PUBLIC SESSION

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10:31 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:31 a.m.]

CHAIR JOHNSON: All right. Good morning, everyone, and welcome to our October MACPAC public meeting. It's so good to be here, and if you celebrate Halloween, then Happy Halloween to you. And I'm sending out a special nod to the Hogwarts and Gryffindor family today with my attire for sure.

But I do also want to just start out by saying that I want to thank you all for your understanding and support during my absence at the last meeting, as we mourned the death of my father and worked to really support my mother and the care she needed.

I'd also like to say thank you to Bob for stepping up to run the meeting as Vice Chair and for his leadership in kicking off our new meeting sessions and welcoming our newest Commissioners to Mike and Doug. So really excited to have them here.

So I will also say that over the last few weeks, I've really been reminded on a personal level, as I've navigated the health care system for my parents, of the importance of the work that we do here at MACPAC. We're

always looking for ways to increase access and ensure quality for those on Medicaid and CHIP, and that's a very important mission I think that we all hold true to our hearts.

And if you haven't already, I want to make sure that you have taken a look at our analytic agenda for this year. It's pretty dynamic, and we hope that you all can really join us for each of those meetings. And you can find information on our website.

So as I take on the chair role for this year, I'm excited to continue to build upon the Commission's important work. Medicaid, as you all know, is a very vital program. It's a platform for innovation, collaboration, and ultimately improving the lives of millions of Americans. So I look so forward to advancing these goals with all of you.

So, with that, let's kick off our very first session. Melinda is going to talk with us about MOUD and related policies. So go for it. Thank you.

MEDICATIONS FOR OPIOID USE DISORDER AND RELATED POLICIES

* MS. BECKER ROACH: Thank you, and good morning,

Commissioners.

This is the first of several sessions that the Commission will have on medications for opioid use disorder. It's meant to lay a foundation for future discussions by providing an overview of medications for opioid use disorder, or MOUD, as I'll refer to it during the presentation. I'll also highlight recent federal policies and other factors that affect access to MOUD and discuss next steps for the Commission's work.

MOUD is the standard of care for individuals with opioid use disorder. There's strong evidence demonstrating the effectiveness of these medications, which include methadone, buprenorphine, and naltrexone.

While providers treating patients with opioid use disorder should offer or refer to counseling and other services, federal guidance emphasizes that access to MOUD should not be contingent upon someone participating in those additional services. There's evidence, for example, that patients benefit from buprenorphine treatment even when counseling services aren't available.

Methadone, buprenorphine, and naltrexone vary in a number of ways. Methadone is an opioid that suppresses

withdrawal symptoms, controls opioid cravings, and blunts or blocks the effects of other opioids if taken. Methadone for the treatment of opioid use disorder can only be dispensed at highly regulated opioid treatment programs known as OTPs.

This closed system of distribution for methadone was put in place due to concerns about potential abuse and diversion. Typically, patients must travel to an OTP for supervised dosing on a daily or near daily basis and over time may be permitted to receive take-home doses.

Buprenorphine is another opioid that works similarly to methadone but produces a less intense opioid-like effect and poses less risk for drug interactions. It can be taken orally on a daily basis or administered through weekly or monthly extended release injections. Buprenorphine can be accessed at OTPs but is more often prescribed in office-based settings by clinicians who have a federal registration to prescribe controlled substances and who are permitted to do so under their state laws.

Naltrexone differs from other forms of MOUD in that it's not an opioid or a controlled substance and has a different effect on opioid receptors in the brain. It has

been found to be less effective than methadone and buprenorphine and is used less commonly for OUD treatment. There are oral and extended release injectable forms of naltrexone, but only the injectable form is approved for opioid use disorder.

Congress and federal agencies have pursued a variety of policies to improve access to MOUD in recent years. Some of these policies are specific to Medicaid and others are more broad. Starting with recent Medicaid policies, the 2018 SUPPORT Act requires state Medicaid programs to cover all forms of FDA-approved MOUD and related counseling and behavioral therapies for a five-year period beginning October 1st, 2020. That requirement was recently made permanent in the 2024 appropriations law.

States could apply for an exception to the coverage mandate if implementing it was not feasible to a shortage of qualified MOUD providers. CMS approved exceptions for provider shortage in three states and four territories primarily due to a lack of OTPs providing methadone.

There are two Section 1115 demonstrations that include a focus on expanding access to MOUD. The first is

the Section 1115 substance use disorder demonstration that has been adopted by many states as a way to pay for services for enrollees receiving treatment in institutions for mental diseases or IMDs. These demonstrations aim to improve access to a full continuum of care for substance use disorder and to improve access to MOUD, among other goals.

For instance, participating states must assess the availability of Medicaid-enrolled providers offering MOUD and require that residential facilities provide MOUD directly or facilitate access to MOUD at another location.

There is also a Section 1115 demonstration opportunity, as Commissioners are aware, to provide Medicaid pre-release services, which states are increasingly pursuing. MOUD is part of the minimum benefit package that states must offer to enrollees nearing release from incarceration.

The SUPPORT Act established a new state plan option for covering services for enrollees receiving substance use disorder treatment services in IMDs. That authority was time-limited but was recently made permanent. Among other requirements, eligible IMDs must offer at least

two forms of MOUD on-site.

The SUPPORT Act also authorized demonstrations to expand the capacity of substance use disorder treatment providers. CMS awarded planning grants to 15 states and selected 5 of those states to participate in a three-year post-planning period. Post-planning states all reported increases in the number of methadone and buprenorphine providers as a result of their activities under the demonstrations.

Finally, health homes were established under the Affordable Care Act to support care integration for enrollees with complex chronic conditions, including opioid use disorder.

States can receive enhanced federal funds for health home services, such as comprehensive care management, care coordination, and referral to community and social support services.

There have been a number of policy changes not specific to Medicaid but which affect access to MOUD more broadly. For example, there have been changes to methadone access both during and after the COVID-19 public health emergency.

At the start of the pandemic, SAMHSA relaxed restrictions on the use of methadone take-home dosing, which minimizes the need for patients to make daily trips to an OTP. Those flexibilities were made permanent in a final rule that SAMHSA issued earlier this year. That final rule also removed restrictive admissions criteria, including the requirement that patients have a history of addiction for at least one year before beginning methadone treatment.

In another effort to limit in-person visits during the public health emergency, SAMHSA and the Drug Enforcement Administration allowed patients to start buprenorphine treatment via telehealth without first receiving an in-person medical evaluation. That flexibility has been extended several times while DEA considers public comments on a proposed rule that would allow telehealth initiation but would require in-person evaluation within 30 days.

Finally, last year, Congress eliminated the requirement for providers to obtain a federal waiver to prescribe buprenorphine for opioid use disorder, which was widely seen as a barrier to expanding the availability of

MOUD providers.

There are a variety of additional factors that affect access to MOUD. I'm going to highlight two commonly cited barriers -- provider shortages and utilization management.

The limited availability and maldistribution of MOUD providers are well documented. For example, a recent federal study found that roughly a third of U.S. counties had no OTPs or buprenorphine providers serving Medicaid enrollees in 2022. Most OTPs treated Medicaid enrollees, while most office-based buprenorphine providers did not. Stigma and the high cost of treating patients with opioid disorder coupled with low reimbursement rates can dissuade some providers from offering MOUD or accepting Medicaid patients. Federal, state, and local laws can also create barriers.

As noted earlier, methadone for opioid use disorder is limited to highly regulated OTPs and cannot be dispensed in traditional outpatient settings. State laws may pose additional barriers; for example, through certificate of need requirements or restrictive zoning laws that can make it difficult to identify new locations or

provide convenient access.

While Congress eliminated the federal waiver requirement for buprenorphine prescribers, states can continue to impose barriers; for example, through state scope of practice laws that limit the ability of non-physicians to prescribe buprenorphine.

States and managed care organizations established utilization management policies to ensure appropriate care and reduce the potential for fraud, waste, and abuse. However, these policies are often cited as barriers to timely access to MOUD.

Utilization management for MOUD has declined in recent years but is still widely used. Examples include the use of prior authorization and quantity limits or maximum daily doses. In 2023, roughly half of states required prior authorization for methadone or had at least one MCO that did. Prior authorization for buprenorphine is less common, though still widely used.

In the coming months, I'll return to discuss state coverage of MOUD and recent changes in MOUD utilization based on a claims analysis. I'll also present themes from interviews that we conducted with national

experts and stakeholders in six states regarding MOUD access. That work and the background information presented today will form the basis of a descriptive chapter for the June report.

Staff are also considering potential follow-on work focused on specific policy issues that have come up in our work to date such as prior authorization for MOUD. This is one area where staff could do additional research and evidence gathering to inform the Commission's work in the next report cycle.

If you have any initial thoughts on that today, we welcome your input. It would also be helpful to know if you have any clarifying questions or would like any additional information on any of the topics discussed today.

Thanks.

CHAIR JOHNSON: Thank you so much, Melinda. This was very helpful.

So she's given us a little bit of direction here in terms of your thoughts about prior auth and any clarifying questions.

Any questions from the Commissioners? Let's see.

I have a couple of hands. John, you want to start us off?

COMMISSIONER McCARTHY: I'm really looking forward to this great work. It's a great start. I love it.

A couple of things that I would like you to take a look at as we go forward. Number one is there's been some new guidance coming out on parity and what needs to be done. So how does that work with what we're doing and where substance use treatment falls under the parity rules? I know we're looking at Medicaid, but it's a bigger picture in that one.

The second piece is if you could look at rates and how substance abuse providers are paid, because you talked about this a little bit, the lack of providers. One of the issues is rate payments. This is an area which is somewhat -- not convoluted. That's not the right term. But it's difficult because people think of payments as pretty simple, but this one is a little more complicated. So if you could dig into and explain to us how providers are paid, so that when we talk about a lack of payment, we would know what areas that rate enhancement may be needed.

Thanks.

CHAIR JOHNSON: Thanks, John.

Let's do Jenny, then Mike, then Heidi.

COMMISSIONER GERSTOFF: Thank you, Melinda. I'm really excited about this work too, and I think there's a lot that we can explore, and there's a lot that you've presented so far.

This is one that a lot of people close to me have been working on. So I spent some extra time after reading your materials to talk to them about barriers, the ones that you highlighted and others, things that they're seeing in the field to help me understand what concerns we might explore.

I think you absolutely nailed the points in your meeting memo and the presentation. You laid out a lot of the first steps in eliminating some barriers, but it sounds like even after a state has eliminated things like prior auth and dosing limits, we're still not seeing treatment rates near what we would hope for.

There are three main considerations I have wanted to share and then some anecdotal results from a pilot program in Seattle as just a reference point for taking down more of these barriers.

My first one is the fentanyl addiction that we're treating today and how it is so different from heroin and OxyContin of the past. The incredibly short nature of fentanyl and the precipitated withdrawal symptoms that come multiple times a day are much more severe. This means that dosing needs for treatment are higher, and it's a lot harder to get people into treatment, especially as many programs are still relying on an abstinence model.

I also wasn't aware that despite the intense pain and other very severe symptoms of precipitated withdrawal, a person cannot be admitted to the hospital just for their withdrawal symptoms or just with an OUD diagnosis. They would have to overdose before being admitted.

And there's a lack of clear guidance for providers for best practices and indications for induction to treatment for fentanyl addiction.

Providers, another big one. But people are not coming to providers. So we don't have enough providers, and also, we can't get people to come to those providers.

The best success has been taking the providers out into the community, because some people, they've had painful past experience trying to get treatment. There,

again, are not enough providers offering treatment, and there hasn't been good communication to potential patients of treatment options that we have beyond the abstinence-based models.

The evidence is showing that outreach programs in the community are far more successful, but there are barriers and limitations there as well, and that's hindering the ability of providers to offer those programs, things like needing to register individual sites. So, if you go to a homeless encampment, you would have to establish that as a site and pay a fee. There are issues with transporting a controlled substance and several other limitations there.

The most effective treatments are also the most cost-prohibitive, which is a big deal. It's way easier to calculate the upfront cost of administering products like Brixadi and Sublocade than it is to quantify the savings that we may achieve through offsets in reduced ED visits, reduced inpatient stays for overdose, or improvements in someone's economic status.

These treatments are expensive, and I know that both state and federal budgets are already stretched. So

upfront costs are a big barrier, but if we consider beyond that initial cost, there are programs that are showing these outcomes of savings, and they're beginning to have data to share.

I have a friend who works for the Seattle program that I mentioned. It's just a small outreach program. They have maybe 100 clients, they been treating for about a year. Their clients have a high rate of being unhoused, and many of them have co-occurring mental illness that goes untreated because of their OUD. So these are some of the hardest clients to reach and to retain, but they've been very successful.

So their program technically is an off-label use of Brixadi because they don't require abstinence to get started. The Brixadi is a lower dose than the month-long Sublocade long-acting injectable, and it allows them to begin to come off of the fentanyl without symptoms.

And they do a couple of low-dose initiations there, and then once they are free of the withdrawal and off of the fentanyl, they move to Sublocade. It's very expensive.

But they've had zero overdoses in the last year

for their clients on the program. They have clients who have gotten into stable housing. They have clients who have gotten stable employment. They have clients who are pregnant, and those babies will not be born with neonatal abstinence syndrome.

They're so successful because of the model that they're using, but they're also using a combination of both Medicaid and SAMHSA funding. And because the overdose rates in our area have come down, they're losing funding, and so they'll actually be able to help fewer people.

Their clients only have to make a good decision one time a month when using the Sublocade versus Suboxone films. They have to do that three to four times a day because the fentanyl wears off so quickly and because the Suboxone wears off so quickly.

Team members from the pilot program are reporting that when they pull their van up to a homeless encampment, they've had people running out and lifting their shirts and following the van and asking to get signed up. There's so much success in this very hard-to-reach community, but they don't have enough staff or supplies to expand. But I think looking into that kind of thing, guiding that will be

helpful in the research.

Other things that I think can support treatment, including Sublocade and Brixadi on state formularies, federal pricing negotiations that could reduce costs for Medicaid programs, increased dosing limits for treatment of fentanyl addiction, and other research to improve clinical guidance and develop updates to evidence-based practices. There, you have in your materials millions of people suffering from OUD and covered by Medicaid, and while it may be expensive to help them overcome addiction, it can achieve exactly the goals we want to see, people who move on from safety net programs to be successful members of society.

Without social safety nets like Medicaid that helped me when I was a single teenage mom, I couldn't have gone to college, and I couldn't have succeeded to be a taxpaying, highly paid consultant sitting in this room today.

And I would love to see the program successfully support people through the hardest times in their lives so they can achieve big and small wins the way I know they want to.

CHAIR JOHNSON: Thank you so much. Heidi, then Mike, Doug, and then Carolyn.

COMMISSIONER ALLEN: Thank you. Thank you for this. I found it very informative and helpful. I want to second what John said about thinking about how Medicaid pays for these treatments, both with the provider rates. And I noted you had in your materials the so-called buy and bill policies, and I was wondering if that was specific to one drug or another, and if that could be responsible for some of the discrepancies that we're seeing in providers being willing to provide these treatments.

And then I was really interested in the section on utilization management. I guess there's a sense of, okay, there's this big shift in states moving away from utilization management for these treatments, but yet there's still a very substantial number of states that have them, across all of the different treatment. And I thought it would be really interesting to see this data that is provided in Table 2 in our materials mapped onto the rates of overdoses in a state. Because I'm curious if these are states that overdose rates are low and therefore, we can still have utilization management, or if these are places

where it's really high and it might be why they have so many overdoses.

So I just am very curious about that, and I would like us to really think through what would be the role of MACPAC in advising states and CMS and Congress about what is the role of utilization management in these treatments.

CHAIR JOHNSON: Thank you, Heidi. Mike?

COMMISSIONER NARDONE: Yes. Thank you very much for this great presentation and all the comments of my fellow Commissioners. Very helpful for me.

