.

COMMISSIONER HEAPHY: Is that survey administered in a conflict-free way, so it's done with the individual as opposed to a member of the care team or care provider doing that. So how sound is that data.

VICE CHAIR DUNCAN: Thank you, Dennis. And again, Brian, Drew, thank you very much. Brian, don't worry about the letter from CMS. It'll be a phone call instead. But you did a great job on your first presentation.

VICE CHAIR DUNCAN: Now we'd like to open it up to our audience for any questions. Again, for public comment we need you to raise your hand if you want to say something, introduce yourself, the organization you represent, and please keep your comments to three minutes or less, please.

PUBLIC COMMENT

* [No response.]

VICE CHAIR DUNCAN: All right. Going once,

twice, three times. Thank you.

We will adjourn, and we meet back tomorrow morning starting at 9:30 in the morning. So we look forward to the conversation tomorrow, and 9:30 is when the Public Session begins.

All right. Thank you. Everyone have a great day. And I also want to say a thanks to our IT team for dealing with being in a new place and getting us back on. So thank you to your guys. Thanks. Bye.

* [Whereupon at 4:23 p.m. the meeting was recessed, to reconvene at 9:30 a.m., on Friday, September 20, 2024.]

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PUBLIC SESSION

Bernard K. Jarvis Hall of Learning
Association of American Medical Colleges
655 K Street NW, Suite 100
Washington, DC 20001

Friday, September 20, 2024
9:30 a.m.

COMMISSIONERS PRESENT:

ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
DOUG BROWN, RPH, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
MICHAEL NARDONE, MPA
JAMI SNYDER, MA

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:30 a.m.]

VICE CHAIR DUNCAN: Good morning and welcome to Day 2 of our '24-'25 analytical cycle here at MACPAC.

For some of the new attendees I'd like to welcome two of our new Commissioners to MACPAC, Mike Nardone and Doug Brown. For those in the audience who would like to learn more about Mike and Doug or the other Commissioners feel free to visit MACPAC.gov for more information.

I would also like to recognize our fellow Commissioner; Verlon Johnson is MACPAC's new Chair. Verlon was excited to lead us through this inaugural meeting of the meeting cycle. Unfortunately, she has had extenuating circumstances that prevented her from being here this week, so she will join us at our meeting in October.

And with that, Melissa, I will turn it over to you.

INTRODUCTION TO WORK ON RESIDENTIAL SERVICES FOR YOUTH WITH BEHAVIORAL HEALTH NEEDS

* MS. SCHOBER: Good morning, Commissioners. Today I will be introducing our work on appropriate access to residential services for youth with behavioral health

needs. This presentation will begin by providing some context and an overview of work to be accomplished during this and future analytic cycles, followed by a discussion of the types of and use of residential treatment by Medicaid-enrolled youth before concluding with next steps.

Decades of research point to the clinical and fiscal benefits of providing individualized, home and community-based services, or HCBS, services to youth.

In 2003, the President's New Freedom Commission on Mental Health outlined the significant challenges states faced in providing HCBS services for youth. The report recommended that the Centers for Medicare and Medicaid Services develop a demonstration to examine HCBS as an alternative to psychiatric residential treatment facilities, or PRTFs, to evaluate the effectiveness of community-based placements for youth with serious emotional disturbances.

In 2005, the Community Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration was created. An evaluation of the demonstration found that HCBS cost substantially less than care in PRTFs, and children showed statistically significant functional

improvement.

In 2013, CMS and the Substance Abuse and Mental Health Services Administration released joint guidance to assist states in designing HCBS for youth with behavioral health conditions to provide care in the least restrictive setting. The guidance included information on which Medicaid authorities could be used to provide services such as intensive care coordination, family and youth peer support, and respite care to enable children to live with their family and participate in their own community.

Despite the 2013 joint guidance and additional guidance from CMS, MACPAC's June 2021 Report to Congress found that states report challenges in using Medicaid authorities to design, implement, and sustain a continuum of care for youth with behavioral health conditions.

This difficulty is occurring as the number of youth with behavioral health needs rises. From 2007 to 2016, pediatric emergency department visits increased for children ages 5 to 17. In 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association issued a joint declaration of a national emergency in youth mental

health.

In response to the youth behavioral health crisis and media reports, as well as the Commission's continued interest, MACPAC is planning a multicycle analytic work product that will examine access to and the use of behavioral health services. We are beginning by examining a single component, appropriate access to residential treatment facilities, of the full continuum of care for children and youth.

In this first phase of work, MACPAC is examining if states have the tools they need to provide appropriate access to residential treatment for youth with behavioral health needs. We have conducted a literature and federal policy review. Later this fall we will conduct interviews with state Medicaid, child welfare, and behavioral health agencies and stakeholders to understand how states are using federal flexibilities to ensure appropriate access to this restrictive setting when medically necessary as well as the tools states are using to prevent inappropriate or overutilization of this service. We anticipate future phases of work examining the continuum of behavioral health care for youth that will span multiple analytic cycles.

Behavioral health disorders for youth typically emerge in childhood or adolescence with about half beginning by age 14. These disorders can negatively affect physical, emotional, and social development. For example, children with behavioral health disorders have higher rates of school absenteeism and are more likely to be involved with the juvenile justice system.

Residential treatment services are behavioral health interventions intended to provide intensive clinical and therapeutic treatment only to those youth who cannot have their needs safely met in a less restrictive setting.

Next, I will discuss the federal policies that affect access to residential treatment.

The mandatory EPSDT benefit requires coverage of all medically necessary care for youth under 21 enrolled in Medicaid, including prevention, screening, assessment, and treatment services. The IMD exclusion originally prohibited Medicaid payment for any individual under 65 in an IMD, which are defined as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases."

This morning I will focus on two exceptions to the IMD exclusion. First, an exception for youth was added in 1972. The psych under-21 benefit allows states to cover services for youth under 21 delivered in psychiatric hospitals, psychiatric units of general hospitals, or PRTFs. Although this is an optional benefit, states must cover treatment in a PRTF if an EPSDT assessment determines it is medically necessary. If a state lacks a facility to meet the assessed need, the state Medicaid program must reimburse for placement in an out-of-state facility.

Second, Section 1115 demonstrations permit states to states to pay for short-term inpatient and residential substance use disorder treatment services in IMDs and to receive federal financial participation, or FFP, for services delivered to children in child welfare, in certain treatment settings that I will discuss next.

Medicaid-enrolled youth typically receive and access residential treatment services at one of three types of facilities: PRTFs, qualified residential treatment -- that should say programs, I apologize for the typo, instead of providers -- and other residential settings.

PRTFs are accredited non-hospital facilities.

Prior to admission, a youth's health care team is required to certify that community resources do not meet the treatment needs of the youth and treatment of the youth's condition requires an inpatient level of care. Youth must receive active treatment specified in an individualized plan of care. The use of seclusion and restraint in these facilities is limited, and any use must be documented. Other conditions of participation are detailed in Appendix N of CMS's State Operations Manual.

Enacted as part of the Balanced Budget Act of 2018, the Family First Prevention Services Act, or FFPSA, made significant reforms to the child welfare system. This law limits the use of Title IV-E foster care payments to specialized congregate care settings, called qualified residential treatment programs. QRTPs provide a trauma-informed, time-limited placement setting for youth in child welfare with behavioral health needs.

Title IV-E funds may reimburse QRTPs for "maintenance" costs, including room and board, but do not reimburse the cost of treatment services. States may use Medicaid to cover the costs of clinical and therapeutic services if the QRTP has 16 beds or fewer.

QRTPs with more than 16 beds are likely subject to the IMD exclusion as they are facilities that are primarily engaged in providing treatment or care of persons with mental diseases. If the QRTP is an IMD, federal financial participation is available only if the facility also meets the requirements to be a PRTF.

Other residential settings include public or private congregate care settings that do not meet the requirements of a PRTF or QRTP. These placement settings use many names, including therapeutic school, wilderness or ranch program, or treatment academy, et cetera. While states typically regulate publicly funded programs, some do not license or regulate private or faith-based programs.

There is no uniform or commonly recognized definition of these programs. A 2022 report by the Government Accountability Office, or GAO, noted that the U.S. Departments of Health and Human Services and Department of Education told GAO that they collect some data from states, but that oversight of residential facilities, including residential schools, is a state function.

Some states claim FFP for services delivered

within these facilities by allowing Medicaid-enrolled providers to bill for clinical and therapeutic services. Room and board may be paid with Title IV-E dollars for eligible children subject to the time limits imposed the Family First Prevention Services Act, or with state or local general funds for children who are not Title IV-E eligible.

Next, I will discuss the difficulty in understanding which Medicaid-enrolled youth use residential treatment.

Understanding the use of residential treatment by Medicaid-enrolled youth is challenging. There programs use many names. A 2006 SAMHSA survey of respondents from 38 states reported 71 types of facilities.

MACPAC's literature and federal policy review and prior work by the GAO suggest there are gaps in federal and state policies governing appropriate access to residential services for youth. There is no national data set or central repository listing all residential treatment facilities from which we could analyze the demographic and eligibility characteristics of youth who received such services.

A 2018 analysis of Medicaid claims data found that roughly 4 percent of children ages 0 to 18 had a claim for residential services. A MACPAC analysis of 2022 data from the National Survey of Drug Use and Health, or NSDUH, found 2 percent, or 194,452 noninstitutionalized youth aged 12 to 17 reported a stay in a residential mental health treatment center. However, it is important to note that the NSDUH is limited to only noninstitutionalized youth aged 12 to 17.

The Adoption and Foster Care Analysis Reporting System records the number youth in foster care living in an institution, but that category it not limited to residential facilities. It also includes settings such as maternity homes.

Youth with behavioral health needs may be referred to residential treatment providers from several sources. Referral pathways include behavioral health treatment providers such as emergency departments or crisis response services. Child welfare agencies can also petition the court for a placement order.

Custody relinquishment and voluntary placement agreement are tied to a youth's eligibility for Medicaid.

The parents of youth with behavioral health conditions frequently report difficulty in accessing home and community- based services. As a last resort, parents may choose to place their children in the child welfare or juvenile justice systems to obtain needed care, often after exhausting private insurance benefits or when coverage is unavailable, inaccessible, or unaffordable. Although Medicaid's role in providing services to justice-involved youth is limited, all children receiving Title IV-E assistance are automatically eligible for Medicaid.

Some states permit parents to voluntarily place their child rather than relinquish custody altogether. Under such agreements, a state agency assumes custody of the child for a specified period of time. Children who are voluntarily placed and are eligible for Title IV-E also automatically become eligible for Medicaid.

Given the dearth of literature and national survey data, I plan to return next month to present findings from a selection of reports examining state-specific policies and barriers to accessing appropriate residential treatment services. These reports were prepared by state legislatures, organizations designated as

the state Protection and Advocacy system for people with disabilities, and U.S. Department of Justice findings assessing states' compliance with Title II of the Americans with Disabilities Act. After the new year, we intend to convene an expert panel to provide additional subject matter expertise to the Commission.

During this meeting, I would welcome your questions and thoughts on specific areas to pursue during interviews with state agencies and stakeholders, and would welcome your thoughts on the direction of research. Thank you.

VICE CHAIR DUNCAN: Thank you, Melissa, and I want to just tell you personally I'm excited about this work.

So you've heard Melissa's presentation, where we're headed, looking for input from the Commissioners. Anyone want to provide some feedback? Angelo.

COMMISSIONER GIARDINO: Thank you for taking this on. I think it's a really important piece of work.

One area that I would be particularly interested in is the situation where children from a different state are sent to a residential facility, to a different state.

What is the ability of that residential facility in the new state now to handle one level up?

One of the things that I'm concerned about, and I hear a lot about, is that some of these facilities, with checkered pasts, are willing to take just about anybody. Many of those kids, they're really not adequately prepared to handle. So the child comes, they start getting reimbursed from whoever, and then the child decompensates. That facility cannot handle that care, and then they drive them to the children's hospital and dump them at the emergency department, where then the children's hospital has to deal with someone who should never have been brought to that state. And the residential facility really has no responsibility whatsoever at that point, and that sending state may very well not compensate the children's hospital anymore because that wasn't the deal that they made.

So I'd really like to understand, as you do your work, how often do people that get accepted into these facilities actually stay in the facilities, and how often do they decompensate and end up in a children's hospital or a general hospital where then they're not getting the care they need, and those institutions actually don't get

compensated by the sending state's Medicaid program. Thank you.

VICE CHAIR DUNCAN: Thank you, Angelo. I've got Tricia, Patti, Heidi, Tim, Sonja, then John.

COMMISSIONER BROOKS: Melissa, were you going to respond?

MS. SCHOBER: No. I was just going to say thank you for that, and I will add it to the list.

COMMISSIONER BROOKS: You mentioned that there are a number of states that allow voluntary placement. Do you know how many?

MS. SCHOBER: I do not off the top of my head, but certainly that will go in the final product.

COMMISSIONER BROOKS: Yeah, I think it would be interesting to understand why more states don't allow that. I mean, it's gut-wrenching for families who have a child that has significant needs and their only option is to give up custody, which leaves scars on everybody for decades.

So that voluntary placement, I know it's only a very small piece of the pie, but it would be interesting to understand more about why more states aren't doing it.

MS. SCHOBER: Of course. And the last report we

were able to locate on custody and relinquishment in voluntary placement agreement is quite old. The GAO released one in 2001 that found about 12,700 children were relinquished to child welfare or juvenile justice agencies, but that hasn't been updated.

The Assistant Secretary for Planning and Evaluation, ASPE, is engaged in a project. They put out a release of project profile in July of 2024, and they're looking at two states, Kentucky and Florida, using administrative data from both child welfare and Medicaid, to look at issues of custody relinquishment and voluntary placement.

I can say, from some review of the literature, that one of the reasons more states might be reluctant to use voluntary placement is typically the child welfare agency will not accept the voluntary placement until they have identified a bed, a placement spot for that child. And if one cannot be located expeditiously the voluntary placement agreement cannot be executed.

VICE CHAIR DUNCAN: Thank you, Tricia. Thank you, Melissa. Patti.

COMMISSIONER KILLINGSWORTH: All right. Melissa,

thank you. I'm excited to see this research evolve, where we might be able to have impact. If I think of one topic that made 25 years in state government feel like Groundhog Day every day it was this one, you know, what is the continuum of care for children with really complex behavioral health needs, over and over again.

As we think about access, I want us to think about access not just in terms of numbers or beds, if you will, but access in terms of quality, both the quality of the experience of these youth and their families and then also the outcomes, in particular the impact of those outcomes on post-discharge in the community 10 years later. Like what does that look like after the delivery of these services.

I'm particularly interested in thinking about these services within the overall continuum of care, and in particular sort of model our system of care principles and practices. So when a child or a youth is placed in a residential treatment facility, are we really working sort of in coordination with the overall system of care, with community-based providers who ultimately might be treating that child later, with the school, who absolutely will have

a role in that child's future. And particularly with the youth and the family, some of the statistics are just startling in terms of kids who are placed in these facilities, and there's very little engagement with the youth or with the family in terms of treatment planning. So I think that's really important.

And then the other thing I would like to see us really think about is kind of the intersection of children and youth with behavioral health needs broadly, and then children and youth with IDD and behavioral health needs. Because it's sort of like if this is the challenge, that's an even greater challenge because the behavioral health system tends to not know how to deliver appropriate treatment services to kids with IDD. So I would like to be sure that at some point that's a part of the research that we do. Thank you so much.

VICE CHAIR DUNCAN: Thanks, Patti. Heidi.

COMMISSIONER ALLEN: Thank you. I echo many of the sentiments raised by other Commissioners. I'm interested in these out-of-state placements. I am wondering to what degree some of them are driven by some states that require youth to consent to residential

treatment and do not allow involuntary admissions. And I'm very interested in pursuing the situations where private insurance is not paying for these services and families are forced to relinquish custody of their children in order to access care. And, of course, I'm also very interested in understanding the quality of these programs and how well they help people reintegrate into the community after a stay.

So that's it for me. Thanks.

VICE CHAIR DUNCAN: Thanks, Heidi. Tim.

COMMISSIONER HILL: Yeah. It was earth-shattering before everybody else started talking, but just to reemphasize what we've heard from others, less of an emphasis on placement and access for me, which are important issues, and more of an emphasis on outcomes in reintegration for youth as they go through these services. I think we all too many times don't think enough about what happens to these kids when they get through, so having more of an emphasis on the quality and the reintegration.

VICE CHAIR DUNCAN: Thank you, Tim. Sonja.

COMMISSIONER BJORK: Thank you. Like Heidi I'm interested in some of the drivers behind out-of-state

placements, so even a broader look than Heidi mentioned. What are the factors, and what are the major factors that cause out-of-state placements. Does a particular state have certain policies that make it so there are hardly any programs in their state, with regard to licensure or other policies? Does it have to do with negotiating payment for those services? Is it a rate-based problem so that they have an easier time when they have to do perhaps a letter of agreement with an out-of-state provider versus figuring out a contract within their own state?

So just looking at all those different factors that impact a state's ability to have their own residential program so that a family doesn't have to deal with an out-of-state provider.

And then like everybody else I sure am interested in those post-discharge quality measures and reintegration back into the community.

Great report, Michelle [sic]. You sure have an interesting topic to dig in on here.

VICE CHAIR DUNCAN: Thank you, Sonja. John.

COMMISSIONER McCARTHY: This is a great one. I mean, there is so much on this one, and it's very timely,

so hopefully you can get through some of these things. I know it's going to take a while to get there quickly.

A few things I really would like to see in here. Because specially PRTFs, there are not that many of them, it would be nice to see if we could get a count of all the PRTFs in the U.S., and part of that would just be talking to states.

The second part of that is talking to providers, and back to what Sonja just said, what are the barriers for providers to become facilities, and what is that? I will tell you, Sonja, for instance in Ohio, one of our issues -- Ohio had no PRTFs when I was there. The current Medicaid director is trying to get PRTFs into the state.

The issue was we had a pushback from the mental health community, which was we shouldn't institutionalize kids. And so they didn't want us to have PRTFs because it would have defaulted towards institutionalization. But in the end, we needed them, so we were sending kids out of state. So that is one of those conundrums you get into, and I can see both of those.

But Melissa, what I would like to see is us do a scan of all 50 states plus D.C. to get what are the rates

that they're paying. Because some of the people that we've worked with, and the states that we've worked with, states are paying upwards of $1,000 a day for PRTFs, and what PRTFs are saying is -- and I'm going to make it up -- I've got 16 beds, and I've got 25 people who need these beds. So their rates just keep going up and up.

And the states actually can't pay those rates usually because of the state plan, so now you've seen some interesting PRTF state plans which say we will just pay a market rate, which Mike and Tim know, CMS never used to approve state plans like that. It was always like you had to have a methodology for what was in there. But that's where it's gotten to. And a part of the reason is because we use managed care so much, managed care plans can pay more. It's like how much are managed care plans paying.

So whoever we hire to look at this is looking at both SPAs and how much are being paid and then how much managed care plans are being paid. Because I think a part of this is, for us to make a recommendation, we're going to have to look at some of these things around what are the barriers to providing this service, payment rates, and especially across the states, not just within a state.

Thanks.

VICE CHAIR DUNCAN: Thanks, John. Mike.

COMMISSIONER NARDONE: Thanks. I just wanted to touch on a couple of things that I'd be interested in. We've been talking a lot about out-of-state placements. I think part of that would be how many kids actually come back to the state that they were placed out of, if there is information available on that.

I agree and second Patti's issue around more complex cases involving IDD, and I'd be very interested in if there are models that seem to be effective in terms of providing services in the home and communities around some of those more complex cases.

And I'm really curious. I mean, this is an area where it seems like there are a number of systems that have to coordinate in providing services to this population -- behavioral health, criminal justice at times, maybe IDD, child welfare. And I know there's been some prior work around coordinating guidance around that. And I guess I'd like to see if there are models at the local level, where this has been successfully implemented, both in terms of provision of service but also in terms of understanding the

braiding of funding that goes into this.

Because it does feel like this is an area where people could be pointing the finger at the other system, that it's not our kid. They would be in IDD. They should be in BH. No, it's over here. And I guess it seems to me that's one of the big challenges in understanding are there effective models that we should be looking at in terms of these kids.

VICE CHAIR DUNCAN: Thank you, Mike. Dennis.

COMMISSIONER HEAPHY: Thank you. First, it boggles my mind that there is no oversight of a lot of these residential programs. That may be beyond the scope of MACPAC, but it would be helpful to understand how these programs can go unregulated.

And also a couple of things. One is it would be really helpful for me to see comparison between what's available to the youth and what's available to adults, a side-by-side comparison of the types of services that are available. And then to look more upstream, like respite versus residential treatment. And I think we're siloing this because schools are really on the front line, and how are states working with schools and their mental health

programs? And Heidi has asked in the past, like how are school-based social workers being engaged in these programs? And what efforts are being taken to advance peer counseling, recovery coaching for youth, and what are the disparities between populations that some folks have alluded to, in addition to race and ethnicity, but high rates of mental health diagnoses among youth with learning disabilities or IDD.

I think I need to better understand what is available upstream to prevent the kids from having to go into these residential programs. Are there services available?

VICE CHAIR DUNCAN: Thank you, Dennis. Tricia.

COMMISSIONER BROOKS: I really think this is a first that almost every Commissioner wants to speak on this topic, which shows the kind of interest and concern we have for kids.

But I think that sort of building on John and then Dennis, moving upstream. I mean, why aren't we doing more in terms of access and effectiveness of home and community-based services to keep these kids out of residential services? What more can we understand about is

there action that can be taken before a kid needs to be placed in a residential setting.

VICE CHAIR DUNCAN: Thank you, Tricia.

COMMISSIONER BROOKS: Thank you.

VICE CHAIR DUNCAN: Tim, do you have your hand up again, or that left up? Okay, thank you. Jami.

COMMISSIONER SNYDER: So I'd just like to echo the other Commissioners' comments in terms of investigating the reasons for out-of-state placements. And in particular I know one of the reasons that surfaced a lot during my tenure as Medicaid director was the need for specialized programming for children with very specific behavioral health diagnoses. So just curious to know the degree to which that is a driver of out-of-state placement.

VICE CHAIR DUNCAN: Thanks, Jami. Doug.