I guess what I was wondering, Melinda, you discussed some of the policy levers that the federal government has made available, and one of the things you mentioned was the 1115 authority for SUD demos. And I guess what I was just wondering, we've had a fair amount of time with those now, having actually been in government when these were initiated. And I'm just wondering if anything is coming from those demonstrations that perhaps provide some insights into best practices that deal with making more of these medications accessible to people, addressing some of the provider capacity concerns that you raised, or perhaps you mentioned different models like

mobile treatment, as well as maybe other initiatives to address transportation issues, that when you have 35 percent of the counties without OTPs established in their areas.

So I didn't know if this was part of your thinking, but I just wanted to raise that as something I was interested in learning a bit more about.

CHAIR JOHNSON: Thank you, Mike. Doug?

COMMISSIONER BROWN: Thank you, Melinda, for the presentation. I have a couple of comments around the UM, and if you would just go back one slide, I think page 11 has the chart here. And I want to make sure that folks aren't looking at UM and saying this is totally bad, because there are absolutely appropriate UM criteria around these drugs, because they are not free of abuse, misuse, or diversion. And we know from the CAA, where they finalize some of the rules and regulations around methadone, that they limit it to 28-day supply for stable patients and 14-day supplies for patients who aren't stable.

And I would ask that when you go back and maybe refresh this data that the limit of this slide is for states that have both fee-for-service and MCO. It would be

good to see all states on here, 51 programs and the territories. Because I would expect that at that point you would see methadone across all states having a quantity limit. There are also quantity limits on some of the other products in there.

With specific regard to preferred status, what we see in states when they have preferred drug lists, some states that review these select a particular product -- let's use buprenorphine-naloxone, for example -- they'll pick one or two products there, and there might be another product that's equivalent, that is non-preferred. So they have preferred, non-preferred status, but there is most often, I cannot think of an example where there's not, a preferred agent across there. The question here is does not have preferred status, and yes, you can find a product that does not have preferred status, but there could be a product with preferred status there.

And there are a number of states that don't consider this class as part of a preferred drug list program, so they don't list the class at all. It does not mean that the drugs are not preferred or not made available. And as we know from Medicaid, all drugs are

available. Some drugs require prior authorization to get through there.

And again, I think there are some pieces here that it's important that the UM be balanced, that patient safety is part of the discussion here. And I'm not saying that some states may have more restrictive criteria and folks could argue in those states that it is. I just think that we need to kind of take a step back and think about this in a way of what's the benefit, what are the concerns, and how do you thread the needle through all of those pieces. Thank you.

CHAIR JOHNSON: Thank you, Doug. Carolyn?

COMMISSIONER INGRAM: Thank you and thanks for putting this together. I think my questions are similar to some others but I just wanted to add on a little bit more in terms of your future research. You mentioned a little bit about the difficulty in terms of access in rural communities, and I wondered if you could look a little bit into also tribal communities and access in those areas, and if there are any innovations in treatment in tribal communities.

I know of one up in San Juan County, where they

do both what we would call kind of Western medicine and Traditional healing, and one facility that's had some success with that. But I'm just wondering if there are others that we should be looking at in terms of models for access to care.

And then the other question I had besides the rate issue that I think both Heidi and John brought up was around training, and is one of the reasons because there are some issues around dispensing these medications and abuse, is lack of training also a reason why we have issues with access, not just the rates.

And the other area is just looking into, in some of the communities, are there innovations around things they've tried with either regulatory or legal issues to try to overcome people's fears about getting treatment, I guess the fear that people have around the stigma and the legal ramifications of getting treatment. Are there things that communities are doing to address that, so that people are more willing to go into treatment. So thank you.

CHAIR JOHNSON: Thank you, Carolyn. John?

COMMISSIONER McCARTHY: I think one of the things we can also take a look at as we go forward, or at least

you can explain to us on some of these, is clinically, is there agreement on how these services should be provided? Because the last time I looked there's not always clinical agreement on the provisions of these services, meaning just from the standpoint of how often should you do lab testing.

So it gets back to what Doug was talking about. That then gets to some policy decisions. For instance, do we care about diversion? Is that a good thing or a bad thing? We've always, in the past, thought about it as bad, but then during COVID we came to using telemedicine because we wanted people to get things faster. So that's one piece.

And then the second part is a little bit what Jenny talked about, and on the clinical side of things we had the opioid epidemic and we've put tons of resources into it, and it feels like, I'm not saying it is, but it kind of feels like people have thought, hey, it's over. We stopped doctors prescribing opioids and now it's over. Maybe it is, maybe it isn't, but it definitely has changed. Fentanyl has changed things.

So as Jenny said, if we look at some of those different areas around the clinical piece of it, because I

think for us it's sometimes hard to make the policy if the clinicians aren't in agreement on how things should be treated. If you don't have clear clinical guidance, it's hard to make policy decisions around it. Thanks.

CHAIR JOHNSON: Jami? Thank you, John.

COMMISSIONER SNYDER: Melinda, I just want to thank you for really focusing some energy on this important topic. Just based on my experience, I would like to see us kind of look further into the issue of stigma. That was a major barrier to the accessibility of this sort of treatment in my service as a Medicaid director in two states. I think there's just a real ample opportunity for more community education, provider education, as you alluded to in your presentation, in particular around the prevalence of opioid use disorder in various communities and the efficacy of this treatment for individuals who struggle with opioid use disorder.

I also just want to echo Carolyn's sentiments on looking at innovations in this space and how Medicaid programs are leveraging different financial resources to really support MOUD treatment across states, including leveraging grant dollars.

CHAIR JOHNSON: Thank you, Jami. Any other questions? Oh, Heidi. Okay. Thanks, Heidi.

COMMISSIONER ALLEN: Sorry. I had something on my list that I forgot. Can you also look into naloxone as a standalone? Is Medicaid making that available to people? Are there copays? I mean, so this is a treatment model, but is Medicaid engaging in a harm reduction?

MS. ROACH: I'll just say we haven't included naloxone in the current scope of work, but it's something we can think about, going forward. We're sort of looking at it differently from the three forms of medication for opioid use disorder. But it's something we can add to our list.

COMMISSIONER ALLEN: I'm not sure how the other Commissioners feel, but to me it feels like a really important piece, like you want people to stay alive long enough to be able to participate in treatment, and it is such an important tool in the arsenal of opioid use disorders. I'm particularly curious about copayments, how difficult is it for people to get prescriptions or to fill them, and particularly if they're being asked to spend money on it.

CHAIR JOHNSON: Thanks, Heidi. Dennis?

COMMISSIONER HEAPHY: Yeah. I was concerned about the 34 percent of counties that are not providing these services, and are there states that have implemented best practices to broaden the number of counties that are actually making these services available. Because otherwise we get a consolidation of people around one medical center or one place or city, and they have to leave their homes and go to this place, so it may actually exacerbate the problem. So what have states done to resolve the county issue. And going to Heidi's point, what was pointed out about providing these medications in the community, going out to people rather than having them come into these centers.

CHAIR JOHNSON: Thank you, Dennis. And John.

COMMISSIONER McCARTHY: I had first a question to come back to what Dennis just said. The 34 counties, I want to clarify. Did I read this correctly? It's 34 counties don't have methadone treatment.

MS. ROACH: I'll double check while we're talking, but I think it's that they have neither an OTP nor buprenorphine providers.

COMMISSIONER McCARTHY: Okay, because --

MS. ROACH: That are serving Medicaid enrollees.

COMMISSIONER McCARTHY: Yeah. Those are two totally different things. If it's just methadone providers that's one thing, because you could always go to a doctor.

I want to go back to what Heidi was saying about naloxone, and I'm not disagreeing, Heidi, with what you're saying, but I also don't want us to get too far down a path. In essence, how do we keep focused on treatment versus, naloxone's not a treatment. It does keep people alive. So I think that's going to be one of those tough positions to take a look at on that one.

But the other thing I would like you to look at is, and I don't know if this would be a correlation or causation, but Heidi had asked for the map earlier. I agree with what you're saying, and if you could also add to that, if you could look at overdose deaths in expansion states. Because is there a correlation, causation at all with that. Because I know in Ohio, when we expanded, a big part of our expansion was due to the fact that Ohio is ground zero for opioid overuse and deaths, so we expanded to get more people into treatment and to see if now that

years have gone past what that data would look like for the various states and looking at overdose deaths, and has it made a positive impact.

CHAIR JOHNSON: Thank you, John. Commissioners with thoughts, feedback? I think we heard a lot about UM, around provider availability, clinical. Is there anything that you're missing that you need, or did you get what you need from us today, Melinda?

MS. ROACH: No, I think this has been really helpful feedback and we have a lot to take back and think about before we return. I think it will be in January. So thank you very much.

CHAIR JOHNSON: Thank you.

VICE CHAIR DUNCAN: Okay. Now we'll continue our conversation on timely access to home- and community-based services. Tamara and team have done a deep dive into provisional plans of care that she'll share with us an update.

So, with that, Tamara, welcome. By the way, I like the orange in respect for Halloween today. You did well.

TIMELY ACCESS TO HOME- AND COMMUNITY-BASED

SERVICES: PROVISIONAL PLANS OF CARE

* MS. HUSON: Thank you. I was trying to be festive.

CHAIR JOHNSON: Yeah. Okay. Heidi is a black cat. I'm not going to call Tamara a pumpkin. I'm not going to do it.

[Laughter.]

MS. HUSON: Okay. Well, thank you, and yes, Happy Halloween.

Okay. So the focus of my presentation today is on provisional plans of care, a type of preliminary service plan that can be used for individuals accessing home- and community-based services through Section 1915(c) waiver programs.

Okay. So this is an overview of what I'm going to be talking about, and I'm going to start with just a little bit of background since we've talked about this topic a couple of times.

So you'll recognize this slide. It is not new. But we're going to focus today on step three. So this slide shows a high level -- at a high level, the eligibility process for non-MAGI populations and the steps

in the process that typically must be completed before someone can receive Medicaid HCBS.

So, again, for this session, we want to focus on step three, which is the development of a person-centered service plan, or a PCSP. And a PCSP is a document that describes the services and supports an individual requires to meet their needs and their individual preferences.

Beneficiaries are required to have a PCSP in place before they can receive HCBS. Specifically, the statute says that HCBS can only be provided pursuant to a written plan of care.

So one tool that states have to help expedite this process is to use a provisional plan of care. So CMS allows for provisional plans of care, also known as "interim service plans," and this identifies the essential Medicaid services that can be provided in a person's first 60 days of waiver eligibility. And provisional plans of care have been allowed since 2000, when it was described in a state Medicaid director letter known as Olmstead Letter No. 3, which was issued in response to the 1999 *Olmstead v. L.C.* decision. And the gray box that you can see on this slide here contains an excerpt from that letter on the use

of provisional plans of care.

States must document in Appendix D-1 of their Section 1915(c) waiver if they allow for the use of provisional plan of care and their procedures for developing such plans.

Okay. So, first, I want to talk through the results of our waiver review. So, as you will recall, we contracted with the Lewin Group to conduct an environmental scan for us on state take-up of different flexibilities and policies around the use of presumptive eligibility, expedited eligibility, level of care determinations, and person-centered planning processes. And so, as part of that, the scan included a review of whether states had language in their Section 1915(c) waivers on the use of provisional plans of care.

So we reviewed the state data from that as well as some data that we received directly from CMS, and so using both of those data sources, we found that 23 states allow for the use of provisional plans of care across 57 Section 1915(c) waiver programs. However, I do just want to note that since our slides were finalized, we were made aware of one other state with three waivers that allow for

provisional plans of care. So that brings our count to 24 states across 60 waivers.

So the data on this slide shows the number of Section 1915(c) waivers with language on provisional plans of care by state, and of the 23 states that we originally identified, five of those states have language allowing for the use of provisional plans of care in all of their waivers.

We also found in our review that most states allow for their provisional plans of care to be in place for 60 days, although some states do specify shorter time frames, such as 30 or 45 days. We also saw that about half of states that have multiple waivers with provisional plans of care, they use the same description across all of their waivers, while some other states may use different processes across their different waiver programs.

So this table provides the count of waivers that have language on interim service plans by waiver target populations, and of the 57 waivers, we found that the most commonly targeted populations include individuals with intellectual and developmental disabilities, followed by individuals with physical disabilities and older adults.

I also want to take a second to note that while provisional plans of care are expressly allowed for Section 1915(c) waiver programs, our environmental scan found one state, Maryland, allows for the use of provisional plans of care in its Section 1915(i) state plan amendment and also in its Section 1115 demonstration. So, for example, Maryland's Section 1915(i) program, which is targeted at youth and young adults with serious emotional disturbance or co-occurring mental health and substance use disorders, allows for the use of provisional plans of care for crisis situations in order to respond to the immediate needs of the participant and their family.

Okay. So next to talk a little bit about the findings from our stakeholder interviews. Over the summer, we conducted stakeholder interviews to gain a better understanding of state use of provisional plans of care. We spoke with officials in five states that our environmental scan had identified as having language on provisional plans of care in their Section 1915(c) waivers, and of those five states, we saw that in one state, they had language on the use of provisional plans of care in all of their waivers. In two states, they had language in

about half of their waivers, and then in two states, it was in just one or two of their waivers. We also spoke with four national organizations and officials at CMS.

State officials and national experts all said that provisional plans of care are most often used for emergency situations such as natural disasters or hospitalizations. For example, one state told us that they implemented the use of interim service plans at a time when the state was experiencing multiple wildfires. Another state shared with us that they've used provisional plans of care for individuals who have been hospitalized or who are residing in homeless shelters.

While our waiver review found that 23 percent of all Section 1915(c) waivers allow for some use of provisional plans of care, our interviews indicated that few states actually use them. So of the four national organizations that we spoke with, none of them were aware of any states using provisional plans of care. And then of the five states that we spoke with, one state said they're not currently using this flexibility, two states told us that they rarely use them, and then two states are actually unsure. But the two states that told us they use

provisional plans of care were able to provide us with some data on the percentage of new waiver participants per years that had had a provisional plan of care. So one state shared data for four of its waivers, and they reported that the percentages were 0, 3, less than 5, and 6 percent. And then another state that was able to give us data for one of its waivers shared that the percentage was somewhere between 1 and 2 percent. However, despite their infrequent use, one state official noted, in particular, that provisional plans of care are an important tool particularly for those with urgent needs.

States that use Section 1115 demonstrations to offer presumptive eligibility for non-MAGI populations are often designing these programs similar to how a provisional plan of care operates, but they have some additional flexibility.

As I already mentioned, provisional plans of care are not intended to be extensive, but rather a way to quickly provide the most critical services until the full PCSP can be developed. And this is similar to the goal of presumptive eligibility in which states want to provide enough HCBS during that period of presumptive eligibility

to enable individuals to live in the community while the state completes their full Medicaid LTSS eligibility determination.

So states kind of operationalize that goal of presumptive eligibility using a shortened version of their level of care assessment and offering a limited benefit package during that period, and so that is similar, again, to how a provisional plan of care provides a limited set of services at the beginning.

So to give one state example, one state that has a limited benefit package during the period of presumptive eligibility offering limited personal care homemaker services, adult daycare services, and skilled nursing services, they allow those services to be available for up to 90 days or until an applicant's eligibility decision is rendered, whichever comes first.

But you'll note that for Section 1915(c) waivers, a provisional plan of care may only be in place for up to 60 days. So they have a longer time period in the 1115.

Okay. So to turn to the topic of guidance, as I noted earlier, provisional plans of care have been allowed since 2000, but since Olmstead Letter No. 3 was published,

no further guidance has been put out.

There is a brief mention in the Section 1915(c) technical guide about how states should describe in Appendix D-1 on service plan development the procedures that the state will use to develop interim service plans and the duration of said plans. However, in our interviews, we really got mixed responses on the need for additional guidance.