COMMISSIONER BROWN: To follow along Jami's comment, I'd like to know how many beds are being held, to what degree can we determine, but what beds are being held in a state for out-of-state placement, and then does that create a shortage of in-state beds in that state, and then that state is sending folks out of state when there are beds in-state and they're bringing folks in.

VICE CHAIR DUNCAN: Thank you, Doug. Adrienne.

COMMISSIONER McFADDEN: So I have a few points. I think I would really be interested in understanding some experiential interviews, particularly for youth and their parents or guardians in indigenous communities and other historically marginalized groups. I also want to echo others' interest in the out-of-state placements, but really would want to understand the impact of virality on some of the use of interstate providers.

I definitely echo all the statements around quality, and I echo the post-discharge reintegration, but particularly interested in the interface between the juvenile justice system and particularly BIPOC communities.

VICE CHAIR DUNCAN: Thank you, Adrienne. Carolyn.

COMMISSIONER INGRAM: Wow, this is a big area where I think we're all going to have a lot of questions going in, so we appreciate your work on this.

Similar to Adrienne I'm curious about culturally appropriate treatment and if there is any training around that, especially thinking about our American Indian and Native American kids that are out there that are accessing

this care. Are there facilities available that are trained in terms of dealing with kids who come from different cultural backgrounds.

VICE CHAIR DUNCAN: Thank you, Carolyn. Heidi.

COMMISSIONER ALLEN: This always happens, where people who speak right before you take what you're going to say. I would like to add Alaska Natives to that list. I spent three years working in a residential adolescent facility in Idaho, and a significant portion of our daily census were Alaska Native kids who were sent to Idaho and stayed with us until they turned 18. Some of those young people were with us for up to three years.

So I'd really like to specifically look at indigenous and Alaska Native youth to see how often they are in placement but also in out-of-state placements.

VICE CHAIR DUNCAN: Thanks, Heidi. John.

COMMISSIONER McCARTHY: I forgot this last time. The other thing, and Melissa, you were starting to hit on this, but I think for the layperson, which many of us are, is really getting into who are the kids we're talking about going into these facilities. I think all of us sometimes have an image in our mind of who the kids are, but that may

not be it. And I think Patti hit on this one.

So for example, what I'd also like to see is what is the difference between a PRTF and an ICF that serves youth. Because in some states they aren't PRTFs but they are ICFs that are serving youth, who are IDD but who have very high behavioral health needs. So what is the difference there, between those things, and is that something that is being used in the care for these kids. So again, it's both who are the kids going into these facilities, then second, what other alternatives like ICFs that are being used.

VICE CHAIR DUNCAN: Thanks, John. Dennis.

COMMISSIONER HEAPHY: I just want to go back on the siloing of schools and Medicaid programs or health care programs. Are medical programs using IEPs? Are individualized education plans being part of the care planning process for youth, or are they totally separate? Because it seems there should be greater integration between the IEPs kids have and what's happening in the care planning process.

I just think it's real urgent that there be more interface between the school system programs and the kids'

Medicaid and health care programs.

VICE CHAIR DUNCAN: Thank you, Dennis. Jenny.

COMMISSIONER GERSTORFF: In states where I've worked recently, I've seen increases in utilization of beds in eating disorder residential treatment programs. And I'm just wondering where that might fall here, and if that's a subpopulation we might focus on.

MS. SCHOBER: Yeah, thanks for that. I think that speaks to an earlier question about those specialized treatment facilities. Those typically are placement settings that involve eating disorders. Children who have very aggressive behaviors, sexually acting out or fire-starting are among the specialty placements that are especially difficult for states to locate for young people who need treatment, and a safe treatment placement setting.

VICE CHAIR DUNCAN: Thank you, Jenny. Thank you, Melissa. Melissa, I think you've heard this is an exciting topic in a lot of places. But I want to close with being a father of a child that's touched every alphabet ladder in the mental health world, all the things you named as well as others that weren't named, I'd also like to include families. It was touched on, different populations, but

families who experience this and struggle.

I've had the fortune of living in three great states -- Tennessee, Wisconsin, and now Connecticut -- and I can tell you all three states worked diligently to try to find places for these types of children that need this type of help, and it is a struggle. So I'm glad we're interviewing the states to find out what the needs are. But as far as it relates to outcomes, I think talking to families who have children that are going through these programs and then coming back home, and then just getting into the cycle would be important.

So I appreciate it greatly. Thank you.

Do you think you've got what you need?

MS. SCHOBER: Yes, and then some. Thank you all.

VICE CHAIR DUNCAN: I think you've got 10 years of work here. Thank you very much, and thank you, Commissioners, for weighing in.

All right, let's get ready for our next hot topic. Chris, it's yours.

And, Allison, yeah, I was talking to Kate. I think we're going to start trying to get walk-up music to play during the time of transition. I think our audience

would appreciate that.

MANAGED CARE EXTERNAL QUALITY REVIEW (EQR)

* MS. REYNOLDS: Well, that may be a very hard act to follow. My hope is that you'll find external quality review in light of the managed care rule equally as compelling, and we've saved about two-thirds of our time for you to have a discussion. So that's the challenge I'll set out for you today.

So this morning, Chris and I are here to revisit the Commission's previous work from 2022 and 2023 on external quality review. Again, Chris walked through the managed care rule that had some implications for this work, and Kate mentioned that we had sort of that pause in the work, so no reason to ask you to remember work from March 2023. Ask any questions that you wish.

So we are going to take a look at Medicaid managed care quality oversight. We are going to take a look at both the federal -- or all three: the federal, state, and plan level. We're going to briefly go over external quality review in terms of the requirements and the process and the activities. We're also going to do a brief recap of that work that we did with Bailit Health in

2022 and 2023, both the method and also some of the findings, most compelling findings that we thought had the most support in light of the 2024 rule. And then we're going to, again, save the bulk of the time to offer three discussion questions for you, and we're hoping that you can really dive in and give us some guidance as to what, if anything, you'd like to see in October for policy recommendations or any additional information or steps you'd like to see us take between now and then.

So this is a graphic that depicts the federal, state, and plan-level activities involved in quality oversight for Medicaid managed care. So, as you can see, it's iterative, and it is a continuous feedback loop.

So CMS, as indicated from Congress, has the broad oversight authority. It's their responsibility to hold state Medicaid agencies accountable, and then state Medicaid agencies are tasked with holding the managed care plans with which they contract accountable for the services that they offer to beneficiaries.

For state Medicaid agencies, they use the quality strategy that they developed to set their priorities within the general framework that CMS has developed through

statute and regulations as well as the development of some EQR protocols for each of the activities, and then plans that are subject to the EQR process, they take the federal regulations, they take the state's quality strategy, and they should develop a QAPI, which is a Quality Assessment and Performance Improvement program that reflects both of those components.

Okay. Just a few things to go over in regards to EQR requirements. So first, it's an annual process. Second, the EQROs, or external quality review organizations that the states contract with to perform these activities, have to be approved by CMS. There's a few that have the majority of the contracts in states, and then there's a number of one-offs, if you will. So HSAG, IPRO, some of these may be very familiar to some of you.

Also, the EQROs have to be independent. They have to be independent of the state Medicaid agency, and they have to be independent of the managed care plans that they're assessing.

Third, each state has to produce in the spring an annual technical report that summarizes all of the plan and all the EQR activity that took place in the previous

calendar year.

And finally, as Chris noted yesterday, primary care case management entities, or PCCMs, are now excluded from the mandatory EQR activities as a result of the final rule.

Okay. In regards to EQR activities -- this is a little bit of alphabet soup, but I will try to make it clear. So there are four mandatory EQR activities that states must implement. So the first of these are your performance improvement plans, or your PIPs, and these can be clinical, and these can be non-clinical. But basically, they're targeted interventions to address a specific issue. For example, picking several zip codes where health equity issues, where you want to see improvement in a particular subset of your Medicaid population, and you're going to put in some specific clinical intervention to see if it seems to improve those outcomes is a good example.

Performance measure validation, or PMV, involves standardized measures in this state and -- more acronyms -- oftentimes use measures such as HEDIS or your Child Core Sets, for example. And this validation activity that the EQR does is really looking at the information technology

system that the managed care plan is using to pull the data for those measures and validate the accuracy of that data.

Third, mandatory activity is your network adequacy validation activity that the EQR performs, and again, this is often related to the accuracy of the systems that you're using to make sure that you're reporting accurate data.

And then the fourth mandatory activity is your triennial compliance review, and there's a lot of flexibility here for states in terms of how they do this. So there's 14 operational areas, if you will, your management information system, confidentiality, your grievance and appeal system, care coordination, et cetera. And those are 14 standards that are set out, and every three years, plans have to have those standards assessed. But if a state wants to do all 14 in one year or all 14 every three -- or what I've often seen is seven in year one, seven in year two, and then year three takes a look at the CAPs, or corrective action plans, that the EQRO might have put in place from years one and years two. That may be something a lot of you are familiar with.

So of the four activities, there's also seven

optional activities, and they're listed here. And it's just worth noting that not only are they optional in terms of states, of course, don't have to do an optional activity. They don't even have to do one of these activities. So they're optional on both fronts.

And then a final point to make here is that the 75 percent federal match has some qualification requirements. It has to be a qualified EQR activity. It has to be conducted by one of those approved external quality review organizations using those CMS protocols that they develop, and it has to be of a managed care entity that qualifies as an MCO, because we do still have those other entities that are part of the managed care process.

And all of those activities go into an annual technical report that has to be submitted to CMS by April 30th for the previous calendar year's activities, and the annual technical reports summarize the state's activities, and then the managed care rule adds new requirements that are really relevant to our study and our discussion today. Most notably, EQROs are required to include outcomes data and quantitative assessments that result from three of the four mandatory activities.

I know you're on the edge of your seat wondering what's the one that they're not requiring, and it's the compliance review activity. So we're eager to hear your thoughts on why that might be and what, if anything, is there for us in terms of discussion around that topic.

Okay. Just quickly -- and Chris can jump in here if he wishes, of course, because I was not here. But to all of you and my predecessors, the study with Bailit Health took a look at four policy questions, which are listed here, which were basically around how do states implement the EQR requirements, how do states and CMS use the results to support oversight of managed care plans, and how useful -- not only transparent and accessible, but how useful are the EQR technical reports, all that data? How useful are they to various stakeholders?

And again, the last time that this topic was discussed at a Commission meeting was March of 2023.

Okay. So again, we had a number of findings that resulted from the report that Bailit Health finished, but there were really two major categories, if you will, of findings. So one of those was around implementation of the EQR requirements.

So the connection between what the EQR activities are evaluating and what states consider a priority in evaluating their plans don't always align, and there may be other areas where the states want to focus their interest and may already focus their interest, right, through reporting that's included in their reporting manual or, frankly, other activities that are required.

Second -- oh, sorry. And so we wanted to just have you think about this discussion question, but we'll put it up at the end and have our vice chair facilitate a discussion for us.

So the discussion question related to this group of findings is, how should the external quality review process fit in with other state and CMS oversight strategies and access and quality-related requirements that have been added under the 2024 managed care rule?

Okay. A second bucket of findings was around oversight and improvement, and so at every Commission meeting, I've heard some keywords that are applicable to this work, "transparency," "usability," "standardization," and all of those concepts are relevant to this work.