So the two states that we spoke with that are using provisional plans of care shared how this is a longstanding flexibility that they've used. They feel comfortable with it, and they told us that they do not feel the need for any additional guidance.

National experts, on the other hand, pointed to the fact that since so few states are using provisional plans of care, that they expressed a desire for additional guidance, particularly because it could encourage more states to use this flexibility. One expert, in particular, advocated for the more routine use of provisional plans of care, not just in emergency situations.

We also spoke with CMS about this, and they indicated to us that they do not plan on releasing

additional guidance. So the officials we spoke with, again, pointed to Olmstead Letter No. 3 and the longstanding ability that states have had to use provisional plans of care, saying that there's no new policy that warrants additional guidance. They also noted for us that they haven't received any recent technical assistance requests on this issue.

Instead, CMS really highlighted for us how they've been trying to promote the use of provisional plans of care, such as in a recent webinar, there's a mention in the preamble to the access rule, there was a recent Center for Medicaid and CHIP Services informational bulletin titled "Ensuring Continuity of Coverage for Individuals Receiving Home- and Community-Based Services" that notes this as a flexibility, and they've also been speaking about it at recent Advancing States HCBS conferences.

In all of these different instances, CMS has reiterated the authority that's already provided in Olmstead Letter No. 3 about how states can use provisional plans of care to facilitate a quicker initiation of waiver services, and they've been clear that in order to elect this option, states need to submit an amendment for their

waiver.

Okay. To briefly wrap up with some next steps, I plan to return in January with a draft chapter for our March 2025 report to Congress, and that will include information from my past few presentations, including on presumptive eligibility, expedited eligibility, and provisional plans of care.

We're also conducting some additional work on level of care assessments and person-centered planning processes more broadly. So we'll return with that work in the spring and in the next meeting cycle.

Then for this meeting, of course, I welcome Commissioner questions and feedback specifically on this topic, and with that, I turn it back to you.

Thank you.

VICE CHAIR DUNCAN: Thank you.

Fellow Commissioners, any questions? Comments?

All right. Patti, then Jami.

COMMISSIONER KILLINGSWORTH: Well, it's a lot of work that leads us to increasing access to home- and community-based services, so thank you for this.

I do think it might be helpful in just a moment

for you to kind of walk through the methodology of identifying the states. Tennessee was the state that actually uses provisional plans of care. Tennessee calls them initial plans of care, have done that probably, I'm guessing, since the early 2000s. I'd have to go back and look at the exact policy, but it wasn't long after the Olmstead letter came out. And it is, in fact, a part of the waiver documents but not using the term "provisional plans of care" and so maybe got overlooked in the review that Lewin did. There may be other states in that same situation.

I'd say this. What we know is that there are probably opportunities to really improve access if more states choose to use this flexibility and to use it beyond emergent circumstances. Tennessee also uses it in their 1115 demonstrations for the two MLTSS programs.

Part of my concern is that we understand maybe the reasons why states have been more hesitant to sort of take advantage of this longstanding flexibility, and maybe we can dig into that just a little bit more.

Are there issues with being able to initiate services timely, especially when people have kind of

complex needs and you want to be sure that the services, the service providers have the right training and expertise to be able to deliver supports in the way that they need or want them? Maybe challenges in sort of transitioning from what is a provisional or initial plan of care to a more comprehensive one and how that sort of implicates adverse benefit determinations in the fair hearing process and maybe even sort of differences among entities who might develop an initial plan of care, say, as part of the level of care determination, which is how we did it in Tennessee. It was part of that initial assessment to determine functional eligibility for the program versus the entity who would then in turn develop that more comprehensive plan of care and I think concerns about differences in perspective that then led to challenges again in that sort of transition process from one to the next.

I will say it's pretty intuitive if you just think about it. Developing a real comprehensive person-centered plan is going to take a minute. You have to get the right people together. You have to really get to know that individual. You know, you want to really create a picture of the supports that they need and how they want

those supports to be provided. And allowing time for that matters, but it also matters that things that are needed right away to help ensure safety and stability in the community are available to people. So it's a policy that makes good sense. We just need to maybe understand what have been the barriers to making it more broadly utilized and see if we can make recommendations.

Oh, I would just say this, in that regard, when we think about policy recommendations. Do we really need a waiver amendment to be able to do what is good for people and make services available to them with a flexibility that's been available since 2000? When you do this under 1115 authority, it's probably not as spelled out, if you will, in that waiver itself. It might be, for example, in the contract language that CMS would review, and so maybe there's an easier way to do this in 1915(c) short of saying, no, no, you have to amend the whole waiver in order to be able to make services available more quickly to people.

VICE CHAIR DUNCAN: Thank you, Patti.

Jami, then Michael, then John.

COMMISSIONER SNYDER: Well, as usual, Patti

captured my sentiments perfectly. Yeah, I'll just echo what she said.

I'm curious, you know, given that so many states have the authority to offer provisional plans of care, why they're not exercising that authority outside of kind of emergent circumstances and kind of what sort of state policy operational or sort of practical barriers are in place that keep states from really using that as a tool to access.

VICE CHAIR DUNCAN: Thank you, Jami. You asked the question I had.

All right. Michael.

COMMISSIONER NARDONE: I don't have much to add to what Jami and Patti just said.

I think I wanted to understand a little better kind of the barriers. I mean, we've been working -- you know, folks who've been at this for a while have been trying to address some of the institutional bias in Medicaid in terms of HCBS and how can we make HCBS more accessible to people. And, you know, here are a couple of tools, not just the one we heard about today around provisional plans of care, but last time around,

presumptive eligibility. And yet, you know, there doesn't seem to be the type of uptake in terms of utilizing those services.

I can see where there would be some real -- you know, there could be operational concerns in terms of how to incorporate this into workflow, or there could be concerns around budget. There could be other things that maybe I'm not thinking about with -- but I think it would be really helpful to better understand that and also understand, you know, what are some of the levers in terms of educational or informational needs that people might have to understand this, because, for instance, I believe last month, there was discussion around not understanding some of the ins and outs of presumptive eligibility and what it meant for Medicaid FFP.

So I think these kind of tied together really nicely and really appreciate you bringing these forward, and I think understanding the barriers could potentially lead to some recommendations in this area.

VICE CHAIR DUNCAN: Thank you, Michael.

John, then Dennis.

COMMISSIONER McCARTHY: I was actually on the

same direction that Mike was going. I was struggling, Kate, on this one, just like what is the policy problem we're trying to solve because, you know, there's -- and do we just have to look at it in multiple paths? Because there's the first path of people can't get the services because it takes so long to do the financial determinations for a person. So is it really that, the path, versus going down the path of coming up with interim plans? And so it's kind of trying to get that balance between -- not balance. Trying to understand better where the real issue lies on these things, I think, is a struggle to make a policy decision.

So I think the work that, Tamara, you've done is amazing and great, and it's super informative. I think I'm just getting stuck on now like, well, where is the real problem? And it's the real problem because all these problems are hard. There's not one real problem. There's a bunch of little problems, and should we break those up into different pieces and take a look at them, you know, in those specific examples?

And I'll just give you one that Patti hit on. And as a Medicaid director, knowing this is tough is,

you're often dealing with these cases where it hasn't been planned out. Something happened terrible to the person. They are now in the hospital. They're trying to get that person home. The family is not ready to take care of them. And so if you were to send them home, you basically would be sending them home with 24-hour care, but your waiver is probably not going to support 24-hour care. And if you send somebody home with 24-hour care and you give it to them and then when you do the plan of care and it says, hey, now you're only going to get 8 hours of care, it is hard to take the 16 hours away from a person who's now used it and the family members. And so then you get into this -- you're stuck on these things. So, again, it's a little bit of what problem are we trying to solve on this one.

VICE CHAIR DUNCAN: Thank you, John.

Dennis?

COMMISSIONER HEAPHY: I think it's a vitally important opportunity for folks, as Patti and others have stated.

I just want to -- you gave a great list of states and what they're doing in this area. What are other sort of best practices that you can lift up in terms of how

states are doing this?

I thought it was also interesting how the variety of entities that are conducting the assessments, and as Patti alluded to, then who picks up the assessment afterwards. And so that seems to be very -- I mean, that was really confusing. And is there even a best practice around determining what entities are the best ones to be doing the assessment initially, and might those entities continue doing the assessment afterwards to ensure this continuity in the care planning process? Does that make sense?

VICE CHAIR DUNCAN: Yes. Thanks, Dennis.

Verlon.

CHAIR JOHNSON: Yeah, this is really helpful, and I appreciate all the guidance. And I think everyone said it too. What you all have already said, I think we echo that pretty much.

I think I'm just still struck by the fact that when we think about these kind of issues, in general, we think about a lack of guidance, a lack of understanding and education. And so I am struck by the fact that states felt like guidance wasn't needed. CMS felt like guidance wasn't

needed, but our national experts thought that it potentially was. And I just wanted to see if you can pull a bit more on that as to where they were coming from, from their perspective.

MS. HUSON: Sure. So, with our interviews with national experts, again, we spoke with four different organizations. None of them were aware of states that were using provisional plans of care, and quite a few of the organizations we spoke with are ones that work directly with states regularly, have a lot of contact with states.

The general feeling among national experts was they knew this was a longstanding flexibility, and they would like to see more states using it. So I think that was kind of where the sentiment around maybe some new guidance would be something to kind of prompt more states, make more states think about this, and really also encouraging it more as a regular tool, as opposed to when I -- so I did my state interviews first, and then I spoke with the national experts. So I was able to share a little bit with them about what we heard as far as the states were using it, were using it when there was some type of emergency, like a natural disaster, or, you know, people

are in crisis situations in the hospital, et cetera. So, when I was able to share a little bit of that context with them, they said, like, it's great to hear that some states are using this, but it would be potentially a good tool to use more regularly than just those limited circumstances.

Is that helpful?

CHAIR JOHNSON: That is helpful. I appreciate it.

VICE CHAIR DUNCAN: Thank you, Verlon. Any other questions, feedback? Tamara, do you think you've got enough?

MS. HUSON: I do. Thank you.

VICE CHAIR DUNCAN: Thank you. Again, thank you for the deep dive into that.

Back over to you, Chairwoman.

CHAIR JOHNSON: Thank you, and thank you, Tamara. All right. So now we will go to public comments. We invite people in the audience to raise your hand if you'd like to offer comments. But when you do, we ask that you do introduce yourself and your organization that you represent. And as always, we would like for you to keep your comments brief, to three minutes or less, if possible.

We'll go ahead and see who's available.

Okay. We'll go with Claudia.

PUBLIC COMMENT

* MS. SCHLOSBERG: Hi. First of all, thank you for this presentation. It was very informative, and I want to echo the comments of Patti, Jami, and Michael, on the importance of this topic.

I am Claudia Schlosberg. I am a consultant. My company is called Castle Health Consulting. I work with many providers in the long-term care space who are struggling to help people get into services, whether it's assisted living, adult day health, or even home health care, and struggling with the long wait times. We have even seen people become homeless pending not just the eligibility determination but the development of the person-centered service plan, because we have to wait for a case manager to be assigned and for that case manager to develop the plan.

I wanted to make one point, well, a couple of points. I do think that additional guidance would be helpful from CMS when you're talking with states about the importance of adopting preliminary plans of care, and all

you can point to is a guidance letter from 2000. It doesn't provide sufficient confidence that this is something that CMS is really serious about and really would like states to do. That's one thing.

And secondly, I wanted to point out that in the preamble to the eligibility rule, which CMS did something I thought was revolutionary in addressing the ability of states to use projected expenses for spenddown for home- and community-based services. But I just wanted to make a note that in order to do that the services have to be identified in a person-centered plan of care. So you're trying to establish eligibility using projected expenses, but you can't use expenses that are not part of a plan of care.

I raised this issue with CMS. They did address it in the comments. And their solution is that states can use this preliminary plan of care provision, again, citing back to guidance that is now, what, how many years old, back to 2000.

So if, in fact, states are going to seriously consider using projected expenses, the only way they can do it is by adopting this provisional plan of care. So it's

important, and I really want to encourage you to continue your research and develop some recommendations and move this issue forward, because it is critically important for access.

Thank you.

CHAIR JOHNSON: Thank you so much, Claudia. Camille?

MS. DOBSON: Good morning, I guess almost afternoon. Camille Dobson, Deputy Executive Director at ADvancing States. And I would echo everything Claudia said. Thank you, Claudia. We've also talked to states about taking up the new eligibility flexibility, and they have cited this sort of feels like a chicken-and-the-egg process around doing a provisional or interim plan of care in order to allow people to count projected HCBS expenses towards their spenddown eligibility.

I agree, it is unconscionable that it is 25 years and there hasn't been any public guidance. The technical guide is not helpful, with just a brief mention, as Tamara said. And with so many states talking to CMS about presumptive eligibility and trying to sort of tie themselves in knots to get to that point with CMS, this

would be an easy solution to offer.

I think we were one of the national organizations that Tamara and the team talked to -- I can't remember, maybe -- but I will tell you, we were not aware that so many states had the interim plan of care, because as we're talking with states, and they want to talk about presumptive eligibility, we've offered these alternatives, and it's either buried somewhere in an operational process but necessarily, not all the leaders, I think, understand what that is.

And then last, I would say, back to John's point of them both being problems, it's clear that the financial eligibility is the larger, bigger issue for states, that it is virtually impossible to speed up, even using risk-based criteria, financial eligibility determinations less than 30 days, and you cannot deal with crisis situations in hospitals, as Claudia said, with a 30-day wait to get services. So our focus around presumptive eligibility and supporting states and working on that is really around speeding up the financial eligibility process, while they are still operational, all of the things that Patti and Jami mentioned, and Mike mentioned, about the difficulties

in the interim plans of care. It's really the financial eligibility that seems to be the biggest hurdle.

Thank you, as always. Great topic, and I appreciate it.

CHAIR JOHNSON: Thank you, Camille. And then we have a comment from Eric, as well. Eric?

[Pause.]

MR. CARLSON: Eric Carlson, Justice in Aging. I appreciate this topic being on the agenda. I want to reemphasize how important it is from a practical point of view. We see this in the hospitalization situation where people, as a practical matter, are able to move from hospitals to nursing facilities, even if, for example, financial eligibility is undetermined at that point, whereas it's essentially impossible to get into an HCBS setting at that point. And that leads to people moving into nursing facilities, perhaps unnecessarily, and leads to them staying in nursing facilities oftentimes on a continuing basis, due to the difficulty at that point of moving back to an HCBS setting.

We are amongst the groups that were consulted for this study, and we did report that we just haven't seen

much. We, at Justice in Aging, have done webinars and tried to promote this, and asked our network for examples, and I can tell you that we've gotten back essentially radio silence. There is just very little indication that it is being done on a practical basis.

We intend to look at the states that have been put forward in this research and dig in a little more to that. But consistent with what other folks have said, we just haven't seen much evidence that this is being used in the field.

So for that reason the guidance that we're talking about as being necessary is, in part, for the practicalities, but as people mentioned, part of it is just to promote this issue, and let people know that it's real, that this is not just something that's been sitting around in the Olmstead Letter for 25 years. It's real. It's important now. It can be done.

So what CMS could do, would be, from our perspective, some perspective of some portion of maybe putting a little bit of meat on the bones of how this would work, and what states should be thinking about. There is some piece of that. And then another piece of just pure

promotion, saying this is available, this is a good idea, we encourage states to take this up.

And we thank MACPAC for bringing this up, as well. We see this as part of some helpful momentum in this direction, and hope that next year and the year after that we'll see a significant increase in the ability of people being able to access provisional plans of care and to get into HCBS settings as promptly and efficiently as possible.

CHAIR JOHNSON: Thank you, Eric. Any other comments? I see none. But I do want to remind you all that if you do have additional comments, you can submit them through our MACPAC website at any time.

And with that I think we are at lunch. Okay, we're going to lunch. We'll be back at 1:00 with a very exciting panel on multiyear continuous eligible for children. So we'll see you at one. Thank you.

* [Whereupon, at 11:44 a.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

VICE CHAIR DUNCAN: All right, ladies and gentlemen. We are getting ready to get started, so put on your game face. Madam Chairman, they're all yours.

CHAIR JOHNSON: Thank you so much, Bob. Welcome back. We are especially excited about this next session, which focuses on multi-year continuous eligibility for children in Medicaid and CHIP. We know it's a key issue that some states are talking about in terms of improving the coverage retention. We have Joanne, who will lead us through a conversation, some background, but more importantly, or more exciting, that we're going to have an actual panel discussion as well.

PANEL: MULTI-YEAR CONTINUOUS ELIGIBILITY FOR CHILDREN

* MS. JEE: All right. I'm going to pretend you didn't say that I'm not exciting.

CHAIR JOHNSON: I didn't say that.

MS. JEE: Okay.

CHAIR JOHNSON: But you know I said it.

[Laughter.]

MS. JEE: Okay. Great. So good afternoon, Commissioners. We are going to talk about multi-year continuous eligibility for children this afternoon, and as Verlon said, we have a really great panel lined up.

But before we do that let's just go through sort of the quick run of the show. I will give you just a little, tiny bit of background information to help set the context for the panel discussion, and then we will move right into the panel discussion, and then as our usual sort of tradition we will then have lots of time for Q&A, hopefully lots of time for Q&A with the Commissioners and the panelists.

So just to get us grounded, churn is a phenomenon that has long been recognized in the Medicaid program, and I'm sure you all are familiar with it. But it's a situation in which beneficiaries disenroll and then reenroll in coverage within a short period of time. And MACPAC has done some research looking at rates of churn. The two data points that you see here on this slide are from that analysis, which is a little bit dated now, but still important, nonetheless. And that analysis showed that about 8 percent of children in Medicaid and 16 percent

of children in separate CHIP experienced churn, and then in that second sub-bullet there you'll see that we did find some differences in churn by race and ethnicity.

The work also found that states that have implemented 12-month continuous eligibility, which we're going to talk a little bit more about on the next slide, but states that had adopted that policy in Medicaid and CHIP had fewer children that were enrolled for fewer than 12 months.

So just to sort of level set on what we mean by continuous eligibility, there is 12-month continuous eligibility which is now mandatory, and continuous eligibility is the policy in which children, people, individuals stay enrolled in Medicaid and CHIP for a specified period, in this case 12 months, regardless of changes in income or circumstance.

Beginning January 1, 2024, states were required to implement 12-month continuous eligibility for children under age 19, and that was required in the Consolidated Appropriations Act of 2023. And prior to the mandate, states had a state plan option to implement continuous eligibility for children but could specify a younger age

limit for continuous eligibility and a shorter duration. So the CAA of 2023 changed that, mandating 12 months and up to age 19.

As states have been implementing 12-month continuous eligibility, some states have also been looking to longer-term continuous eligibility policies, which we refer to as multi-year CE policies, and have been doing so through Section 1115 demonstrations. So far, three states have been approved, Oregon, who we will hear from on the panel, New Mexico, and Washington, for children ages 0 to 6. There are some exceptions specified in the special terms and conditions, and these exceptions are similar to the ones that exist for the state plan, the 12-month mandatory continuous coverage policy, as well, and those are listed on your slide. For example, a change in state residency. A state could disenroll a child who is in that circumstance.

The special terms and conditions for these demos also require states to have some sort of system for beneficiaries to report changes in circumstance and for the state to then accept that information as well as updated contact information. The special terms and conditions also include some specifications around the evaluation and

monitoring of these demos, specifically related to churn, the use of preventive services, as well as other costly and avoidable services.

Okay. So that's just a quick background. We will move now into the panel conversation, and I'm super happy to introduce to you Commissioners our wonderful panel. We have Cindy Mann, who is a partner at Manatt Health, and as many of you know, has held numerous leadership positions at CMS.

We have Emma Sandoe from the Oregon Health Authority. Emma is the, I guess, pretty newly minted Medicaid director there, but has had leadership positions in the North Carolina Medicaid program.

And then we have Laura Barrie Smith, who is a senior research associate at the Urban Institute. And Laura is leading a lot of research related to continuous eligibility, of course, among other topics, as well.

Okay. So thanks to the panelists for being here. It's really nice to see you this afternoon. Why don't we go ahead and get started.

Cindy, I have a level-setting question for you. To help us get the conversation started, can you just say a

quick couple words about what prompted states to look at multi-year continuous eligibility policies and what do they hope to accomplish by implementing them?

Cindy, I think you're on mute.

* MS. MANN: Sorry. And my phone rang, all at the same time. Sorry.

MS. JEE: You are in high demand.

MS. MANN: Yeah, well, or ill-prepared. Sorry.

I wanted first to thank the Commission for having this discussion and also for inviting me to join the discussion, so very much looking forward to it.

I think that in terms of why are states thinking about this, what's prompting some of this, is first to remind ourselves that states have really made, long made the commitment to cover children, to make the commitment for covering kids in Medicaid and CHIP. So the upper-income eligibility level in Medicaid, looking at Medicaid and CHIP, is 255 percent of the poverty line, and the highest income eligibility levels are for young children.

So we start with a strong commitment to children in the Medicaid program, and that is well above, as I'm sure everybody on the Commission knows, the minimum

standards that states have to implement for the Medicaid program.

So we've got that commitment, but churn has long undermined that commitment for children, and that's, of course, because coverage is fundamental to getting care. The data show that children without continuous coverage are children less likely to receive both preventive care and to see a specialist. And all kids and youth need this care, but it's particularly an issue for kids with special health care needs, kids and youth with emerging physical and mental health issues, and for all young kids where the evidence is so strong that childhood is such a critical time period to build the foundation of health and well-being for children as they grow and move into adulthood.

I think the other factor, besides the ongoing commitment to kids, the recognition of churn as interfering with that, and we see Congress recognizing that in the action to make one-year CE mandatory, is the public health emergency, which was an eye-opener. On one hand, states really saw the benefits of ongoing coverage without interruption. They saw a reduction, as Joanne pointed out, in racial and ethnic disparities in coverages, and at the

same time they saw when it was time to unwind that the states saw churn very much in play, and, frankly, disproportionately impacting the kids, even though because of those eligibility levels kids were more likely than adults to retain their eligibility at the end of the PHE than adults.

So what do they hope to accomplish? I think the states that are moving in this direction, obviously we have Emma Sandoe here and she can talk directly. But we've seen a couple of different kinds of proposals emerge from states. One is to create a continuous enrollment policy that's targeted to certain populations of kids, in certain kinds of situations, transitional situations and others. For example, Arizona has a proposal to do two years of continuous enrollment for former foster care youth, while other states have focused on that critical period of development for young children, guaranteeing uninterrupted coverage during their preschool years and days.

Let me just leave you with a taste of how I think extraordinary the momentum has been. Oregon, just to give that perspective on timing, Oregon and Washington had their waivers approved in the fall of 2022, and altogether we

have seen 14 states since then implemented or are planning to move in a direction of improving and adding to the federal requirements for continuous enrollment for kids. And if you just look at that multi-year coverage for preschool-age children, we have a dozen states now that have moved ahead. We have two states that were approved in the fall of 2022, and state, New Mexico, has been approved, and nine additional states in the wings, six with waivers actually pending, and three additional with enacted legislation.

So it's really hit home, I think, for states in terms of their desires to be true to their commitment to kids' coverage and to see that they actually get the care that they need during their coverage period with Medicaid.

MS. JEE: Great. Thanks for that, Cindy. It's helpful to hear about the breadth of state approaches, I guess, and the number of states that are interested in this policy.

Emma, I'm going to turn it to you. Oregon was the first state that was approved for the multi-year CE. What were your primary objectives in pursuing the policy, and can you provide a quick update on your implementation?

* DR. SANDOE: Sure. I'll start actually with the last. We got our waiver approved back in 2022, and implemented very quickly, in part due to the pandemic unwinding time period. So we've actually had this in place now for two years, so we consider the implementation period complete and are in ongoing maintenance and operations.

The reasoning behind our policy, which I just want to add, we have 0 to 6 continuous coverage for children and then a two-year period for both over the age of 6, all beneficiaries with the exception of a few small categories, since nothing is 100 percent straightforward in Medicaid, but for the vast majority of our beneficiaries it is a two-year enrollment period after age six. But the 0 to 6 particular policy was a large focus since there has historically been an emphasis on those specific years for children, and our health context in our state was focusing on birth to six in terms of ensuring that we are providing health care services for those age ranges as well as additional social services.

And what we learned from the pandemic was that maintaining that coverage significantly reduced churn, and looking into the reasons for people disenrolling prior to

the pandemic was a real emphasis on paperwork incompletion rather than people no longer being eligible for the vast majority of people that were being terminated, specifically in that age range. And that really was many of the driving forces.

While efficiency was in our systems, it is a key goal, it really was the health effects of the individuals and making sure that we were not terminating enrollment for people that were eligible, and the data was really showing that many people remain eligible who were being removed from coverage prior to the pandemic. So efficiencies within IT systems and for eligibility workers and care is definitely a benefit, however not the main driver of the reason behind going with this policy.

MS. JEE: Thanks for that, Emma. It's helpful to hear what your objectives were but also how you were taking lessons from the PHE and incorporating that into your policy and implementation.

Laura, I want to turn to you with a question about lessons learned from the PHE, with respect to monitoring and data collection. Is there anything that was learned during the PHE that might be particularly relevant

for these demonstrations, or for these policies?

* DR. SMITH: Yeah, good afternoon, everyone. Thanks to the Commission for having me today.

So the number one thing about the PHE, and during that period, and there's concrete evidence that the Medicaid continuous coverage provision contributed to that drop in uninsurance. So we'd likewise expect that multi-year continuous eligibility for kids will reduce uninsurance among kids.

But a big lesson learned from the PHE and unwinding that's relevant for the continuous eligibility demonstrations is that we've learned that many people were not aware of their continued enrollment during the PHE and/or were not aware of their potentially discontinued eligibility or what they needed to do to maintain coverage during the unwinding period.

Our team actually has a paper coming out later today that lays out the importance under multi-year CEE of monitoring and collecting data, not only on administrative records of who is enrolled or staying enrolled, but also ensuring that families are aware of disenrollment and what it means for providing access to care, and that self-

reported data from families themselves will be really crucial for understanding this.

And then second, under the unwinding period, as Emma was saying, many children who lost coverage did so for procedural or administrative reasons. So under multi-year CE, when that sixth birthday approaches or whatever the end of the continuous enrollment period might be, states will really want to make sure that families are aware of the state, what they need to do to maintain coverage, and states themselves will also want to anticipate these transitions, make sure they have updated contact information, and try to minimize the number of procedural disenrollments for children who remain eligible, so greater reliance on automatic renewals, for example, and really having a multi-modal, targeted communication and outreach strategy.

MS. JEE: That's great. Thank you for that. So this next question is both for Cindy and Emma, and maybe we'll start with Cindy. What are some of the key programmatic or policy considerations that states think about as they design their multi-year CE policies?

DR. SANDOE: I can start and turn it over to you,

Cindy.

MS. MANN: Sure.

MS. JEE: Okay.

DR. SANDOE: So I think for the most part this is a relatively straightforward implementation process on the state side. The IT system build is pretty straightforward. It is mostly about changing dates in IT systems. I think there are a couple of areas where there are a little bit more policy considerations. One is in a family where there are people that may have different timelines around dates, for instance, a child is 3 and another child is 8 or 10 or 7, to give an odd number, the enrollment period will be different for those individual family members as well as the parents. So aligning information and getting that communication, as well as aligning if a family has completely different time periods, as much as possible, so that as the redetermination process occurs it is more, as much as we can in a family unit, so that we don't have situations where certain members of the family lose coverage due to paperwork reasons and other families don't. So that is a little bit of an IT alignment processes.

And then one other sort of complication is around

Social Security number. You are not given a Social Security number when you are born. That process takes a little bit of time, and that is an issue that the Medicaid program has faced for decades, and it continues to be an issue, particularly with the fact that getting that Social Security number, and the family incorporating that into the individual's record, is not automatic and does not occur at the time of enrollment.

I can let Cindy go into more detail on that, or other items that we've seen.

MS. MANN: Sure. I can just jump in. I think you've covered a lot of the territory.

Obviously, a key initial design decision is who they're going to apply the continuous enrollment policy to, even on the young children multi-year. Most states have gone to six. Some states have gone to age five. Colorado is proposing age three, but thinking about a different age. So, you know, picking the age that you're going to be doing it or--and in the case of, like, Oregon and some other states, thinking about other complementary other policies that you want to do, like Oregon did it for the older kids, Arizona for the foster care kids, and so forth.

I think much of what you need to think about on implementation in your systems, states have pretty much figured out with respect to having implemented one-year continuous enrollment. So, as Emma said, it's sort of changing the date, right? You don't disturb a child's enrollment either for a year or for two years or for five years, right? So that part has actually been pretty straightforward.

The SSN issue that Emma raised, as she noted, is not a unique issue to CE. We've got that issue as kids -- the infant eligibility as kids turn one. We have to make sure we get SSNs. That problem won't go away with continuous enrollment, but hopefully, the coverage won't go away while everybody's chasing down the number, the SSN number.

You know, I think, as Laura said too, the good communication with families and with stakeholders, providers, and plans are really important so that everybody understands what the rule of the game is and that if there's something that's happening to a child's enrollment and they're otherwise should be protected by CE, there's a mistake and that should be identified and corrected as

opposed to, oh, that's just the way Medicaid is. So we want people to really understand it.

We want people also to understand it because, ultimately, it's about taking advantage of the care that the child needs, so really thinking about -- and a lot of states are really digging into this at this point, how to up the ante, how to make sure your managed care plans, for example, are making sure that all those preventive care services, which have long been required, are actually happening, and they're not interrupted by churn, kids with special health care needs. So states are thinking of maybe additional incentives language with their plans and monitoring, overseeing what kind of care that kids are getting. And, you know, the idea, of course, is not to just have kids enroll but to have kids finally get the need, get the care that they need.

MS. JEE: Great. Thanks for that.

Just to follow up quickly on that question, are there any fiscal or budgetary considerations that you might want to note?

DR. SANDOE: So this is not a free policy. It does have costs associated with it through the 1115 process

of determining budget neutrality and ensuring that the budget for the 1115 includes all aspects of the policies. This is a policy that does have cost to it, because maintaining people enrolled in coverage has cost versus terminating people for paperwork reasons or for other procedural reasons.

But really what this illustrates is that dynamic of the Medicaid program that we are constantly facing of investments in early childhood and health care at an early age can lead to savings down the line, whether or not that also leads to that individual saving the Medicaid program money versus another insurer, because they may go on private insurance later in life or whatnot. It's sort of the dynamic that we sort of constantly face with a lot of aspects of the Medicaid program if we are making investments in childhood health, how that is developed and potentially seen as health savings down the line.

I think decades of research shows that that Medicaid has made significant improvements to children's health, which has led to cost savings further down the line. But that's a dynamic that is present, because it is an investment early on.

MS. MANN: Is it okay if I jump in a little bit?

MS. JEE: Yeah, of course.

DR. SANDOE: Just to add a couple points. Obviously, totally agree with Emma's points.

So costs obviously do matter and particularly at the state level, because there will be some additional expenditures, and we've been -- we've been and others have been providing some technical assistance to states as to how to compute those costs as states plan for it.

At the state level, however, the cost is not -- and this is a point I think really worth stressing. It's not expanding coverage. The cost is really to live up to the promise that the state has already made to the children. If you're going to cover kids up to, you know, 150 or 200 percent of poverty, you've made that commitment. You know, everybody -- maybe the budget office banks on not everybody getting that coverage or not everybody staying on that coverage, but the commitment is to cover those children. So, yes, there are new costs, but not in the context of a state that's already agreed to take on the responsibility to cover children within whatever the state's designated income level is.