So the EQR focuses -- these activities focus

largely on process, validation, and compliance. Even the activities like performance measure validation are really looking at the systems that produce the data and is there statistical validity in those systems to be sure that the numbers are right as opposed to the outcomes themselves.

Next, what's the usefulness of the report contents to those various stakeholders? The contents of the EQR reports are challenging. We always want -- CMS always wants the states to have a lot of flexibility, but is there room in the discussion that we're going to have around standardization, executive summaries, et cetera, required information that we want to see so there can be some sort of comparison of these EQR technical reports across states?

And then also, the study found that the variation and the lack of clarity on how states take the information from the EQRO and how CMS takes the information when it comes up to them in the annual technical report and what actually happens to it, what comes of it.

Okay. So next steps. So we would like to get your feedback on these two buckets of findings. We would like to find out if there's anything else that you would

like us to dig into, any additional information needed, any additional stakeholders you'd like us to speak with, and then we wanted to let you know that external quality review and the findings from this study are going to be one component that we're incorporating into the managed care accountability project work that has just kicked off that Kate mentioned, which looks at a broad array of activities in contracts and RFPs and et cetera, both sanctions as well as incentives that states might use to hold managed care plans accountable.

So with that, I am going to turn it back over to our vice chair to facilitate what I hope is a robust discussion of these three discussion questions. Thank you.

VICE CHAIR DUNCAN: Thank you, Allison. Wonderful job in presenting to us the information and the questions or comments we have to help tee up the next direction of this.

So I open this up to my fellow Commissioners. Any questions or comments? While you think -- oh, I see Patti. Okay. Patti, go ahead.

COMMISSIONER KILLINGSWORTH: You had to know I would jump in.

So I do think we should look into the value of a more integrated approach so that it doesn't feel like all of these various pieces of quality are sort of happening somewhat in isolation of one another, right? And so I think that's worth exploring. Honestly, I think we would really want to talk to states about that and understand the implications of that and not just assume that that's a good idea, but it seems like it's a good idea.

So in my perfect world, there is this document that is available to people, to Medicaid beneficiaries and their families, that is meaningful to them. It's not just about process and compliance. It's about outcomes that really matter to them, and it's available to them in some sort of a standardized format that is easily understood, that they can actually use as a tool to help them in selecting health plans. That seems so reasonable to me.

I think, you know -- and it should look the same whether you're in Tennessee or Alaska so that, you know, everyone kind of has a level playing field in terms of some basic level information available to them to make decisions. So one, I just think that there needs to be something like that that makes quality information

available and accessible to people.

Beyond that, though, I do think there's value among state stakeholders, among federal stakeholders, and others at being able to look sort of across system at these broader measures of process and compliance. And so while never wanting to sort of take away a state's ability to identify particular quality goals and things that they want to focus on, there does need to be some basis for being able to compare performance short of just, you know, some of the -- HEDIS is certainly an area where we get to do that, but I think there's probably more than that where there would be value. These are sort of really big reports that are just very hard to digest, and so maybe there's a standard format for executive summary and then something that's really tailored to beneficiaries, specifically with measures that are meaningful to them.

VICE CHAIR DUNCAN: Thanks, Patti.

Tricia?

COMMISSIONER BROOKS: I'm not quite sure where to start. It is a very complicated topic.

I've done a good bit of work trying to educate the advocacy community about quality and how it fits into

their work, but it's just not very accessible.

I have done tons of scanning EQR reports when I can find them, looking for keywords that I'm interested in -- "maternal," "pediatric," "children" -- and sometimes you don't even find any of those words in the EQR reports. So I definitely think that the rule, the latest rule was a step in the right direction.

I liked your flowchart or the graphic there, except that the other piece that's missing there is your procurement, right? Like, your quality strategy should drive your procurement, and then when you procure, then it goes into the QAPI of what the managed care plan is going to do and what the PIPs are, you know, to the flow of the report.

So quality matters tremendously in making sure that we are spending our MCO dollars appropriately for the plans that are delivering quality, but if we can't get our arms around those pieces, it's really hard to get people engaged so that they are looking at improving quality.

So I definitely believe that some standardization -- I think you could look at the four mandatory requirements and see if there's some way that those could

be standardized for comparability across states.

I don't know how far you could go into the optional activities, but I do think some way of looking at that report and doing a template that states should follow, that EQR organizations should follow, so that we could take one and put them state by state and see where, in this state, there are opportunities for improvement, in this state, they're doing really well on these things. These are the models we should be looking at, so just anything we can do to make it more accessible to the Medicaid stakeholder community that when -- just like when you say technology and they're like, "Oh my God, I don't get into technology," you start talking quality strategy and that sort of thing, so that, you know, people really want to see the outcomes, but we need to be concerned about how we get from point A to point B to present those outcomes.

MS. REYNOLDS: Can I ask a follow-up question on your request for standardization regarding the four mandatory activities? Are you envisioning standardization in the execution of those activities, meaning the guidance that comes from CMS or the protocols being more prescriptive in terms of not just guidance, but this is

what you must do, and/or are you looking for standardization in the reporting that arises from those activities?

COMMISSIONER BROOKS: Both and both.

MS. REYNOLDS: Thank you.

VICE CHAIR DUNCAN: Thank you, Tricia.

Dennis?

COMMISSIONER HEAPHY: Thank you. I really appreciate all the comments that you made, Tricia, especially the comments were really helpful.

I think if there was any theme in your report, it was the ATR is really unhelpful to any stakeholders. So not much -- they are really not much of value, and so we need to start at that place.

But I think that for me, the issue that I always struggle with is looking at contract oversight versus quality of services, and we conflate contract oversight into quality, and so I don't see contract requirements have something completed in 90 days as a quality measure. I see that as a contract requirement.

Quality is really about access to services, like the number of denials, the number of appeals that are

overturned, you know, waiting times for specialists, care plan quality, care coordination quality. Like, those are things I think are what matter, and yet that information really isn't there for folks to -- either to themselves to choose a plan or for other folks to actually provide external pressure on the state or plans to -- or CMS to do more to improve the quality of the services that are being provided.

So I really think -- I thought it was interesting where states get along with -- what's the entities that do the state plan or the state -- I forget what it's called, but they get along really well. But that getting along really well does that lead to results in terms of the outcomes that are going to lead to real change and improvement of these plans.

MS. REYNOLDS: Are you referencing the relationship between the state Medicaid agency and the external quality review organization?

COMMISSIONER HEAPHY: Yes. Thank you.

MS. REYNOLDS: You're welcome.

COMMISSIONER HEAPHY: They get along really well. Well, that doesn't mean anything to me if the outcomes

aren't there, and so I would like to see a lot more emphasis on even the reports themselves that they put in plain language so they can be used, that they're actually usable for folks, and they not be hidden on the internet, but that states be required to put those reports, both the full report and plain language report on their websites, so people can easily access those reports. And they'd be put on those websites on a regular basis.

Probably give more information than you need, but I think it would be great to have a panel. I think someone mentioned that, but have a panel discussion with folks who are part of these plans but also some of the national advocacy groups, like maybe Justice in Aging or other folks as well. So yeah, I think we need to hear directly from folks about what they would like to see as the quality measures that matter to them and in choosing their plans. Thanks.

MS. REYNOLDS: Thank you.

VICE CHAIR DUNCAN: Thanks, Dennis.

All right, Heidi.

COMMISSIONER ALLEN: I really agree with what's been said, especially Dennis and Tricia.

And I think about, like, you know, as a parent who's trying to find a school for my high schooler, how easy it is for me to go to a website and see schools compared on a series of metrics that are important to parents, like the graduation rate, the percent that go to a four-year college, the number of students who feel safe in the school. You know, there's just a set of metrics, and I do look at them and I know other parents look at them to determine, you know, where to send our kids, in a school district that has choice, like we do in New York City.

And we're assuming that Medicaid enrollees do have choice, and I think if the question is, are these assessments useful in consumers making decisions, the answer is clearly no.

And I think that standardization is part of how you make that useful. If everybody is compared on different metrics, like, how do you even know what's important? And I don't know that the metrics totally align with what patients would consider important. So this does seem like a real opportunity for improvement.

But also, I do believe that this idea that consumers are ever going to be able to make a really

informed choice, I think we found that that's probably not true. People have a lot of demands for their time and attention. The idea that they can go and do 20 hours of research is not great, but they are used for public accountability. The variety of stakeholders that Tricia meant, advocates can go in that, and they can use that.

And then I wonder -- I'd like to understand more this idea of what happens when people aren't performing well, and what I hear, what I read in the report, it varies. Some people get a phone call. Some people go on a performance improvement plan. But I'd really like to know who successfully have created levers that are in response to this specific assessment to really drive MCO change. Like, are they the states that have random allocation into managed care, and then they say if you aren't performing appropriately, we will start sending people to other managed care companies? Like, is that the most powerful lever? Are there other levers? Do they ever really say we're not going to contract with you anymore? Like, does that ever even happen? And so do the MCOs take them seriously at all if they aren't performing? Is it just like a little haphazard whack-a-mole, like, okay, let's try

to get this metric, or does it ever really lead to profound organizational change in the way and really trying to address a problem? Because if it's not useful, then what's the point? That's my thinking.

MS. REYNOLDS: Just to make sure I made the point, we do have the managed care accountability work that has kicked off, and so a lot of what you just discussed is going to be included in that work, both sanctions, incentives, not only in the contracting, but also the procurement process.

COMMISSIONER ALLEN: Awesome. And is that going to be really integrated with this work so that we can see that connection? Because that would be amazing.

MS. REYNOLDS: It is in terms of the policy questions and sort of the methodology, and so external quality review and other oversight tools that states and CMS use. And so part of that is also to look at, you know, what role, if any, you know, in this discussion around flexibility and standardization, right, this secret perfect ground, and so that's what that's looking at. And of course, share any and all that you would like, because the work will be ongoing.

VICE CHAIR DUNCAN: Thank you, Heidi. Thank you, Allison.

Dennis, you have your hand back up?

COMMISSIONER HEAPHY: Yeah, thank you.

I wanted to talk about star ratings, because the star ratings right now are Medicare-focused and don't really touch on access to HCBS and other community services, and so it would be really helpful to see something about what states could, should be doing on the Medicaid side, that there's some sort of maybe standard, and then a good standard across states in terms of the star ratings. But also, they can create their own star ratings as well in addition. So someone can go directly to a website and see what the star ratings are for those different --

MR. PARK: Yeah. So, Dennis, I just wanted to kind of reflect back to the managed care rule, and there is a requirement for states to implement this quality rating system that will be somewhat standardized in terms of there will be a certain number of mandatory measures. And I think there are a couple of like HCBS measures that could -- you know, the goal is to kind of function like the star

ratings of Medicare, where there will be some comparability, you know, across those measures.

Individuals are supposed to be able to kind of put in some of their own characteristics, like, you know, what drugs they're taking, you know, and find out, you know, which plans may be better suited for them.

It will take a few years for all those requirements to go into place, but there is something that will address that in the managed care rules.

COMMISSIONER HEAPHY: Thanks.

VICE CHAIR DUNCAN: Thanks, Chris. Thanks, Dennis.

Carolyn?

COMMISSIONER INGRAM: Yeah. Similar to, I think, something that some of my colleagues brought up earlier, but just it would be helpful to see how much the EQRO information is being shared on websites at state with Medicaid advisory committees, when they come out with legislative bodies. So getting some feedback from states about how they actually use it in their process around transparency and how it's being distributed would be helpful. Thank you.

MS. REYNOLDS: Thank you.

VICE CHAIR DUNCAN: Thanks, Carolyn.

Jami?

COMMISSIONER SNYDER: I know you mentioned it earlier during our presentation, but I would be really interested in hearing more from states on the work that they're doing to better connect their quality strategy to the work of the EQRO as well as connect their compliance activity to the findings that are detailed in EQRO reports.

VICE CHAIR DUNCAN: Thanks, Jami.

Dennis.

COMMISSIONER HEAPHY: This might be a little bit difficult, but in a lot of states, there's a too-big-to-fail issue, and so are states reluctant to actually push against the plans to try to improve the quality if the plan is the only one in the state or if there are only two in the state? Like, how much hardball is taking place? I don't know how to phrase that in a way that -- it would be helpful to ask states what kind of barriers they face to moving the needle on quality and with plans and that's transparent. I don't know. It just seems to be -- it's very difficult for states to push back on plans when

they're the only way to get health care to these populations.

COMMISSIONER INGRAM: That's a really good point, Dennis.

VICE CHAIR DUNCAN: Thank you.

Allison, I think you had a lot of discussion. I want to end on -- because a couple of questions I see about this. One, I think the focus should be on outcomes, and Tricia used a word about "accessibility." I want to use a word called "digestibility." Heidi touched on a little bit. How do you understand what that is?

But to the question around standardize and track consistently, I think that is critical. Patti touched on if you're in Tennessee versus Alaska. I think we need to be able to knit together from state to state the outcomes, because you see so many of the players in multiple states, and is there consistency across the country in developing these outcomes so that we are getting the maximum usage out of our Medicaid dollars via access or via outcomes? So anything we can do to standardize and create that continuity and consistency in the EQR reporting, I think, would be instrumental in saying, "Yeah, we've got this

right," or "No, here's room for improvement." But to the point made, a beneficiary can look and see and make a judgment call based on what their needs are off of that report.

I think this is great work.

MS. REYNOLDS: May I ask the Vice Chair and the Executive Director just to add a little bit of specificity and what they believe the Commission's desired next steps are?

EXECUTIVE DIRECTOR MASSEY: Sure, Allison. So we'll take the feedback and likely return to the Commission after we have an opportunity to digest.

MS. REYNOLDS: Okay. Thank you so much.

VICE CHAIR DUNCAN: I was going to say I think there was so much feedback. It's kind of like a stew. So right now, you've got to stir it and see what the right ingredients are going to be for us to work from.

Any other comments or questions?

Yes, John.

COMMISSIONER McCARTHY: Because this one is so big and back to what you were saying, I think one of the things for our recommendations that we'll need to be

thinking about is, what is the purpose of these reports? Because what you just talked about is not what that report is for right now. So I think that -- I mean, the report is for a person -- like, I used -- as a Medicaid director, I am looking at my plans, and it is very detailed. I get it. States do them all different, but it's for that purpose. It's not for somebody deciding which plan I should pick. You use the EQRO. So I think that's one of those things that would be great to dig into.

And one of our recommendations may be maybe we have to have two separate reports for those things to be able to get to some of those different pieces, or maybe we don't. I don't know. But I just wanted to bring that topic up. I think that's a little bit of, Allison, when asking where to go and I was thinking about that.

MR. PARK: Yeah, John. And that kind of fits into this, the first discussion question that we posed, that, you know, there's the EQR process and report, but then there's these other new requirements that were put into place with the managed care rule of, like, minimum wait time standards. You know, there's a secret shopper survey. And so what is the -- and the quality rating

system. And so what is the role of the EQR now with all these other components that are assessing, you know, plan quality and access? And so, you know, that's not something we can necessarily answer today or, you know, we may need to do more work, but that is something I think we would be interested in hearing from the Commission if you do have certain thoughts or, you know, priorities where you think EQR should be, you know -- be used for one thing, but these other, you know, systems and policies are used for another thing.

VICE CHAIR DUNCAN: Thank you, Chris.

Carolyn.

COMMISSIONER INGRAM: Yeah. Similarly, somebody made a comment about looking at can the EQRO, you know, be compared across multiple states when you have a health plan operating in many states. Similar to John's comment, that's not what they're for. I wouldn't want to compare EQR results in New Mexico, for example, where we have large, vast deserts with no providers and culturally diverse populations who don't access care the same way they do in other states, and then compare that to the work in New York by the same health plan. It's apples and kumquats

or something or basketballs.

I want us to keep in mind that that's not the purpose of those reports. It is important, I think, for our transparency, and that's why I brought up the comment I did about inside the state, where are these shared? Are they shared back with Medicaid advisory committees, legislative bodies, stakeholders? But comparing them nationally and comparing a health plan, you know, I think that's the fall-down of stars, frankly, and it doesn't recognize the diverse populations in that state and the cultural needs of that population and the rural and frontier nature of how people access care in certain states versus others. So I wouldn't want us to get sucked up into that in looking at this. So thank you.

VICE CHAIR DUNCAN: Thank you, Carolyn.

Tricia.

COMMISSIONER BROOKS: So I agree with John to make the distinction that the EQR reports are more of a state document to have oversight on managed care and not necessarily, you know, for the consumer.

I still think that there are certain aspects of the EQR reports that can be standardized, like network

adequacy, right? Don't we want to compare network adequacy across states, across plans, across states? I mean, you know, looking at does XYZ managed care plan in New Mexico look like the same plan in New York? Are they providing the same level of care? Just to identify areas where there should be focus on potential opportunities for improvement.

But I still want to get back to Heidi's point that to what extent are states using the outcomes of these EQR reports along with the quality measures to actually drive change in managed care, right? I mean, isn't that the goal to make sure that the managed care plans are delivering quality services, identifying those that do really well, learning from them, adopting those best practices across the board, and getting rid of plans that are underperformers?

So I don't think that the rest of the quality strategy negates needing something like EQR reports, and I just think that we have to do more to make them be used for the purposes that they're intended.

So Carolyn's comments about how do they share them, you know, do they just say here they are, they're posted, good luck? Do they do presentations on that? I

think those sorts of things would be helpful.

VICE CHAIR DUNCAN: Thanks, Tricia.

Mike?

COMMISSIONER NARDONE: Oh, in my role as Medicaid director, I look at many EQR reports, and I totally agree they're often very inaccessible even to Medicaid directors in terms of what's contained in them. So I think, you know, to -- I think where I tend to come down on this is I agree with Carolyn. I'm not sure, you know, the cross-comparisons around states. I see them more as a value document in terms of how do we better manage the plans at the state level, and I think making that information accessible to people is really important.

So I think that's kind of a theme that I keep hearing, and I don't know if standardization is the way. I mean, standardization may be the way to get at that, but I do think the important point, as to what Heidi said, is how are states using that information?

I come from a state that I would like to think we were fairly robust in terms of how we manage the managed care plans, and I think part of -- I hope this accountability work is to maybe understand that a little

bit better. I mean, in my state, the EQRO was one of the tools we used, right, along with a host of other tools in terms of working with the managed care plans to achieve the results we wanted to try to achieve, but I think maybe kind of understanding that a little better across states would be particularly helpful and where EQR kind of fits into that.

VICE CHAIR DUNCAN: Thank you, sir.

All right. Allison, great job on your first panel.

MS. REYNOLDS: Thank you.

VICE CHAIR DUNCAN: Chris, thank you.

Next, we have Melissa and Melinda coming up for introduction to work on justice-involved youth.

Oh, time for public comment and a break. Okay. Trying to get us through. All right, I apologize. Let's go to public comment. So, we'll open it up, and again, remember, introduce yourself, the organization you're with, and keep your comments to three minutes or less.

Anyone in the public want to comment on the conversations this morning?

PUBLIC COMMENT

* [No response.]

VICE CHAIR DUNCAN: Going once, twice, sold.

So we'll take a break and return at eleven o'clock. Thank you.

* [Recess.]

VICE CHAIR DUNCAN: Thank you. Welcome back. We've got Melinda and Melissa joining us, and so I will turn it over to you ladies.

INTRODUCTION TO WORK ON JUSTICE-INVOLVED YOUTH

* MS. SCHOBER: Good morning again. Today we'll be introducing our work on Medicaid coverage and care for justice-involved youth. This presentation will include background information on the use of Medicaid funds for health care services during incarceration and recent policy developments. My colleague, Melinda, will provide a review of prior MACPAC work on justice-involved adults. This will be followed by findings from a review of the literature on the health needs of justice-involved youth, before concluding with next steps.

Federal law prohibits the use of Medicaid funds for health care services for Medicaid enrollees when they are inmates of public institutions, except in cases of

inpatient care lasting 24 hours or more. This prohibition is commonly referred as the inmate payment exclusion, and it applies to adults as well as children and youth.

While Medicaid's role in covering services for incarcerated individuals is limited, it is an important source of coverage for eligible individuals released into the community. However, Medicaid-eligible individuals, including youth, face barriers in accessing care during and after incarceration. Data sharing between carceral health systems, state agencies such as child welfare and community providers, is limited and contributes to discontinuity of care.

States have reported challenges in ensuring access to Medicaid coverage for adults in jail awaiting trial, as average lengths of stay are short and individuals may be released without advanced notice.

Similar challenges exist for youth. Most juvenile commitments are for an indefinite term that permits the youth to be held until they are 18 or 21, to meet goals specified in their placement and rehabilitative plan.

There have been several recent federal policy

changes designed to improve health care transitions for incarcerated adults and youth.

The SUPPORT Act requires states to suspend, rather than terminate, Medicaid coverage for eligible juveniles who become inmates of public institutions. The SUPPORT Act also requires states to redetermine eligibility for youth for whom Medicaid has been suspended prior to the youth's release and to restore coverage upon the youth's release. Beginning in 2026, the 2024 Consolidated Appropriations Act will require states to suspend rather than terminate coverage for adults.

The SUPPORT Act also required the Secretary of Health and Human Services to issue guidance on Section 1115 demonstration opportunities to improve care transitions for Medicaid-eligible individuals leaving incarceration. Guidance issued by CMS in April 2023 described how states can receive federal financial participation, or FFP, for pre-release services furnished to adults and youth for up to 90 days prior to their release. A number of states have pursued the Section 1115 demonstration opportunity, and we will discuss that later in this presentation.

The 2023 Consolidated Appropriations Act requires

state Medicaid and Children's Health Insurance Program, or CHIP, programs, beginning in 2025, to provide certain screenings and diagnostic services to eligible youth in public institutions in the 30 days prior to release. States must also provide Medicaid-eligible youth targeted case management services in the 30 days prior to release and for at least 30 days thereafter. States can receive FFP for these services.

Beginning in 2025, the 2023 CAA also provides states the option to receive FFP for Medicaid- and CHIP-covered services provided to eligible youth held in public institutions prior to being adjudicated in a delinquency hearing.

In July 2024, CMS released guidance on these requirements. The guidance noted that states must provide any screenings and diagnostic services in accordance with the Early and Periodic Screening, Diagnostic, and Treatment requirements. Targeted case management services must include a comprehensive assessment of individual needs, the development a person-centered care plan, and monitoring and follow-up activities to ensure that the care plan is effectively implemented and adequately addresses identified

needs.