I think it's an important -- it's really perfecting the coverage that the state has already committed to and ensuring the kids actually get the value for it and don't have added problems because of gaps in coverage.

But on the federal level, I just want to stress for those who are focused on the budget neutrality minutia of going to an 1115, which I know many you rightly are, is the state -- is the federal government has actually accepted the notion that these are kids that are already -- the state has already committed to cover, and so there is no offset required by the federal government.

So, you know, you have costs at the state level if you're doing it, for sure. The feds will have costs because they'll have -- by reducing churn, they're going to have more months of coverage, but they have viewed it as part and parcel of the state accepting responsibility to cover those kids. And so there's -- it's what's called, for those who follow the minutia, a "pass-through" or a hypothetical in the budget neutrality spreadsheet world, and you don't have to offset any -- you, the state, don't have to offset any additional federal costs with a way of

finding federal savings.

MS. JEE: Great. Thanks for mentioning that. I think it's hard to get away from a conversation about 1115s without talking about budget neutrality, so thanks for raising that.

Okay. So I want to turn back to the monitoring and evaluation sort of questions, Laura, and bring you in here. What aspects of the demonstrations do you think are most important for monitoring and evaluation, and are there particular outcomes that you think ought to be addressed?

DR. SMITH: Yeah. With support from The David and Lucille Packard Foundation, our team at Urban has been focused on identifying the most important outcomes and how states and other stakeholders or researchers should prioritize their research questions around CE, thinking especially about what makes for realistic and measurable, short, and intermediate and longer-term outcomes.

We know that states will be focused on measuring reductions in churn and uninsurance among young kids as the key first order outcomes.

We also know states are planning to look at preventive care use, so well-child visits, primary care,

dental care, as more kids coverage and reduce discontinuities in coverage. We think of these as more sort of intermediate-term outcomes.

And then in the longer term, if we do, in fact, start to see increases in coverage and use of primary and preventive services, we could eventually expect to see more downstream outcomes of reductions in hospitalizations and other indicators of improved health and possibly improved educational outcomes as kids' developmental needs are getting addressed earlier.

And then one other outcome I want to mention that may be initially overlooked is the potential impacts on reduced stress and improved well-being for parents and guardians, both from not having to worry about renewals for their young kids all the time but also the simple peace of mind that their kids have coverage, that this will be the case even if they earn a little bit more income next month or have another change in circumstances. But, of course, these can be hard to measure and may require a collection of new data from families themselves.

MS. JEE: Great.

And, Laura, just staying with you for one more

question, are there any sort of issues or challenges that come to mind as a researcher and, you know, that you think states maybe will be grappling with as they consider their design and implementation of their evaluations?

DR. SMITH: Yeah. As in many impact evaluation studies, as much as possible, evaluators will want to use rigorous quasi-experimental research designs, such as difference and differences models, which include comparison groups who were not affected by the policy and compare changes and outcomes before and after the policy is implemented between the group that's treated by the policy and the comparison group.

One big challenge here is that these research designs will be tricky, given that the multi-year CE policies are being implemented on the tail end of the PHE and the unwinding, which really kind of muddies the waters for the immediate pre-period and can make it difficult to establish valid comparison groups, especially evaluators who might be hoping to use out-of-state comparison groups since different states had very different experiences related to coverage and access to care during the PHE.

Other challenges will be in measuring and

interpreting some of the outcomes. One example of this, if we see an increase in well-child visits resulting from continuous eligibility, this may lead to earlier diagnosis of developmental or health issues, which in the long term is a good thing for kids' health, good thing for their educational outcomes, but may in the short term make it look like children's health is actually getting worse.

And then one final example of a challenge is just that since most kids are generally healthy, many poor health outcomes are relatively rare. So studies may be underpowered to detect realistic effect sizes. So it will just be important to sort of manage these expectations.

MS. JEE: Great. That's helpful.

I know the Commissioners want to get in here with questions. So I'll just have one last question, and we'll end with Emma, our state panelist. Is there any insight that you can offer into Oregon's sort of approach or thinking about your evaluation?

DR. SANDOE: Sure. So very much along the same lines as what Laura mentioned earlier, we are looking at those well-child visits and income to determine whether or not we are indeed maintaining people who are eligible,

which was what we saw in the data, that the vast majority of people remain eligible through the continuous enrollment period, but really wanted to verify that through the data.

And the other thing I would note is that even though we just implemented this policy recently, we are in the process of gearing up for our renewal, because that is the timeline of 1115 policy, and really looking towards this data to evaluate and determine the next steps in terms of renewal and how we can ensure that we are meeting the goals of the original waiver through the renewal process, so using what we -- the information that we are beginning to see and beginning to collect to determine our next steps on the renewal.

MS. JEE: Great. It is hard to believe that you're thinking ahead to the renewal.

Okay. So that's all the questions that I had, and I look forward to the Commissioners' questions for the panel.

CHAIR JOHNSON: Thank you, Joanne. Thank you, Cindy, Emma, and Laura. I thought this was very helpful.

Let me turn to my fellow Commissioners and see if there are any questions, and I have a few. We'll do

Jami first.

COMMISSIONER SNYDER: Thanks so much for joining us today.

Emma, my question is for you. I know Cindy mentioned the importance of kind of partnering with your managed care organizations, I guess in your case, CCOs, and ensuring that families are aware of continuous eligibility and also that they're submitting the right documentation when their kiddo reaches that age point where they need to, you know, submit documentation in order to maintain ongoing eligibility if, in fact, they're eligible. I'm just curious to know about kind of the work that you're doing to partner with CCOs in the state of -- of Oregon. Excuse me.

DR. SANDOE: Thank you. And yes, so our CCOs have been excellent partners through the public health unwinding process and moving towards the continuous enrollment steady state of our new policies. It certainly has been an area that has historically and, in many states, still exclusively a place that is more on the side of the Medicaid agency and the state various enrollment, whether they have a single streamlined application for multiple programs or whether that exists outside in the Medicaid

program.

That historically has only been in that space and not in the managed care organization space, but the pandemic and utilizing the pathways of communicating with members, managed care organizations has really been a lesson of the importance of making sure that we are aligned, because questions can come from members to any various avenue. And, particularly, they work very closely with our managed care organizations on a variety of different topics and making sure that our managed care organizations have all of that information and know where to find enrollment dates and other pieces of information that had historically only lived in the eligibility space is important.

So we have worked closely with them on communication materials and making sure that they have all of the materials for their call centers and their presentations with their community organizations that they liaise with on a regular basis and really sharing those talking points. We worked really hard throughout the unwinding period, and that -- and as such, this particular policy on really revamping how we think about member-facing

materials and have worked alongside our managed care organizations to ensure that both us and the managed care organizations are really taking a person-centered approach to the way in which we communicate and making sure that those communications are not written in legalese and can be understood, because this policy is certainly complicated, particularly in those instances that we have family members with varying dates. So we really tried as much as possible to incorporate community input into the materials that people would be receiving related to those enrollment dates so that it was as plain language as possible, and our managed care entities really assisted with that.

CHAIR JOHNSON: All right. Thank you.

Sonja?

COMMISSIONER BJORK: Thanks, Verlon.

I was wondering if the panelists could focus a little bit on foster youth and what kind of experiments or approaches that different states are using with foster youth who are becoming adults. In California we offer coverage up to age 26, but I was wondering the context of CE in different states. How is it working, or what are different states trying? Thanks.

MS. MANN: I can jump in, but Emma is also trying to help that population as well. So you probably want to hear directly from Oregon.

So I think the multi-year CE is just so well-suited to the needs of the foster care population, right, either kids currently in foster care and the youth transitioning out of foster care. It's just -- you know, I'm sure you all know the transitions for those children and youth are just enormous, and then the health care doesn't always smoothly tag along. So if we can smooth out that issue for this particularly vulnerable population and vulnerable both on physical health and mental health sides and just, you know, generally in terms of their life trajectory, it makes a lot of sense.

As I mentioned, Arizona has a proposal to do two years of continuous enrollment for those that are transitioning out. Understanding it's just a point in time where lots of changes are going on for that youth and worrying about suddenly being responsible for paperwork to maintain health coverage seems a pretty inopportune moment for them to deal with that.

So I'm hopeful actually -- and Oregon has a

policy for all children, as Emma talked about, and youth, regardless of the zero to six to get the two years' continuous coverage if they're older. So that encompasses foster care kids as well. So I do think it's an area that as states are thinking both about broader eligibility criteria for continuous enrollment and targeted interventions, that foster care youth and youth moving out of foster care would be a really appropriate target population.

DR. SANDOE: Yeah, and I would say that we and all states cover former foster youth up to age 26, so they remain eligible. Even if they are going through the redetermination process, they will remain eligible. But people do fall out of the system because we may not have address information or other things like that, or not out of the system but it becomes harder to reach people.

And I would just say that doing continuous enrollment is one piece of a very complicated puzzle, and if we are only reaching out to people at their sixth birthday, and every two years, and that is the only time that they are hearing from the Medicaid agency, we are not doing health care correctly. We need to make sure that we

are engaging with our members that we serve on a regular basis, to make sure that they are aware of the benefits that they have, that we are doing care coordination, that we are really trying to address the needs of the beneficiaries that we serve, particularly the former foster youth who often do require additional levels of care coordination, and really having that movement from Medicaid coverage through their 26th birthday to whatever other coverage is appropriate for the individual during that youth period is important.

But they also need to know how their benefits are changing because youth in former foster care have a different level of benefits sort of provided to them throughout their continuum of care, and particularly for all youth the change of EPSDT coverage and what that means, we're trying as much as possible to smooth that EPSDT coverage through youth, so that people are, as much as possible, continuing to receive specific care that they had been receiving. But that is always going to be a challenge of maintaining that EPSDT benefit in a way that we can, after that person is no longer eligible for EPSDT.

CHAIR JOHNSON: Thank you. Carolyn.

COMMISSIONER INGRAM: Thank you. And I want to thank the panelists for joining and taking the time to educate us today. Cindy, you go into some information about the budgets and budgetary constraints, and I wanted to know if you could just elaborate a little bit more on states that you're working with. Are they looking at limiting that population from 0 to 6 because of the budgetary constraints whereas other states, right now we just have the information about Oregon has done more expansive population with some of their kids, with children with special health care needs. Is it mostly based on those budget issues is why states are kind of picking certain populations over the others? That's my first question, and I have one more.

MS. MANN: Yeah. Good question, Carolyn. Thank you. I don't think that budget concerns are necessarily -- I mean, obviously every state is different and every revenue situation is different in states, and evolve year to year, right. So there's no general answer as to how it will affect that.

But I think, by and large, states are thinking about what they want their policy to be. Initially, some

of the early states -- Colorado, I would say, even though it's not approved yet, it was an earlyish state, in legislation. They were not sure where CMS was going to go, not sure if CMS would approve going all the way up to age 6, not sure what budget neutrality was.

So I think as things have gotten more clear, at least at the federal level, that there's no required offset, to the extent that states are aware of it, but that helps them think about some of the financial obligations that they will face. But there are some.

So, again, I think that once you get past it's not an expansion. It's really giving life to the commitment that's already been made to the children you already cover, on paper anyway, that the conversation about how that policy weighs with whatever cost it is to the state, and there are costs, has really been won out. I'm not aware. There may well be states where, oops, sorry, we floated it, it came with a price tag, and it was too much. They may have to tailor it a little bit. But it's been pretty warmly received, I think, by governor's office and I think by legislators.

COMMISSIONER INGRAM: Thank you. That's helpful.

And then my second question was just on the system issues. There's been a lot of talk lately that system issues are causing families or kids to fall off of eligibility. And I'm just wondering in your research -- well, I guess the whole panel -- if you all have seen that, that states need to maybe be more on top of those system issues, or if that's really actually happening in some areas, or if it's hard to say. Thanks.

MS. MANN: I mean, I think the system issues have been front and center during the PHE. I mean, even before the PHE, a lot of states adopted mitigation plans at the behest of CMS or at their own proposal, to say my system isn't doing everything it's supposed to be doing under regulations. And so many have adopted mitigation plans, and in addition CMS has issued guidance -- well, initially when the PHE started, that if you have noncompliance issues, you're going to have a couple of years after unwinding to try and get your systems into compliance. They recently issued guidance to states starting what that process will look like, releasing a template.

So yeah, I think the issue of ex parte determinations not being done appropriately for kids, in a

number of different states, which, you know, that's an issue that many states weren't aware of, that the feds weren't aware of, that came to light.

So those are all issues that I think are really both contributing to states wanting to move their programs forward and address these changes. They've got a lot on their plates, a lot to juggle. But also CMS being clear that within some reasonable period of time states need to bring those systems into compliance.

Meanwhile, continuous enrollment can, at least, be probably the most comprehensive mitigation plan because whatever the systems issues, at least if you can get in the program, you can stay in the program, for whatever period of time the CE period establishes.

CHAIR JOHNSON: All right. Thanks. I see Tricia, Mike, Heidi, and Dennis. We'll start with Tricia.

COMMISSIONER BROOKS: Thank you, and thank you all for being here. And you know how excited that my colleagues and I at the Georgetown Center for Children and Families are about this particular policy. And I've had more than a few conversations with all of you about this.

Emma, I know that you're new in your role in

Oregon, so if this question is putting you on the spot, please tell us you can get back to us. But Oregon has what has been framed as a school readiness metric. It was originally focused on the systems level and it has now moved to the individual social-emotional level. And I think one of the exciting things about multi-year CE for young children is identifying those developmental delays, addressing those so that kids are ready to enter school.

Can you share more about that particular metric and how that's going for Oregon, or do you want to take a pass and come back to us?

DR. SANDOE: I did not plan for this to be a question so I think I'm going to take this back and double check with my team, because I don't want to provide you with inaccurate information.

COMMISSIONER BROOKS: Well, thank you for that. And just another point. Cindy, thank you so much for raising the issue about hypothetical budget neutrality. It exists, and I think that's a good frame, not only for convincing states to go for an 1115 but also for making the case that this is a really important policy going forward.

I remember back in 2009; you first floated this

concept of multi-year continuous eligibility. What is your hope for if we can maximize the opportunity, what are we going to see at the end of these five-year waivers? What is the real outcome we want to be? Reducing churn is always great, but there's so much more that we can do here.

MS. MANN: Yeah. Thank you for all of your advocacy on this topic and for your question. You know, I think as Laura said, states will be obviously doing their evaluations. But I think there is a way states can get a window into exactly how this is working very quickly by looking at their claims data, by looking at various data that comes to them, and seeing whether those preventive care visits are actually happening at the pace at the American Academy of Pediatrics recommends and EPSDT requires then that periodicity. Are they happening, you know, I've looked at recent data, MedPAC's put out data, and even at the very young child's age it gets worse as you age. But we're missing a lot of kids.

But then there's also the T. There are the developmental screens, so important in hearing and vision and oral health. So important in terms of developmental disabilities, spotting a potential learning disability,

spotting other issues early enough and then moving to the treatment. And we saw recently, at the end of September, CMS issued guidance on what the benefit requirement is for kids, for all kids under 21 actually.

So really that's the goal is to make sure that kids get the early periodic screening, the diagnostic testing, and the treatment that the law promises them, and that I know states really want to see them have. There have been barriers on a lot of areas to kids getting that care. But one has been the churn. So that barrier goes away, and with that commitment and that commitment of financial support that the state is making; to say we are going to continuously cover our kids, comes a responsibility to make sure that care is actually delivered in all those areas.

Feedback loops with consumers, with families, how is it work, where are the access issues, as well as reviewing data, all of those kinds of mechanisms have always been really important, but now can be implemented and acted on in ways that otherwise you were hampered when you kept seeing kids losing coverage over the course of a year.

CHAIR JOHNSON: Thank you so much. Mike.