I will now turn it over to my colleague, Melinda, to discuss prior work on justice-involved adults.

* MS. ROACH: Thank you, Melissa, and good morning, Commissioners. We thought it would be helpful to recap the Commission's June 2023 chapter on adults leaving incarceration, since it helped spur the work on children and youth that Melissa will be discussing today and in future sessions.

Some of the considerations highlighted in that chapter around efforts to improve transitions for justice-involved adults are also relevant when thinking about certain efforts specific to children and youth.

Adults in the criminal justice system include those in jail awaiting sentencing or serving shorter sentences, adults in federal and state prisons and individuals under community supervision. Justice-involved adults are disproportionately low income and people of color. They also report high rates of behavioral and physical health conditions, trauma, and disability, and experience an elevated risk of death after release from incarceration.

The chapter described state-funded efforts to expedite Medicaid enrollment and to provide in-reach services to adults leaving incarceration and how those efforts are often limited by the inmate payment exclusion. Increasingly, states are pursuing Section 1115 demonstrations that allow them to use Medicaid funds for services provided to eligible individuals, adults and youth, in many states, and in many instances, as well.

States can receive federal matching funds for services provided up to 90 days before release, and must cover a minimum set of services that include case management, medication-assisted treatment for all types of substance use disorders, and a 30-day supply of prescription medications provided upon release. And states are doing that under the CMS guidance that was released in April of 2023.

The Commission's chapter was published not long after CMS released that guidance and approved the first demonstration in California. California is now one of 11 states with approved demonstrations, and there are 13 more states with applications pending CMS approval.

The chapter discusses considerations for

implementing pre-release services. Coordination between state Medicaid agencies and correctional authorities overseeing facilities where pre-release services will be provided is essential. Early engagement of state and local corrections leaders can help states anticipate and overcome operational challenges as they begin implementation. Determining how to operationalize Medicaid-covered services before release may be particularly challenging in jails, where individuals awaiting trial may be released without advanced notice and lengths of stay are often short.

The chapter also underscores the need for Medicaid and correctional authorities to have systems that support the timely exchange of relevant information, such as release dates and eligibility status, and the difficulty of establishing and enhancing those systems. Improving data-sharing between correctional and community providers is also needed to promote care coordination and continuity as individuals leave incarceration.

The chapter discusses considerations related to the types of providers delivering pre-release services, whether they be community or carceral providers, and the important role that peer support specialists can play in

engaging patients and connecting them to care.

The last consideration discussed relates to the importance of monitoring and evaluation, particularly given the unprecedented nature of these demonstrations and the significant needs of the populations affected.

And I will turn it back over to Melissa.

MS. SCHOBER: Thank you. In 2021, the most common placement settings for justice-involved youth were detention centers, long-term secure facilities, and residential treatment centers. Detention centers are typically short-term facilities where youth are held pending disposition of charges or awaiting final placement. Long-term secure facilities are settings where youth are typically confined for several months or more, and residential treatment centers are facilities that focus on providing treatment services to youth with significant behavioral health needs.

Over the past two decades, the number of youth under 21 held pre-trial, pending placement, or committed to youth facilities has declined. Some of the recent declines may be related to the COVID-19 pandemic when arrest rates dropped and states sought to reduce the use of correctional

and other congregate care settings.

Youth of color are overrepresented in all types of carceral settings. Detention rates for Black, American Indian/Alaska Native, and Hispanic youth remain higher than for white youth. An analysis of 2020 case processing data found that Black male youth had nearly three times the referral rate to juvenile court by law enforcement following arrest than white males.

Although the detention rate for all racial and ethnic groups has declined since 2010, the detention rate for Black youth was more than six times higher than the rate for white youth, and the rate for American Indian/Alaska Native youth was almost five times that of white youth.

Apart from racial and ethnic disparities, the literature review found that Lesbian, gay, bisexual, transgender, and queer youth are overrepresented in detention and other carceral settings, likely as a result of increased contact with law enforcement related to homelessness or status offenses such as running away.

As with adults, justice-involved youth have high rates of unmet physical health needs and higher mortality

rates. The majority of youth in carceral settings have behavioral health needs. Studies found between 40 and 70 percent of incarcerated youth meet the criteria for having at least one behavioral health disorder compared to 20 percent of youth in the general population. An estimated 60 percent of youth in juvenile facilities met the criteria for substance use disorder in the 12 months before entering custody, while more than a third met the criteria for alcohol use disorder.

During this meeting, we welcome your questions regarding adults and youth in the criminal justice system. Your feedback on the juvenile justice work presented thus far would be especially useful, as would your thoughts on potential opportunities and challenges associated with implementing mandatory pre- and post-release screening, diagnostic, and targeted case management services for justice-involved youth.

We will return at a future meeting to present findings from the interviews and will continue monitoring state and federal activity related to justice-involved individuals. Thank you.

VICE CHAIR DUNCAN: Thank you. So I'll open it

up to the Commissioners as we embark on this work. Points of interest as the team looks through this? Angelo.

COMMISSIONER GIARDINO: First, I wanted to thank you both. When you did the adult work, you promised that you could bring the youth-related work back, and I appreciate that.

This is such a high-risk, vulnerable population, which frankly, to many in the public, is a very unattractive group because they're demonized and seen as delinquents. You know, in my conversations with people in the public a lot of times these kids are seen as getting what they deserve. So I'm really glad that we're highlighting their needs.

And I would request the following. Since so many of them are victims of some form of trauma in their lives I think a guiding principle here should be what trauma-informed care would say would be an idea rehabilitation program. Because as I understand justice-involved youth, while there is a punishment element involved it's really oriented towards rehabilitation and the reduction of recidivism. So think trauma-informed principles would say that fragmentation in their care plan, pre and post

incarceration, would be really important to keep at a minimum.

So if you could help us access the experts in this field who could provide the evidence around the need for continuity of care in a care plan and how destructive it is for these kids to have different care providers, to feel that nobody is in their corner, I think it would be really important to focus on continuity of care and how our policy could assure that.

So again, thank you for taking this work on.

VICE CHAIR DUNCAN: Thank you, Angelo. Tricia.

COMMISSIONER BROOKS: Yes, I totally agree with those comments. Since the provision went into effect on doing the screenings 30 days prior to release, it would be helpful, I think, to monitor states so that we can identify best practices. You know, are states getting on top of this? Are they already doing it? How are they doing it? What can we learn from that?

I also would like to better understand the intersection between juvenile justice kids and those that would qualify as former foster youth. You know, what's the overlap with foster youth and juveniles in detention or

incarcerated, and are we doing a good job of making sure that we get them enrolled in former foster care, which covers these youth up to age 26. Thank you.

VICE CHAIR DUNCAN: Thank you, Tricia. Carolyn.

COMMISSIONER INGRAM: So this is, I think, exciting that we're taking this on. There have been states that have been doing some of this work before all of the regulations came out, or managed care companies that have. So I think somebody said best practices. I'd call some of them innovations. But what are organizations doing to make sure that prescriptions get delivered, are appropriately ready the minute the person comes out of the facility, if that's what's needed, what types of agreements are in place to allow people to come into the facilities, to be able to help work with the kids before they have to go out and exit. There have to be certain agreements in place. You can't just send in case management teams and show up and say, "Hey, we're here to help." You have to have those legal documents in place. And so it would be good to see what types of best practices are out there in terms of agreements that states could share.

What is being done, again, around the culturally

appropriate care as somebody comes out of these facilities, in terms of getting them back into the community in an appropriate setting for them.

And I think then the follow-up after -- and again, in a lot of communities we just talked about how we don't have great facilities for treatment for children. So what are we doing, or what are states doing in terms of communities where that isn't available. How are they getting treatment for the kids back in the communities where they live if the services aren't there in some capacity? Are there some innovative ways that they're doing that? Is it through televisits? How are they going back and checking in terms of the follow-up to make sure that outcome is there and that recidivism doesn't happen.

And I'll pause there. I think that's a good list to give you. I'll reserve my right to come back and let some of the other people go. Thank you.

VICE CHAIR DUNCAN: Thank you, Carolyn. Adrienne.

COMMISSIONER McFADDEN: Melissa and Melinda, thank you so much for this background and introduction. I think it's a really important topic. I think I have more

of a supportive comment, in that I think this work is going to be extremely important over the course of the next time period and time frame.

I agree with Angelo's comments. I do think that from my experience we tend to sacrifice physical and mental rehabilitation for the social rehabilitation because the correctional health care system is more poised to provide episodic care versus sort of continuity of care and continual longitudinal health care services.

I do believe that particularly for this population, a disruption of care can be detrimental to their continued pursuit of health, and I think this will continue to be an important topic that you need to learn from not only best practices of states that are doing this but maybe best practices in other populations. You mentioned peer support, which is wonderful. I think there is also maybe some value to looking at some of these centering models that we've used a bunch in pregnancy, that maybe could be applied to some of these juvenile-involved youth, as well.

VICE CHAIR DUNCAN: Thank you, Adrienne. John.

COMMISSIONER McCARTHY: I just want to say this

work that states are going to start doing around juveniles is super hard. I mean, it is probably one of the hardest things that states are taking on. I mean, duals work, when I was talking about that, it was super hard. This is really hard because there are so many new requirements, and there are things that the systems just don't know or talk about. And I know we're talking about juveniles, and we started with adults also.

And just, for instance, when a person is being released -- so this issue around we have to give somebody services 30 days prior to release, well, that release day may all of a sudden show up tomorrow. And they didn't get services 30 days before because they didn't know that. So there's a little bit of like how are some of these rules going to be enforced.

As a policymaking entity, what I would really like us to look at is when we're talking to states about this, Trish used the word "monitor." I don't like using that word, "monitor." I don't think that's our role is to monitor but it's to make policy decisions. So it's what are those barriers that states are running into so we can find out, to be able to make recommendations that say here

are things that need to be changed going forward. I don't know what those are, and I think states are going to be discovering those as they go along.

And this is somebody who did this for adults before I left, in Ohio, and we only could do it in prisons because it was so hard to do. We weren't enrolling them early. We were just getting them set so the day they left they were enrolled in Medicaid.

But this is really, really difficult work. It's good work. I'm not saying that it shouldn't be done. It's just very difficult, and I just want to find out what are those barriers that they're going to be running into and what needs to be changed. And just even on data and HIPAA pieces, and like with schools and you can't exchange data. Like what are all those things that they're running into that we can make recommendations if there needs to be rules or law changes going forward on these things.

VICE CHAIR DUNCAN: Thank you, John. Dennis.

COMMISSIONER HEAPHY: Thank you. I would support the HCBS for BH folks or LTSS needs. So when folks are transitioning out of their institutions, they can actually access these services.

And also, I think it's really important that so many folks are diagnosed with autism or learning disabilities, once they're in the criminal justice system. I agree with John and other things, Adrienne and other folks, about the importance of care coordination and care planning and the continuity of care planning. Because someone may be out for a certain period of time and then back in for a certain period of time. But as long as knowing that someone is going to be out there and the care plan is still in place, I think is huge.