COMMISSIONER NARDONE: No. thank you all so much for this great presentation. I'm very excited about this continuous eligibility. I have spent some time in the Medicaid director's chair, and I've often had to make the case to skeptical budgeteers.

So I was curious, and I think you kind of touched on this. And Emma, I just was wondering, and maybe this is not a fair question either if you're kind of new at this role, I was wondering in your contact or in your conversations with budget folks, is there a business case that you've been able to make to them that it's important for them to be supportive of those kids and the eligibility policy or are there maybe particular metrics or indicators that as you're doing your monitoring and kind of the review of claims data that, you know, Cindy was talking about, might be kind of supportive of the move to continuous eligibility. Because I'm thinking it might be helpful to other states to also hear what the arguments are that have been persuasive, I guess, in kind of making the case for CE.

DR. SANDOE: Well, if the Commission would allow

me to remove my Oregon hat and put on a very old hat of North Carolina, I was very involved with the 1115 development in North Carolina, which did include the continuous enrollment. And at the risk of speaking for my former state, I would just say that the evidence around working towards prevention and the importance of childhood, early detection of diseases, as well as treatment, all of the arguments that we make for EPSDT has been, and was part of the conversation around the importance of this particular policy.

I think that the commitment that states have to children is strong, and there are many strategic goals around ensuring early childhood development, because it is so crucial, that aligning this particular policy with those broader policies around early childhood education, early childhood social and emotional well-being, et cetera, because it is so intertwined. And the early data that we do have from the PHE period as well as other pre-PHE periods does indicate that children really that are eligible for Medicaid to begin with, remain in that eligibility level through their childhood.

So this is really more about alleviating that

burden, ensuring that people are getting care. Certainly providers have been instrumental in making that argument, as well, to legislators and others, because there have been so many instances where a child is receiving regular care or receiving treatment, and then that is interrupted by administrative policies and sort of having those children no longer be part of that work. And that has been a persuasive argument to many people because providers really see it at the individual level.

CHAIR JOHNSON: Thank you. That was really helpful. So we are actually at time, but I wanted to check with the panel to see if you are able to stay for a little bit longer, since we have a couple of other questions in the queue. Is that okay? All right. Perfect.

So Heidi.

COMMISSIONER ALLEN: I thought I was going to get cut off. I would be so upset. Hi. So happy to visit with you all. Thank you for this wonderful presentation. I have like one comment and one question.

My comment is, are you tracking parent insurance related to this policy change? I know there is compelling evidence that children's coverage continuity was tied to

parental coverage continuity, and I'm wondering about the converse relationship and whether, on the one hand you're getting fewer notices and renewal reminders from Medicaid because you're not getting them for your children. Does that make parents less likely to reenroll and more likely to fall off on coverage, or does not having to apply so much for their kids create more bandwidth that they are able to take care of themselves? I just think you might have to do some qualitative work on that to try to understand what's happening, but I think it would be super interesting.

And then my second kind of question/comment is related to, say this is a big success, and people are like it didn't actually cost that much money, it really improved all these outcomes, and we're really excited, we think this idea is very worthy. Would the next step be to go from 7 to 13, or what would be the next waiver application?

And I just want to make a pitch for, if it's going to be that incremental, what about thinking about 13- to 19-year-olds, which is an area like 0 to 6, where there's a lot of very specific needs that have long-time implications for people's health. You know, adolescents

have sexual and reproductive health needs come up, and they have behavioral health needs come up, and that might be a better option than trying to just go incrementally, age by age. So I'm curious about that.

And I just want to say how happy I am to see you in Oregon, Emma, my home state. I know that Oregon is going to love you and that you're going to love Oregon. So I hope that this is all going well for you.

That's it for me.

CHAIR JOHNSON: Thank you, Heidi. Dennis?

COMMISSIONER HEAPHY: My question somewhat builds on Heidi's, and I'm thinking actually specifically folks with complex medical needs, and why wouldn't that extend to 19, or actually beyond 19, to 22, or seeing these folks transitioning into adulthood, because we want to make sure they've got continuity of care.

So why isn't there more focus on folks with really medically complex needs to ensure there's continuity of care throughout their -- ensuring that that transitions into adulthood? It just seems like it's something that states would want to have in place, and I think probably cost savings if there's no reduced churn in those

populations. That's my question. Thanks.

DR. SANDOE: Are we allowed to respond?

CHAIR JOHNSON: You are allowed to answer the question, and sorry I didn't let you -- allow you to answer the last question. So feel free to do that one as well. Thanks.

DR. SANDOE: So one thing that I want to point out is since we do have the zero to six and the 12 -- or the 24-month for all populations, we are evaluating both. So we are getting additional data on enrollment and sort of income fluctuations to really be able to have better data and better understanding of sort of where there are people falling off for procedural reasons who remain eligible.

So part of the 1115 evaluation of this period is really focused on understanding with more granularity where in what age range we're seeing the income fluctuate to the point that people are no longer eligible and getting a better understanding of the -- both churn but also whether continuous enrollment for two years does increase some of those necessary visits and care coordination later in life as well, so in the 13 to 19 period and up through 22 and all the rest.

So, hopefully, we'll have more data, and I'm looking forward to all of your comments and recommendations on our renewal in the next 18 months or so.

COMMISSIONER HEAPHY: If I could just clarify my question and say that most of the folks, kids I'm talking about, will be on Medicaid for the rest of their lives. And so, like, doesn't it make sense to actually just ensure there's continuity of care?

DR. SANDOE: Yeah. And we are doing that analysis by eligibility group. So that will indicate, to a large extent, some of those more complex cases and where we see people potentially falling off in the two-year period.

DR. SMITH: And I can just add a little bit about some evidence on kids with special health care needs. I know that on the one hand, kids with complex health care needs are less likely to experience churn, but on the other hand, continuous eligibility policies, in particular, are shown to especially improve access and outcomes for that population, so definitely an important group of kids to cover continuously.

MS. MANN: And just to throw in, I think there's both -- as you hear from both Laura and Emma -- real

interest in states and thinking about different populations.

Certainly, I think kids and youth with special health care needs may be extending to adults As you suggest, Dennis, their situation isn't necessarily going to change in terms of their eligibility. Thinking of periods of, you know, transitions and particular stress, like the homelessness provision, like the transitioning to foster care, thinking about parents so that it's the whole family. So all of those, I think, are areas that are right for further attention.

I would just give the perspective that, you know, I have Medicare, and I have employer-sponsored coverage, and I don't renew every year. There's an expectation that it stays with me. I can leave it, but I don't renew.

Now, I understand, you know, Medicaid isn't a means-tested program and has different configurations, but there has to be something between losing, you know, 10, 12 percent of the kids in any given year to thinking about how do we really just stabilize coverage and make sure that everybody has a place to get their coverage continuously and always.

So I think there's some bigger-picture thinking that needs to be done, but I think certainly that some of the groups that you're all flagging are likely ones for states to give more considerations to.

CHAIR JOHNSON: Thank you. That was a very helpful perspective.

Patti?

COMMISSIONER KILLINGSWORTH: So, as a mom of a child who had lifelong disabilities and special health care needs, I really understand and appreciate the value of this policy, especially for kids and youth with special health care needs.

I have missed those deadlines before personally in the midst of medical crises, and I just -- figuring out the way to make that easier is important.

My question is really about -- not so much about the policy, but about how to operationalize the policy in a way that states actually embrace it and do it. And I'm a little concerned about leveraging 1115 authority as kind of the mechanism to get there. I have a little bit of a love-hate relationship with 1115 authority, and it's so flexible. But it's also so hard sometimes, and the delays

are really lengthy.

I had an amendment, an 1115 amendment pending from 2020 when I left state government in 2022, that the last time I knew, it was still pending in 2024, right? And so it just has to be easier than that with some sort of alternative authority or maybe even like a template authority for states who are going to use 1115 that is specific to something like this that -- you know, that everyone agrees is really, really important.

MS. MANN: So I think they're listening to you.

So a couple of things. One is, there are some bills -- there's a proposal that President Biden made in his budget. There's some bills pending in Congress and also being developed in Congress that would turn both multi-year coverage for kids, in some cases for parents. There's not even an option for parents to do one year. So I think thinking about turning those into options for states is in the ether but will need some attention.

On the delays on 1115, obviously, there's an election, so we'll see what happens. And, hopefully, the strong support we've seen across the board on multi-year and continuous coverage will be seen, which I think rightly

it is, and we see this in some of the state legislators. It is not a partisan issue and hopefully will remain intact regardless of what happens.

But this administration is moving to templatize the request. It is a pretty simple 1115, and it does get lost in the queue, which is quite long. So both making it easier for states to apply and assuming a state adheres to what's been approved before, very easy and quick for the Feds to approve.

So, hopefully, you're going to see that developing soon, but I think, ultimately, getting away from the 1115 structure is a good thing, at least for some of these policies.

COMMISSIONER KILLINGSWORTH: That's exciting. Thank you so much.

CHAIR JOHNSON: Great. And I think we have one final question from Jami.

COMMISSIONER SNYDER: Thanks so much, Verlon, and thanks for staying on the line for a couple of additional minutes.

So I think this is super exciting in terms of ensuring that kids are able to connect with critical,

clinical, and preventive care. But I don't see this work in isolation of some of the really -- the other incredible work, especially, Emma, you're doing and states all over the country are doing related to health-related social needs and social determinants of health. So I'm kind of curious to know from you, Emma, and from you, Cindy, because I know you've worked with several states around their 1115 demonstrations related to social determinants of health, how you see this work as contributing to your efforts to connect families to housing, nutritional supports, and other health-related social needs.

DR. SANDOE: I feel like you teed me up to say we are now within 13 hours of launching our housing services in Oregon, the first in the country to go statewide with the housing HRSN benefit through the 1115 waiver. And there is a lot of asterisks to that, I realize. I recognize the important work that many other states have made in this work, but we are very, very thrilled to be launching that benefit.

That benefit and the existing climate benefits and the upcoming nutritional benefits are really meant to be connecting people to existing long-term services, but

that doesn't happen overnight. For example, the rental assistance can last up to six months, and that would be unfortunate if it were interrupted by a procedural determination, for instance.

This is really meant to be working hand in hand to ensure that we are getting the best value out of those investments we are making in health-related social needs, because again, the investments are meant to ensure that we are making health improvements that we will see in long term, because while there are very many immediate health improvements from ensuring people have housing, food, and climate-related services, they are also very much focused on those long-term health needs that we may not necessarily realize. So ensuring that people can get the full value of those services and that the Medicaid program also is able to do the full care coordination that is required to ensure that people are remaining on a pathway towards improved health is absolutely crucial.

And we're so excited for the next 13 hours. So we're looking forward to November here.

MS. MANN: You're making me do my Oregon Pacific time conversion so I can figure out exactly when this is

kicking off.

[Laughter.]

CHAIR JOHNSON: Exactly, exactly. That is very, very exciting.

So I just want to say this has been a great panel conversation for sure. I think we've learned a lot, and I'm sure we'll have many other questions ahead of us as well. But, you know, this is -- you know, I think Jami shared from her opening statement, how exciting this all is. And to see the three of you, three true leaders in this area really helping us understand this and move forward is very exciting, I think, for all. So thank you so much for coming on.

Joanne, anything else you need from the panels at all?

MS. JEE: No. Just my thanks.

CHAIR JOHNSON: All right. Thank you so much. We appreciate you.

MS. MANN: Thank you.

DR. SMITH: Thank you for having us.

CHAIR JOHNSON: So we're now going to move into the Commissioner discussion. We obviously had a lot of

great information that was just shared with us. You all had some great questions and some observations, and so I'll open up the floor then for you all to ask away and lead us on.

Tricia.

COMMISSIONER BROOKS: Okay. So I could talk about this for all of the 15 minutes and more that we have left. So I'm going to touch on a few things that I didn't hear in the conversation.

So going to communications, which people recognize the importance of, but what I didn't hear are things like health literacy and health insurance literacy, because I think that is a key part of helping to educate families about the care their children need in order to have healthy development.

And then the role of the MCOs, it was touched on a little bit, but also health care providers. I don't think it will shock anybody in this room to know that if you say EPSDT, not every MCO and not every provider actually knows what it is or how to deliver on it. So we need more education with MCOs and health care providers, that training on EPSDT.

And then when you move further down, we have lots of tools for examining outcomes. We've got EPSDT screenings, the 416 report, the external quality technical reports from MCOs, the Child Core Quality Metrics, which are now mandatory.

But we can go deeper than that, and I lift up Louisiana as an example, because they have a great dashboard. I can't say that it's up to date, but they've got the makings of a dashboard that breaks down all of the quality measures, all of the HEDIS measures, in particular, which many of the core set measures are, by plan year after year is what we want to follow. And they break it down by demographics as well.

So, if we're going to get underneath all of this, we can look at outcomes to see, is this MCO performing better than that one? What are they doing differently, or is this population more affected? Where do we target our education? So I think that is a key here, at least on the monitoring side.

We need very clear MCO roles and responsibilities, and they tie back to the state quality strategy for MCOs. I tell advocates always, take a look at

your quality reports, take a look at your quality strategy, search for child, search for maternal, search for pediatric, and tell me what you find. And you will find that often there's not a lot of emphasis on these particular populations. Not so much on maternal health. I think that's changing a bit. But on kids, kids are cheap to cover. We're not going to save a whole lot of money, and the money that we are going to save getting to -- I think it was Mike's question -- is cross-sector educational. If we can reduce the cost of one IEP in schools, what is that worth? How many kids does that cover for six years?

And we need to expect more from the plans. Plans will have continuity of payment. They'll probably not want to see reductions in those cap rates, even if there were to be savings there. So what's the plan? Is the MCO responsible for provider engagement? Is the state, the MCO, and the providers all share in the responsibility? Is the network adequate and reimbursement sufficient? How are the health-related social need waivers going to be integrated into multi-year? Is prior authorization a barrier to pediatric services?

So these are some of the things where, you know, I floated the idea of having a different MLR for kids than for adults. If kids are contributing more to plans' profit or margin, shouldn't that be dedicated to improving children's health and not offsetting the cost of other populations?

And, lastly, I would say that kids have been anywhere from 40 to 50 percent of the enrollment, and in states that are non-expansion, even more than that. We should require plans to have a staff person dedicated to children's health and monitoring that and reporting directly to the CEO so that we know that it's a priority for the plans.

So let me get off my soapbox there.

Oh, can I just say one other thing? And that is, we keep talking about bending the cost curve. We have adults with multiple chronic conditions that are rooted in childhood. If we want to bend the cost curve long term, we have to invest in children's outcomes now, and maybe we'll start to see that we're bending the cost curve 20 years down the road. But we've been talking about bending the cost curve for decades now, and we aren't quite getting

there yet. Thank you.

CHAIR JOHNSON: Thank you.

Jami?

COMMISSIONER SNYDER: I just want to say that as the evaluations are coming out and as data comes out, I'll be interested to see what changes look like in both overall spending and per capita spending, how capitation rates are affected, but also how the percentage of children with third-party liability coverage changes over time. I think that could be an interesting metric.

CHAIR JOHNSON: Okay. Any other Commissioners? Any other aspects of CE demonstrations you're particularly interested in or want to think about from a monitoring perspective?

Okay, Carolyn.

COMMISSIONER INGRAM: Sorry. I can't seem to coordinate raising my hand and getting to the mic fast enough.

I think the areas around quality, quality, I mean, Tricia raised some important points about who's responsible for making sure that we're training up folks to see outcomes in care and KPIs delivered for this

population, and that's a longstanding problem as Medicaid directors that we've all had, trying to raise the quality bar. So really being able to see that measurement is going to be exciting coming out of these states who have pulled this off and starting to see, you know, what are the actual changes on the ground. Did we get, you know, children into more services? Did we get better quality outcomes?

And all those things are -- I know are being tracked. So it will be exciting to see that as much as we can look into those items. Thanks.

CHAIR JOHNSON: That's great.

And I just want to put a pin into the health literacy piece that you talked about, Tricia. I think we did hear a little bit of that from Laura in terms of the elevation rates and folks not knowing exactly how to utilize the services. So I would love to see us do more around that if we possibly could or learn more about it.

Anyone else? Patti.

COMMISSIONER KILLINGSWORTH: Just a quick note, and we talked about this previously, so I'm sure Joanne has it, but really looking at this by population to understand based on the data that's available where we sort of see

longer periods of eligibility having the greatest impact and thinking about, you know, younger kids, children and youth with special health care needs. Dennis talked about sort of all the way up to, you know, young adulthood. So really being able to look at the data and the story that tells in terms of the value, I think, would be incredibly important and helpful to us.

CHAIR JOHNSON: Thanks, Patti.

Mike?

COMMISSIONER NARDONE: I was just going to say that the thing that struck me was the comments about how folks didn't know that they had eligibility, continuous eligibility during the PHE, and I guess that kind of leads me to kind of wanting to understand strategies. It's not just -- it's not quite health literacy. It's more engagement strategies so people are aware of what their benefits are and what the services are that are available to them.

CHAIR JOHNSON: Thank you. Anyone else?

[No response.]

CHAIR JOHNSON: Joanne, do you have information that you think will be helpful from this conversation?

MS. JEE: Yeah, lots of interesting points and lots of things to look for. As the monitoring happens and as the evals happen, you know, I know we all wish up the evaluations and the data could come faster, but I've got the list. So we'll be keeping our eyes on those things.

CHAIR JOHNSON: All right. Thank you for putting together a great panel. We appreciate it and, of course, from your opening remarks, too, as well. They're great.

All right. Now we're going to move back into another public comment session. So, again, I'm just going to remind you to raise your hand if you would like to offer comments, and once you do, please make sure you introduce yourself and the organization you represent, and we're asking you to keep your comments to three minutes or less.

PUBLIC COMMENT

* [No response]

CHAIR JOHNSON: Wait a few more seconds.

All right. Well, if you don't have comments now, just remember that you can submit them to the MACPAC website, and we will go ahead and go to break now until 2:45. Thank you.

* [Recess.]

VICE CHAIR DUNCAN: All right. Good afternoon, and welcome back to our last session of the day. I can't say that we always save the best for last, but again, I think this is a great session and a follow-up from our last meeting. We've got Melissa that's doing a little deeper dive into the youth use of residential treatment services, from some of her research. So Melissa, it's all yours.

YOUTH USE OF RESIDENTIAL TREATMENT SERVICES: FEDERAL AND STATE FINDINGS

* MS. SCHOBER: Good afternoon. Today I'll be continuing our work on appropriate access to residential services for youth with behavioral health needs. This presentation will begin by providing some context and background information, followed by a review of barriers identified in federal and state reports, before concluding with next steps.

As you heard last month, 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 are returning this month to present findings from a selection of reports prepared by state legislatures, organizations designated as

the state protection and advocacy system for people with disabilities, the U.S. Department of Justice findings from investigations related to the Americans with Disabilities Act.

Apart from a limited number of peer reviewed articles, these reports are the only published information on the demographic and clinical characteristics of youth seeking and receiving care in residential treatment facilities, the experience of beneficiaries and their families, and the challenges state child-serving agencies, including Medicaid, face in meeting the complex and diverse needs of these beneficiaries.

Staff conducted this supplemental review of a convenient sample of 11 federal and state reports to provide specific examples of challenges associated with providing residential treatment to further the Commission's understanding. Although the reports we reviewed are public, MACPAC will not name particular states during this presentation.

This examination was not included as part of our original scope of work, and the states that are the subjects of these reports were not part of our usual

qualitative methodology that begins by inviting states to participate in our work. The examples are illustrative of the range of issues states and facilities have grappled with in recent years, including a rising number of youth with behavioral health needs, as highlighted during our September presentation.

The Americans With Disabilities Act was enacted in 1990 to "ensure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shuns them aside, hides, and ignores them." Title II of the ADA requires that public entities administer services, programs, and activities in the most integrated setting appropriate to meet the needs of qualified individuals.

In 1999, in Olmstead vs. L.C., the Supreme Court held that public entities must provide community-based services to person with disabilities when (1) such services are appropriate, (2) the affected persons do not oppose community-based treatment, and (3) community-based services can be reasonably accommodated after accounting for the resources available to the public entity and the needs of others who are receiving disability services from the

entity.

Subsequent rulings found that the ADA's integration mandate applies to people, including children and youth, who are currently institutionalized and those at risk of institutionalization, and that a state's failure to provide home and community-based services, or HCBS, may create a risk of institutionalization.

In response to complaints regarding the failure to provide care in the most integrated setting, the U.S. Department of Justice may investigate states for compliance with Title II of the ADA, as interpreted by Olmstead. State legislators, legislative auditors, or agencies may investigate state departments or programs to examine the characteristics of youth who meet medical necessity criteria for a residential level of care, but for whom no bed has been identified, youth who have experienced placement and residential overstay in which a youth is deemed ready for discharge but cannot be released because no family, foster care, or other placement setting is available.

These reports may also review the cost of institutional care and reimbursement rates, and may include

plans to increase the supply of in-state residential care and home and community-based services. Both federal and state reports typically include a review of data, such as the number of facilities, licensed and staffed beds, length of stay, and the clinical and functional characteristics of youth. Such reports may also include interviews with youth and family, state agency staff, and providers.

I'll discuss the barriers to appropriate access identified in our review of these federal and state reports.

Each of the reports we reviewed noted challenges in finding appropriate residential treatment in state and sometimes out of state for youth with complex or co-occurring conditions, particularly intellectual and developmental disabilities or substance use disorder. In addition, other common barriers to placement included prior juvenile justice or child welfare involvement, prior hospitalization, a history of elopement, sexualized behaviors, and older age. Federal and state reports also noted disparities in placement for youth of color, including indigenous youth.

Some states require that youth be denied

admission to every in-state psychiatric residential treatment facility before seeking out-of-state placement. The most frequently cited reasons for admission denial were externalizing behaviors such as aggression, and an inability to meet the health needs of the youth. A few states noted that prior placement disruption or repeated moves among foster care placement as a barrier to accessing residential treatment services. Frequent changes in placement may affect continuity of care by interrupting home, school, and community behavioral health treatment.

States and the DOJ reported that many youth with behavioral health conditions are able to receive treatment in their homes, schools, and communities, but that states' failure to ensure access to HCBS leads to unnecessary and sometimes prolonged placement in institutional settings, including residential treatment facilities. For example, one state reported that youth waited, on average, nearly a year for targeted case management services. Another report noted that "segregated settings are frequently seen as the only option for children with behavioral health disabilities, because the state fails to ensure access to community-based services that could prevent

institutionalization.

Children experience avoidable and often repeated hospitalizations. Children who experience the cycle of repeated hospitalization are frequently sent to long-term placements in residential treatment facilities. Many of these residential treatment facilities are outside the state, exacerbating the harms of segregation."

Avoidable initial placement and continued stay constrains that availability for in- and out-of-state providers. A residential treatment facility may be well matched to meet the needs of the youth with complex behavioral health conditions, but be unable to serve them because all of the licensed and staffed beds are already occupied, including those occupied by youth who could have avoided this level of care if HCBS were readily available, and those occupied by youth unable to be discharge, which I will discuss next.

DOJ and state reports commonly found increasing lengths of stay in residential facilities, including periods where the youth remain in the facility beyond medical necessity, that is, the youth continues to reside in a residential facility even after a clinical team deems

the level of care is no longer necessary to continue safely treating the youth's behavioral health condition. Such prolonged and unnecessary admission limit the ability of referring providers and agencies to admit and treat other youth. Such youth could be served in less-restrictive settings, but the provider, and the state for youth under the care and custody of the child welfare agency, are unable to find appropriate community-based care and a supervised living arrangements with kin or foster family. Youth who are discharged to temporary or inappropriate placements and experience discontinuity of care are at risk of readmission, which may strain limited residential bed capacity.

Barriers to finding appropriate placement and care prior to discharge included intellectual and developmental disabilities, aggressive behavior, and extensive wait lists for home and community-based services.

Discharge planning is further complicated when a youth has been placed out of state. Caregiver engagement is significantly associated with positive treatment outcomes during and following treatment. When youth are placed out of state, the distance between the youth and

family may make it difficult for caregivers to engage in treatment, treatment planning, and care coordination to reintegrate the youth into their home, community, and school.

A few states also noted difficulty in obtaining real-time information on bed availability. Youth who experience a behavioral health crisis or exacerbation of symptoms may be transported to the emergency department. If the youth does not meet the medical necessity criteria for an acute hospital admission but does require intensive treatment, the ED may refer the youth for treatment in a residential facility. The ED much search, often by telephone, for an open-bed in a facility and then must apply for admission. This is a laborious process where the youth can wait for days before an appropriate placement is located, and safe, supervised transportation arranged.

According to the Joint Commission, this ED boarding increases "psychological stress on patients who may already be depressed or in psychotic state, delays mental health treatment that could mitigate the need for a mental health inpatient state, consumer scarce ED resources, worsens ED crowding, delays treatment for other

ED patients, some of whom may have life-threatening conditions, and has a significant financial impact on ED reimbursement."

Staff are beginning state and stakeholder interviews which will continue through the fall and winter of 2024. We plan to return after the new year with a panel discussion on appropriate access to residential treatment for youth with behavioral health needs. Following that panel, staff will share findings from our interviews with states and experts in the spring of 2025. During this meeting we welcome your questions on the federal and state reports, and if there are specific topics that would help the Commission inform your consideration of the issues related to appropriate access to residential services for Medicaid enrolled youth.

VICE CHAIR DUNCAN: Thank you very much, Melissa. I had shared earlier, during break, that of all the topics in my three years of serving as a MACPAC Commissioner, this is one that has generated calls and emails and word on the street from state officials, hospital officials, and more importantly, families that have been experiencing some of the things you just discussed. So thank you for sharing

the new findings, and with that I'll open up questions or comments from our Commissioners.

COMMISSIONER ALLEN: Thank you so much for this work. I thought it was an excellent compilation of what's out there, which is not enough information. And I find it to be such a particularly troubling situation.

From a personal level, I started my career working in residential treatment, and then went on to get a master's degree to become a social worker. And as the years have gone by, I often think of the three years that I worked there with a lot of shame. I think of all the kids that were put in restraints. I think of the kids that were sent in from other states, some of them kidnapped in the middle of the night by strangers and put on a plane. Some of them basically exiled from their states until they turned 18 and would then just be discharged to nowhere. Kids that got a lot better and then we just kept, because we didn't know what to do with them, for six months, a year.

I think of how they weren't allowed to date, and if they tried to date it could sometimes be even labeled grooming behavior. That they weren't allowed to form close

friendships because we didn't allow cliques. And thinking of how that was how these adolescents spent years of their life, thinking about how few of them went to school during the day, and how inadequate the school was, and what that means for the rest of their life. This just total losing out on social, developmental, academic milestones that they should be participating in.

And then I also think of it as a parent who has a kid with a significant mental health issue and how, in desperate times, when we were wondering if we could keep our kid safe at home, we were desperate for a place that had 24-hour people awake and watching, and that wasn't a hospital, there really was no treatment.

And so I really feel for these kids, and I feel for these families, and just the pervasive sense that I got reading the report was that this is, out of all the things we talk about in MACPAC, this may be one of the most wrong things I've ever seen. You know, I don't know even how to interpret disparities, because on one hand, as a parent navigating the mental health system, with excellent insurance, but finding that almost everything was out of reach. So you would then think that disparity is if people

are underrepresented in treatment, because obviously access is an issue. But on the other hand, what does it mean when kids are overrepresented in that system, considering the outcomes associated with losing years of your life in a treatment program like that.

And I'm desperately hoping that since I was an early social worker that things have changed, but then as I read through the report I'm like, it hasn't. It's just as traumatic. It is so traumatic.

So I don't even know, you know, partly, I think we really should have like a conversation about how we're going to think about disparities, how we're going to think about access. I think we just really need to figure out what we mean by that.

And then I think that this seems like an area that desperately requires innovation and new solutions, new options, new approaches. And I know that there are innovation waivers for a lot of different populations or special issues in Medicaid, whether there are any states that have created an innovation waiver around acute mental health, which could include inpatient hospitalizations.

And I hope that we really continue to look at

this issue and hopefully come up with some recommendations, because I think it's so important. Thank you.

VICE CHAIR DUNCAN: Thank you, Heidi. Anyone else? Patti.

COMMISSIONER KILLINGSWORTH: I won't be nearly as eloquent, I think, as Heidi was, but I will say that I think back on my 25 years in state government, so many of the conversations that I had at the very beginning of my career were the same conversations that I still have at the end of my career, as it related to behavioral health, both for children and for adults, and specifically for certain subpopulations, which made it even more challenging, and specifically people with intellectual and developmental disabilities.

I agree with Heidi that it is an area where innovation is desperately needed. Again, when I think back on 2 1/2 decades that this is an area that seems to have advanced the least in terms of what we know and understand about effective treatment models, in terms of a continuum of options, in teams of a real focus on continuity in community, and ideally, in families when we're talking about kids, for sure. Astonishing that we have so little

information about outcomes and efficacy in an area that's so incredibly critical.

And so I know this is specifically about residential treatment centers. I know we are also looking kind of beyond at the continuum. I'm trying to stay focused, but I think it's really hard to stay focused, because as a practical matter, if we're not careful residential treatment, as Heidi said, becomes a place where kids go and they stay, and they never leave and come back home, or they don't leave and go into sort of a less intensive but equally effective form of treatment that allows them to continue to live in the community.

So I think we have to think about this in the context of a continuum of care that is always focused on more integrated -- integrated into school, integrated into family, integrated into community -- and what we can do to really help people, help young people have the support that they need when they're young, and so hopefully they don't carry many of the same challenges with them into adulthood.

I think we have to continue this work. I think we need to press for real data and real accountability for the way that care is delivered, and quite frankly, real

access, because access that is only available in another state, away from your family, and that not enough of the time leads people to actually get better and go back to their lives again isn't meaningful access.

VICE CHAIR DUNCAN: Thank you, Patti. I've got Sonja, Angelo, and then Dennis.

COMMISSIONER BJORK: Thanks. I would like to see some of the stakeholder interviews and follow-up research really focus on some of the tribal and Native American programs that are out there and might offer some really good information or best practices. And then I also always very much like to see the rural lens, because access is hard for pretty much everything. So many rural communities, they're so creative and innovative in ways that they find to take care of families and children, but they need support. So what is it that we can do to promote models that really help rural residents, rural children and families.

VICE CHAIR DUNCAN: Thank you, Sonja. Angelo.

COMMISSIONER GIARDINO: Thank you, Melissa. One thing I would ask in terms of our work is what is the conceptual framework that's operating in this area? So for

example, in some of the work that I've done with providers that do mental health, restraint and seclusion is really viewed as something that's not cool, and the better systems can really reduce the need for restraint and certainly for seclusion.

So with residential treatment, are there certain states that seem to have embraced a model that uses, let's say, home and community-based services to the extent that they really don't need much of a residential treatment alternative? So could we find those best practices and find out what they did so that they don't need to be sending tons of kids out of state for residential treatment, and they handle these really high-risk situations in a different way?

I'd really be interested, what is the current theoretical framework among professionals who work with these kids so that they don't need residential treatment. I assume there are some states that are quite good at avoiding the need for residential treatment for the children that they're responsible for, and that there are some states that are really at the other extreme, where their network of services, their system of care just

falters, and they have, on a population basis, a number of kids, and when compared to those other best practices in those other states that it's really an outlier.