And so how do we use health care as a means of reducing folks going back into the system? Because I think what someone discovers if they have a learning disability or they're autistic, they could change the trajectory of their lives and get the services they actually need so they won't be returning back. I think looking at the requirements of the plans in terms of providing continuity of care and understanding what the exact needs are of these populations, particularly people of color.

VICE CHAIR DUNCAN: Thank you, Dennis. Jami.

COMMISSIONER SNYDER: Yeah, thank you so much for bringing this work forward. I think it's critically

important. And I just really want to echo John's sentiments around sort of the operational challenges associated with this work, and I would love to hear more from states about some of those challenges because I think it could inform some of our policy discussion in this area.

In particular, I will say in my role as director in two states, the issue of data exchange and communication protocols and establishing protocols that really worked and that both sides of the equation maintained, that was really, really critical to ensuring that the states I served in were successful in coordinating care for both adults and youth as they transitioned out of correctional settings.

VICE CHAIR DUNCAN: Thank you, Jami. Heidi.

COMMISSIONER ALLEN: Yes, thank you so much for this work. I've been thinking about the vulnerability of the population and thinking about while there are similarities between all of these conversations that we're having about adults, if we can, in as much as possible, try to think of young people as different.

And one of the ways I think they may be different is that the people who are Medicaid eligible who are

entered into these systems are likely to also be Medicaid eligible in 15 years, in 20 years. You know, these are low-income populations with a lot of behavioral health care needs, that leads to comorbid physical health care needs as they age, higher prevalence of substance use disorders. And this would be a real opportunity for Medicaid to think of an ounce of prevention is worth a pound of cure.

And one way that I am just curious is if there would be any appetite to think about making recommendations to Congress that for young people that they amend Section 1904(a)31(A) to allow young people to continue to have Medicaid while they're incarcerated, and whether or not that might be an avenue for bringing more resources into the criminal justice system to truly support the mental health needs of young people.

One way to start would be to estimate just how many justice-involved youth are Medicaid eligible, to get a kind of percentage of what we're talking about here. I don't know if it's possible, and I know that there's very little appetite for doing this with adults, but what we seem to be doing is around the margins, trying to make changes towards that. So it's like, okay, now we'll

consider 30 days before they leave, or maybe 90 days before they leave.

And we're bringing it in, but maybe this is a population that we need to consider really bringing it in, and not having the discontinuity of coverage that people experience when they come in, and really having the Medicaid agencies be able to reduce some of the administrative barriers and truly partner with making sure that when kids go to the criminal justice system that there is no discontinuity of their mental health or physical health care.

It might be like a total pipe dream. I recognize that. But I wanted to put that on the table, just to see if anybody thought that it would ever be a possibility. We are able to ask Congress to make these changes. That's what Congress does. What do you all think?

VICE CHAIR DUNCAN: Any comments?

MS. MCFADDEN: Heidi, I would stand beside you in that dream. I certainly think that would be helpful in the continuity to be able to just have them be continuously enrolled.

VICE CHAIR DUNCAN: Angelo.

COMMISSIONER GIARDINO: Yeah. Well, I'm going to invest in hope, as well, Heidi. You know, I think if the evidence -- and again, we have a lot of experts in this great nation of ours, so if that's what's going to help these kids achieve some level of health through their life course we should advocate for that. And I think that's entirely consistent with the Medicaid program and its guiding principles. So I would support that idea.

And I would just also ask, as you're looking at this, you know, we've heard a lot about how hard it is to do this, and I'm sure it is. But I'd also like to understand the opportunity for harmonization of HIPAA, FERPA, juvenile justice. Again, we are the government, so we have those rules for very specific reasons. And if there's a policy reason to harmonize those so that there aren't artificial barriers, the entity called the Congress can harmonize those, because those are all laws, and they make the laws. So if we need to have a recommendation around how to harmonize things so that it's not a nightmare every day that you go to work, I think that would be in our purview, as well.

VICE CHAIR DUNCAN: Thank you, Angelo. Dennis.

COMMISSIONER HEAPHY: I think it would be really beneficial to have folks who have benefitted from these services present to us, and their families, as well. I think it would be really eye-opening for us to hear from them.

VICE CHAIR DUNCAN: Thank you, Dennis. John.

COMMISSIONER McCARTHY: I think to what Heidi said it would be something to look at, but one of the issues, coming from the state side on this one, is when Medicaid expands, the states then pick up costs, which they may not have been before. Or in this scenario it might be different because they were paying for all of it before, so now the feds are picking up some of it.

So I think those are the things to be thinking about as a policy decision that we would be looking at, is what is the net impact, both at the federal level and at the state level, to make a decision on some of those different pieces.

VICE CHAIR DUNCAN: Thank you, John. Melinda, Melissa, do you feel like you got some clarity on the next steps?

MS. SCHOBER: I do. Thank you.

VICE CHAIR DUNCAN: Thank you very much.

All right. We'll head into our last session. Asher and Chris will talk to us about themes from the hospital payment index technical expert panel.

[Pause.]

VICE CHAIR DUNCAN: And, Asher, welcome to your first panel to be presenting. It's nice to have you.

THEMES FROM HOSPITAL PAYMENT INDEX TECHNICAL EXPERT PANEL (TEP)

* MR. WANG: Good morning, Commissioners. Today we'll be presenting our findings from a technical expert panel that we held earlier this June. The panel discussed ways to update a hospital payment index that would compare Medicaid payments across states and with Medicare.

I'll begin with some background information on Medicaid hospital payments, followed by a summary of our previous hospital payment index that we constructed back in 2017. I'll then discuss some key themes from the technical expert panel and conclude with our next steps.

To give some background information, Medicaid payments to hospitals consist primarily of base and supplemental payments, and states have a lot of flexibility

in deciding how they pay hospitals. Base payments are tied to specific services, while supplemental payments are typically paid out as lump sums over a fixed period of time. Looking at fee-for-service base payments alone, Medicaid-based payments tend to be lower than Medicare, and they may also be lower than the actual cost of providing these services. So states will often provide supplemental payments in addition to base payments, and there are multiple types of supplemental payments that address different goals.

Disproportionate share hospital payments, or DSH payments, help cover the unpaid cost of care for Medicaid patients and uninsured patients.

Upper payment limit, or UPL supplemental payments, can fund for services provided through fee-for-service for Medicaid patients, and states can use Section 1115 demonstrations to create uncompensated care pool payments for managed care and uninsured patients.

In recent years, CMS has encouraged states to use directed payments. This is an option created in 2016 that allows states to direct managed care plans to make specific payments for providers. Many states have used directed

payments to make uniform rate increases to help offset the Medicaid shortfall, similar to fee-for-service supplemental payments.

And as the chart above demonstrates, Medicaid supplemental payments are a large share of Medicaid payments to hospitals. In 2022, we found that supplemental payments accounted for more than half of fee-for-service payments to hospitals, and directed payments also accounted for around one-third of managed care payments.

State financing methods also affect net Medicaid payments to hospitals. Medicaid is jointly funded by the federal government and states, and states can finance their non-federal share through state general funds and other sources, including provider taxes; intergovernmental transfers, or IGTs; and certified public expenditures from local governments, typically through public hospitals.

Supplemental payments tend to be made to providers that contribute to the non-federal share. The GAO estimated that in 2018, provider contributions and local governments funded the majority of DSH supplemental payments and nearly half of non-DSH supplemental payments.

Because of this cost of provider taxes and IGTs,

the net payment that hospitals receive may still be less than the sum of base and supplemental payments.

To provide an overview of our previous index, in 2017, we had previously created a fee-for-service hospital payment index that compared Medicaid payments for inpatient hospital stays across states and with Medicare.

The previous index had used 2010 Medicaid Analytic eXtract Claims data, which has since then been updated to the Transformed Medicaid Statistical Information System, or T-MSIS. We adjusted for differences in wage levels and case-mix variations across different states, and we found that Medicaid inpatient fee-for-service hospital payments varied widely across states, ranging from 49 percent to 169 percent of the national average.

We also found that there was variation within states because states may assign different base rates or different payment methods for different hospitals.

After adjusting for supplemental payments and provider contributions, Medicaid payment was comparable to or higher than Medicare. We found that the average Medicaid payment for our 18 selected conditions was, on average, 6 percent higher than Medicare.

Now we'll move on to discuss some themes from the technical expert panel. Earlier in June, we convened a technical expert panel to help update the payment index and discuss ways to incorporate outpatient stays and managed care encounters. The panel included experts in Medicaid and Medicare payment policies, including representatives from federal and state government, hospitals, consultants, and researchers. We identified a number of key themes from the panel, which we'll review in more detail in the following slides.

Since the last payment index, the T-MSIS Analytic File dataset, or TAF, has become the most complete dataset available for Medicaid hospital base payments at both the provider and beneficiary levels.

We conducted internal data validation exercises to assess the reliability of TAF, and we found that the distribution of stays and visits were reasonable and that spending on base payments was comparable to CMS-64 benchmarks. TAF data was also robust for inpatient hospital claims, but the data quality suffered for outpatient claims. We found that about one-third of the outpatient claims were missing HCPCS procedure codes, which

are needed to do accurate case-mix adjustments.

In addition, we found that a large portion of supplemental payment data was either incomplete or unclear compared to CMS-64.

Given these data limitations in TAF, we're considering using other data sources to get outpatient and supplemental payment data. CMS-64 has data on DSH supplemental payments, which is what we previously used in our past payment index, but this information is only available at the state level. Public DSH audits have provider-level DSH supplemental payment data, but the most recent DSH audit available is from 2019 and is lagged by several years.

For non-DSH supplemental payments, we have the newly available Supplemental Payment Validation, or SPV dataset, which contains provider-level data.

We can also use directed payment preprints to estimate the amount of directed payments made to providers. However, in these preprints, states only report projected spending estimates and not the actual final spending amounts. The preprints also do not report spending at an individual provider level.

Finally, we can also look at hospital cost reports to do facility-level analyses, but the hospital cost reports may not be accurate for all hospitals, like children's hospitals.

Another key theme of the discussion focused on methods for calculating the index. The participants acknowledged that an overall payment index would be useful, but because of variations in data quality, the participants suggested conducting the analysis at a more granular level, for example, by breaking down separate payment index components for inpatient versus outpatient claims and fee-for-service versus Medicare payments. This would also allow for different methods to account for varying data quality across different data sources.

To address missing outpatient procedure codes in the outpatient data, the participants suggested focusing on states with high-quality data and using payment-to-cost ratios from hospital cost reports to assess the percent of outpatient hospital costs covered.

In light of these data issues, the participants still agreed that we should try to build a payment index that includes all states and includes outpatient hospital

stays because of their impact on hospital payments.

We also discussed different ways to address outlier payments. Participants wanted to keep the top percentage of payments in the dataset because they could represent legitimate high-cost stays like NICU stays or transplants. Some participants also suggested identifying outliers based on the average daily cost rather than trimming the top percentage of total dollars, while emphasizing that outliers should still be validated for accuracy before we include or exclude them from the index.

The participants also offered different suggestions for adjusting for differences in wage levels and case mix. Our previous index had used wage factors from the Medicare Acute Inpatient Prospective Payment System, but participants suggested using the pre-floor, pre-reclassification wage index because the final wage index that we previously used may not reflect true wage differences across states.

It was also suggested to use the APR-DRG relative weights to adjust for case-mix variations since it would be simpler than using a regression analysis to calculate our own weights.

Including managed care payments is also a challenge due to the lack of directed payment data. As I mentioned earlier, directed payment preprint data do not report actual final spending, and it may only be available at the provider class level. Not all directed payment preprints require a submission either if they are fee schedules set at state plan rates.

States also vary in how they report directed payment spending. For example, some states might capture certain directed payments like base rate adjustments in T-MSIS encounter data, while other lump-sum directed payments may not be reported in claims and would need to be added in from preprint estimates.

Adjusting for supplemental payments and provider financing is also another critical step. The participants encouraged adjusting for supplemental payments at the provider level using the new SPV dataset rather than assuming an equal average spread across all providers.

The previous index, which only had supplemental payment data at the state level, had varying results depending on the type of allocation method for supplemental payments, but now we have the new provider-level data from

the SPV dataset that can help make more accurate allocations across providers.

Allocating at the provider level could also reflect how states might pay more supplemental payments toward specific hospitals and services, like public hospitals or labor and delivery services.

It's also challenging to account for provider financing because states do not consistently report their sources of funding. To get provider financing data, the participants suggested using directed payment preprints, which contain some information on the type of financing source, but not all details on the amount of provider contributions.

The GAO also released a report in 2020 that surveyed states' financing methods from 2018, and although the report had used broad categories to assess financing methods, it's still the best source of information for provider contributions to state financing.

Another important factor to consider is also that funds from provider contributions may not necessarily go towards hospital payments. So we may need to net out the dollars that do not go back towards these providers.

In order to benchmark Medicaid hospital payments against Medicare, the 2017 payment index had previously compared payments across 18 MS-DRGs that were high volume for both Medicaid and Medicare.

For the updated index, participants were interested in incorporating services covered primarily by Medicaid, like pediatrics, labor and delivery, and behavioral health services, but in these cases, Medicare may not be the most appropriate benchmark.

Hospitals that provide fewer Medicare services, like children's hospitals, should also be benchmarked separately from general acute hospitals because of their unique patient mix.

We can also differentiate hospitals based on their facility characteristics, like urban versus rural, and participants suggested using payment-to-cost ratios from Medicare hospital cost reports to compare payments, since states will often use payment-to-cost ratios as a benchmark when rate-setting.

We also discussed different uses for the payment index. Representatives from hospital associations were particularly interested in understanding how hospital

payment rates vary at the provider level across states, especially for supplemental payments.

State Medicaid representatives said that the payment index could help inform Medicaid budgets, pricing, and aligning payment rates, and even if there are data limitations, participants thought that it was still important for the payment index to help increase transparency on Medicaid spending and also draw attention to areas that do need more data.

Finally, the payment index can also help tie payment to improvements in quality, outcomes, and access. For example, the index could help show how payment rates are associated with factors related to access and state outcomes.

For our next steps, we plan to update and expand the payment index with new data sources available. Alongside the payment index work, we'll continue to review narratives from UPL payment reports and directed payment preprints to understand how states are targeting their supplemental payments.

Thank you for your time. We welcome your feedback and any questions you have on our previous index

or our TEP findings, and we also appreciate hearing any additional factors for us to consider, particularly related to methodological considerations or any specific categories of hospitals that you would like us to highlight.

VICE CHAIR DUNCAN: Thank you very much, Asher.

Let's open it up for comments from our fellow Commissioners. Not seeing any yet. Oh, there's Adrienne. I'll go to Adrienne.

COMMISSIONER McFADDEN: Sorry to disrupt.

Asher, you touched on this a little bit, but I just would express an interest. When you talked about rural versus urban hospitals, I reached back into the crevices of my memory as an old state rural health director. I think the small rural hospitals, which are like 49 beds or less, would be an interesting breakout to look at.

MR. WANG: Thank you.

VICE CHAIR DUNCAN: Thank you, Adrienne.

Patti.

COMMISSIONER KILLINGSWORTH: I would like, as we continue to look at this issue, to look at opportunities to introduce value-based components into the reimbursement

methodology for hospitals, and I'll be really specific about that. I'd love to be able to align the incentives in the right way for hospitals to care about where people are discharged to.

I think that the current payment structure incentivizes them to get people out as quickly as they can, and oftentimes the quickest solution is a skilled nursing facility, especially for older adults and people with physical disabilities.

And so if the incentives were better aligned for them to want to help people return home whenever possible, even if that takes a little bit more time, a bit more engagement in terms of coordination to get those services in place, I think those would be dollars well spent, both from a value perspective, but more importantly, from the perspective of appropriate access to community-based services for people who desire that, rather than institutional placement, even if temporary. We know that temporary often turns into long term, and so I think it is absolutely something worth exploring.

MR. WANG: Thank you, Patti.

And also, I want to highlight that in our

directed payment work, we're also looking at directed payments that have value-based payment components, and there are some states that do tie directed payments to meeting specific milestones or, for example, meeting care coordination measures. So that's definitely an area of interest that we're looking in.

COMMISSIONER KILLINGSWORTH: Thank you.

VICE CHAIR DUNCAN: Thank you, Patti.

And, Adrienne, you touched on a couple of thoughts I had as well on the urban versus rural. And, Asher, I appreciate you calling out the uniqueness of pediatric institutions and not caring for a lot of Medicare populations, but in that same vein, I think looking at safety net hospitals versus those that aren't and then as well as academic medical centers versus non-academic medical centers.

John?

COMMISSIONER McCARTHY: Asher, to Patti's point, on that one, I think one of the things, just to give you kind of a jumpstart on that one, if you look at Tennessee, Arkansas, and then what Ohio used to do around episodes of payment, that had some of that built in there of who's

accountable and then where do you go, that part of it.

The other part of it, I think, that would be going back to what Bob said is looking at those hospitals, but at some point in here, I think we would also need to look at what are those criteria that make those up, and so being able to look at that. And I know this is data that's hard to get to, but even when you look at safety net hospitals, what does that mean? What are their profit margins? There are some safety net hospitals that are in -- - I'm not going to say great financial shape, but steady financial shape, and there's others, especially in rural areas -- we're seeing more rural hospitals close.

So if there's any data that you guys can find that not only looks at payment but then ties that in some way, shape, or form to financial stability of a hospital, that would be helpful, too, to look at.

VICE CHAIR DUNCAN: Thank you, John.

Heidi?

COMMISSIONER ALLEN: Thank you.

I'm very excited about this work, and I assume that part of the reason we're doing this is that the 2017 report was so useful. And so many stakeholders found it

helpful, which kind of begs to me the question of, you know, do we really have to rely on the GAO data from 2018 that they had in their 2020 report? I know the GAO did that survey twice. Is it possible that we could commission a replication of that survey so that we could use more timely data since we do this report only ever so many years? Is that a worthy investment of resources to have the best data possible?

I'm just thinking of all of the changes that have happened in the last five years in the delivery system, and it seems like having really solid numbers when you're doing such a rigorous process like what you're describing here would, you know, just really strengthen the analysis. So I just want to put that out there.

VICE CHAIR DUNCAN: Thank you, Heidi.

MR. PARK: Oh, I just wanted to comment to reflect back on the most recent June chapter that we had on financing and the importance of getting that information, you know, at the provider level.

You know, we have talked to GAO about kind of like the effort that went into it, and it was a lot of work. And I'm not sure it would -- like, the numbers would

be updated, but I think we'd still have to do it in those broad categories of, like, you know, base payments, DSH, non-DSH supplemental payments, managed care, you know. It was a lot of work for them to just get it at that level. So I'm not sure to what extent it would be a vast improvement unless we, you know, eventually got to where our recommendations are, where it's more at the provider level.

COMMISSIONER ALLEN: As a follow-up question, so how do you plan to use the data from 2018 when you're mixing it with data that's more contemporaneous?

MR. PARK: Yeah. I mean, it'll be very rough estimates, similar to what we did in 2017, but that was using whatever, like, data from 2012, you know, to get a sense. And Asher presented some of it, you know, like, DSH payments were largely funded by, you know, provider taxes. So, you know, we would try to, you know, account for that, you know, apply that percentage, same for the non-DSH supplemental payments.

The trickiest area will be the directed payments, because those are new since -- really new since 2018. And that's where we'll try to maybe scan some of the directed

payment preprints to get a sense of to what extent certain types of payments are funded by these provider taxes.

You know, we'll still need to think about the methodology as to, like, what percentage should be applied, you know, potentially if they're similar to like DSH or non-DSH supplemental payments. We may just kind of use that percentage as a rough estimate. You know, none of this is -- will ever be perfect, but, you know, we do want to acknowledge the fact that, you know, a lot of these supplemental payments, directed payments are funded by provider taxes or IGTs. And so the revenue that the hospitals get are not necessarily the full amount that they have to cover their costs.

VICE CHAIR DUNCAN: Thank you, Heidi. Thank you, Chris.

All right. Mike?

COMMISSIONER NARDONE: You kind of hit on a couple of these -- I'd be interested in both the high Medicaid hospitals as well as the academic medical institutions. So you hit on those. Thanks.

VICE CHAIR DUNCAN: Thank you, sir.

Jenny?

COMMISSIONER GERSTORFF: From a methodology and documentation perspective, I think it might be worth looking at, on the outpatient hospital side, how policies differ for 340B across states and how that might relate to the resulting reimbursement levels.

VICE CHAIR DUNCAN: Thank you, Jenny.

Dennis?

COMMISSIONER HEAPHY: I don't know how this fits into your work, but we just had several hospitals close in Massachusetts. It was a for-profit hospital chain, and so is there a way to look at differences in utilization of dollars? I don't know. Does that fit into your work? Does it not fit into your work? It's a different project?

VICE CHAIR DUNCAN: So are you thinking for-profit versus not-for-profit?

COMMISSIONER HEAPHY: Yeah. I only bring that up because of what happened.

VICE CHAIR DUNCAN: Yeah, it was Steward Health Care?

COMMISSIONER HEAPHY: Yeah. It was devastating. And so what was that difference?

MR. WANG: Yeah. No, that's definitely an

interesting component. Yeah, we'll take into consideration into looking at different ways that we can break it out, because there's so many different types of hospitals and sub-indices that we could build from it.

VICE CHAIR DUNCAN: Thank you, Chris. Thank you, Asher.

Any other comments?

[No response.]

VICE CHAIR DUNCAN: Good luck.

MR. PARK: Thank you.

VICE CHAIR DUNCAN: All the challenges you presented in the beginning, and then we layer different factors on there. But as Heidi stated, this work is critical and important. So thank you.

All right. With that, that leads us back to public comment. So we'll open it back up for our participants. So if you're in the audience, please raise your hand if you'd like to say something or offer a comment, and again, introduce yourself, the organization you represent, and please keep your comments to three minutes or less.

PUBLIC COMMENT

* [No response.]

VICE CHAIR DUNCAN: We've had a quiet participation group this weekend. So we appreciate you attending.

If there's no comments, then we will adjourn. Our next meeting is at the end of October, I believe, Kate, October 30th? I believe it's October 30th and 31st.

EXECUTIVE DIRECTOR MASSEY: The 31st. October 31st.

VICE CHAIR DUNCAN: Oh, October 31st and November 1st.

All right. Thank you. Everyone have a great day.

* [Whereupon, at 11:52 a.m., the meeting was adjourned.]

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