So if we could really understand what the right thing is. I don't want to, I guess, kind of just be kind of a pedestrian in this area, and say, you know, residential treatment is bad, it's awful, it's warehousing kids. That is my perspective, but I don't know how well that's informed. And are there best practices where you can really serve these kids and not need residential treatment. And should our goal be that for the most part you don't need residential treatment in your system of care because the best practices drive you away from that practice, much like in a mental health facility. It really is viewed as a failure if you have to use restraints inclusion. Thank you.

VICE CHAIR DUNCAN: Thank you, Angelo.

Dennis?

Oh, go ahead, Melissa.

MS. SCHOBER: I was just going to say, very briefly, so in the last month's memo in September, there was a reference to the community-based alternatives to

psychiatric residential treatment facility demonstration that had occurred with the, I believe, nine states over a decade now. Some of those states have sustained investments in their system of care and have reduced the use of residential treatment through things like a blended and braided approach to funding, increased funding for mobile crisis response, so that when a young person experiences a disruption or exacerbation of symptoms, they're treated in their home and community and avoid the ED, which can lead to residential treatment.

Certainly, in stakeholder interviews, we'll be asking about those opportunities and challenges in terms of residential treatment, partially as some of the other Commissioners have raised, to explore solutions that are good for rural communities, Indigenous and Tribal communities and other states, since I would expect but do not yet know that those solutions and practices probably vary by the population of young people to be served.

COMMISSIONER GIARDINO: Thank you, Melissa.

And, again, I take from what you're saying there, there really is kind of a model system and a system-of-care best practice that I would love to see how much evidence we

have that would support us embracing that.

And, again, you know, listening to Commissioner Allen, as a pediatrician, any approach to a system of care that interrupts children's ability to develop their full potential is really -- should be verboten. I mean, you know, we shouldn't be saying, you know, it's tough to take care of these kids, so residential treatment is okay. If that interrupts their normal developmental process, then they're not able to develop fully. So that should actually be kind of a red flag, and Medicaid should probably not pay for that service. And the state should be really encouraged to embrace things that allow children to develop fully and not interrupt their development so that we can control their behavior until they're 18 and then discharged to nowhere.

Thank you.

VICE CHAIR DUNCAN: Thank you, Angelo.

Dennis, then Mike.

COMMISSIONER HEAPHY: Thank you.

Thanks for that report. It was -- I found it overwhelming, to say the least, and it seems like the responses from other Commissioners, they were somewhat

overwhelmed by it as well.

And I'm wondering, from your perspective, greatest hope in terms of areas we should focus on in data collection? Because there's so much that needs to be done in terms of collecting appropriate data to track what's going on in the states and the quality of care these kids are receiving. That's my first question.

MS. SCHOBER: Thanks for that. I think, not to oversimplify, but any data collection or regularized data collection would be an improvement over what we have now.

So, as I talked about in September last month, there isn't a national survey that adequately tracks all young people. So understanding with a routinized definition so that it's measured across all states in an identical form and function, which young people are accessing residential treatment not only within PRTFs, psychiatric residential treatment facilities, but also other kinds of residential treatment facilities would be a useful first step to understand access issues and to understand the age, demographics, and functional characteristics of young people who are receiving the services since we know so little now.

COMMISSIONER HEAPHY: Thanks. That was my takeaway is we need a national system of definitions and data collection to start. It's just like what should be collected in the data, kind of lost that.

But there's also things in terms of diversionary services and starting, like, higher up in the chain and start with peer services, respites, and then short of a hospital or residential treatment center, short-term stays at treatment centers in state, similar to what we have for adults. Why can't there be something tailored for youth that's very similar so they don't have to be taken out of their communities and places that people can go before they have an exacerbation of their condition, where they can say, hey, I'm feeling like I'm going to have something going on, I need to go somewhere? And then they can voluntarily just go to a short-term-stay place in the community, and they come out. And so it's a normalization of the symptoms they're experiencing, what it means to have a mental health condition or behavioral health need.

I've just seen that with folks in my life. The more we normalize folks and what they're experiencing and enable folks and encourage folks to just get treatment as

part of their everyday life activities, the less stigmatizing it is, the less traumatizing it is, the less they need for the high-level intensive treatment. And I just don't think out-of-state treatment should be allowed at all, particularly if there's no oversight. It's just unconscionable. So thanks.

VICE CHAIR DUNCAN: Thank you, Dennis.

Mike and then John and then Heidi.

COMMISSIONER NARDONE: I was just going to -- a couple of folks have mentioned kind of better understanding what some of the innovative service models are. I think some folks mentioned states that are doing a lot of this area. I'd actually be interested also in specific models at the provider level that have been effective in terms of basically allowing folks to remain in their homes and communities with a particular focus on some of the populations that you identified as being hardest to place in state, meaning folks who have IDD and also behavioral health needs.

I also would like to understand are there models of both providing services that allow folks to remain in the community or to remain in residential treatment

services for as little time as possible, institutional services, as well as potential models that allow folks to transition back home to their home state, again, with a particular focus on that population or those populations that are most susceptible to the out-of-state placement.

And I guess the other thing that I'm just curious about is, how do those models then fit with some of the requirements around Medicaid? So I'm thinking about, you know, it's only been recently that crisis services have actually been -- mobile crisis as an actual service that's recognized under Medicaid, right? I mean in the history.

People could cover it, right? But they were covering it through residential, through rehab services. So I'm wondering if there are other barriers or policy limitations that once we've kind of looked at these innovative models, what are the things that maybe Medicaid needs to do to allow these models to be more ingrained in the Medicaid program? And maybe we have all the tools, and there's nothing that needs to be done. It can all be done under HCBS. But I think just kind of understanding if there are limitations that maybe we could comment on.

VICE CHAIR DUNCAN: Thank you.

John?

COMMISSIONER McCARTHY: On this one, this is more for us in thinking of these things. I've heard a number of comments in which I agree with. We definitely do need to focus on home- and community-based services, crisis services, and doing everything you can up front.

Having said that, there is still -- I mean, we're -- humans are complicated, right? And so you can't just say we're going to totally eliminate something. There still might be a setting where you cannot help a child, and maybe residential is the only way to help them.

And, you know, the examples that I ran into here in D.C. when I was Medicaid director and in Ohio were very different. In Ohio, we had no PRTFs. There were zero PRTFs. They were concerned about putting kids -- institutionalizing kids. So we really did focus on home and community services, but there were still some number of kids at any point that we were sending out of state. And it was like, you know, for a program that had close to a million kids in it, we would be sending, like, at any time, seven to ten out of state. But, you know, there still would be.

And those kids had such pervasive problems of there might be a fire starter. We had nobody in the state of Ohio. There wasn't so many kids that we were sending out. It might be one or two. You couldn't have a provider in Ohio that could specialize in that because it was so uncommon. So we also have to think about how many kids have some of these issues, and then how do we deal with that, and then how do we do the oversight of that? How do we have quality oversight of those things? So that's one issue.

The second issue -- and I saw both in D.C. and Ohio -- was there are just some times where there is zero family engagement, for whatever reason, and sometimes it's because it's been hard. So there's no place for this kid. Where they're living at home is not a very great place to be for various reasons. And so what do you do with those situations?

And sometimes they end up in residential for some period of time and then come back to a foster care system who may or may not be able to handle them either. Also, another issue.

So, as a part of looking at this, I don't want us

to get off the track of just saying, oh, PRTFs are bad, and so it's like that's it. They're out of the picture. I still think we need to focus on what we had started focusing on, which is payment rates, oversights, that piece, at the same time, looking at the other piece, because it's complicated. It's very complicated.

Just so everyone knows, I agree with Heidi too. I've seen also the terrible sides of these things, and we'd be bringing kids back. And you were like, hey, that provider was terrible, and we would turn that provider off. We would say we're not sending them there anymore. We report it to that state and say, hey, these bad things happened. And sometimes those providers got shut down; s\Sometimes they didn't. So it's a very complicated issue. I don't want us to view it as, oh, this is pretty simplistic. We just do this one thing. It is quite complicated.

VICE CHAIR DUNCAN: Thank you, John. I appreciate, again, bringing in the reality.

And Heidi?

COMMISSIONER ALLEN: Thank you again. Of course, I always think of things I forgot.

I want to know a little bit more about the "finding a bed" situation. As I read that, like, there's no way to know if somebody has a bed. I'm like, oh, if only something like a computer existed. I mean, thinking of the things that we can do with AI right now and yet you need somebody to go into like a phone book and call people and say, "Do you have a bed?"

But some of that's on purpose. Some of that's on purpose, because when I worked in admissions for an inpatient psychiatric hospital, we were taught to try to prioritize people with commercial insurance. So, if we had a bed that looked like it was going to be opening up, we'd start making a list, and we would make the list and prioritize based on who we thought would stay the longest and who had commercial insurance. And that's just the reality.

So what we had is we had the state buying beds. So the state essentially had something in the contract where they got so many beds. Then what people were waiting for was a Medicaid bed, and I'm curious of how often that currently happens. Is it a Wild West queue? Are commercially insured kids pushing out kids with Medicaid?

So that's one question that I wanted to add to the list.

And then the other thing is thinking on that continuum of care, there's the acute hospitalization, which many kids go to first, which when I first started working in acute mental health for kids was actually pretty long. The average length of stay was about 30 days, which, you know, not great, but it's at least time to try some meds, see if they're working.

And now I think the average length of stay is between seven to ten days, and when my kid was hospitalized, they basically did nothing in that time because there's nothing to do. The kid just sits there in the room alone and does nothing.

So I think that that part of the continuum of care is just -- it's a holding cell until either the kid is willing to say, "I'm safe, and I'll go home. And I'll be good." The parents are willing to say, "We'll take them home. This is terrible. I don't want them to stay in this condition," or they're able to find somewhere else to go. But most of the time, I think they're usually discharged from home, and if they need something else, they're on their own to find it.

And then that discharge into where, there's partial hospitalization. Are kids with Medicaid able to go into partial hospitalization? There's for the kids that nobody will pick up, because I know that some parents feel like they have to refuse to pick up their kids in order for their kids to get treatment.

If I pick up my kid, we'll be left alone entirely to deal with this problem on our own again. So I'm going to say I'm not going to pick them up. That way, they can stay and get treatment. Is there group homes that Medicaid pays for that people could go to before they're ready to go home, rather than going into the foster care system, which requires parents to give up custody?

So I'm interested in those two immediately pre/immediately post kind of transitions too.

VICE CHAIR DUNCAN: Thank you, Heidi.

Anyone else?

[No response.]

VICE CHAIR DUNCAN: Melissa, again, I think you hear the passion and interest.

Oh, Adrienne, okay. Thank you, Adrienne.

COMMISSIONER McFADDEN: Just figured I'd wait

until the last minute to throw you off, Bob.

So I think that the comment I had was actually spurred by John's comment, and so I think they're -- I am really interested in sort of making sure that we get back to sort of the reimbursement rates as well. I do believe that John has had a really valid point, and there may not be a specialist for those really special needs. But there are models out there for high specializations where you can get some cross-training so that those states with limited access can start to upskill their providers that are in state. And are there opportunities to have innovative models to be able to incentivize providers to do so?

Similarly, when the youth are actually sent out of state, I would think it's actually really hard to send them back to their state of residence for a less restrictive setting, particularly because institutions are used to working with institutions in their own state. And so I think that's also something that I would like to explore a little bit more around sort of the networks of sort of where they're repatriating into least restrictive settings even out of state.

VICE CHAIR DUNCAN: Thank you, Adrienne.

John?

COMMISSIONER McCARTHY: I want to go back to that out-of-state definition that we have. I know Dennis said earlier nobody should go out of state, but I think what he really means is people -- I won't speak for Dennis, but sending people far away from their homes.

So, for example, if the state of Ohio only had one PRTF and it was in Columbus and the child lived in Cincinnati and there was a PRTF that they needed to go to and it was in northern Kentucky, it would be 20 minutes away versus two hours away in Columbus. So an out-of-state placement may be better than an in-state placement, depending on location.

So this goes back to one of the things we had asked earlier. Is there any way we can get a map of where these facilities are?

MS. SCHOBER: So we have a list from CMS of psychiatric residential treatment facilities, which are just one type of residential provider. So it's possible to highlight which states have PRTFs, but I do not know of any source that comprehensively collects all residential treatment settings because, again, like Ohio, although now

they've added PRTFs, but not all states have PRTFs. And even when they have PRTFs, children sometimes accrue to other residential treatment settings. So, unfortunately, there's no way for me to provide you a map that would be comprehensive of all residential treatment facilities across the nation.

Certainly, one of the state reports that was highlighted in the memo for the Commission this month noted that because it was a geographically small state, that there were neighboring residential facilities, including PRTFs, where children sometimes went because they were, in fact, geographically closer to home.

I think understanding some of the discussion from last month and this month, the concern, if I'm hearing feedback correctly, is about young people who are sent quite far from home and to your point about those young people being repatriated or reintegrated to their home and community when they've been at a great geographic distance.

VICE CHAIR DUNCAN: Anything else, John?

[No response.]

VICE CHAIR DUNCAN: All right. Dennis?

COMMISSIONER HEAPHY: Just a quick response to

what John was saying. I definitely think geographic distance is a huge factor.

But I'm also wondering this -- and I'm totally ignorant on this, but if laws are different in one state from another, does a child lose some of the rights? Do those rights change to the family and access to that child in another state? Because they'll say, "Well, we don't do things that way in Kentucky," "We don't do the things that way in Connecticut," whatever state it may be that's not the state the child's coming from. So is there a shift in what the person's rights are, what the family's rights are, once they go from one state to another? So that would be my concern, going from one state to another.

VICE CHAIR DUNCAN: Thank you, Dennis.

Heidi?

COMMISSIONER ALLEN: I will note that that's absolutely true, and I think the number one difference in rights is that some states require a child to consent to residential treatment if they're of age of consent. Like, I think is 14 and above maybe in Washington state, which is why kids are kidnapped from their home and flown to states where they can't consent.

So some of it is very deliberate effort to take kids to a state where they have fewer rights than in the states where they reside. I don't know how that intersects with Medicaid, honestly.

VICE CHAIR DUNCAN: Thank you, Heidi.

As I was saying, Melissa, you can hear the passion and interest in this topic. I think you've got a lot there. But I'd just like to add my two cents worth here at the end.

You ask about a panel discussion, and I know this is a lot. But I think you've got to include particularly what I consider the safety net hospitals, where a lot of these patients get stuck, and that's children's hospitals and adult public hospitals.

The other is the states. I love that both Mike and Heidi mentioned, are there innovations taking place? But I'd like to hear from states that are doing innovative things, as well as states and their frustration, because that's what I've gotten since our first pane, is hearing from states who want to do something, want to figure a better path, and struggling.

And what I think is one of the most important is

to interview and talk to families who have gone through this at the risk of having to put their kids in the foster care system to get the access to services and what that means to them and what they're dealing with, because I think it's important to hear from their perspective of what we're seeing and hearing.

So, Melissa, thank you again for a job well done. I, like Heidi, when I read the report, I was extremely dismayed to see that much has changed in my experience in 20-something years of dealing with the system. But this is important. So thank you.

And with that, Madam Chairwoman, I turn it over to you for public comment.

CHAIR JOHNSON: Thank you. Thank you again, Melissa. Thank you, Bob.

All right. Let's go ahead and move into our final public comment for today. So, as we said earlier, if you have a comment that you would like to share, please raise your hand and we will unmute you. You'll need to introduce yourself and the organization you represent, and again, you will have three minutes or less to provide your comments. So let's see.

PUBLIC COMMENT

* [No response.]

CHAIR JOHNSON: All right. We do not have any public comments right now, but again, if you think of one, please feel free to go to our website, our MACPAC website, and provide your comments there.

With that, I think we've reached the end of our day. I think it's been a very productive day, definitely one with a lot of information that we learned, we've shared, and we're looking forward for our conversations tomorrow that will begin promptly at 9:30 a.m. So we'll see you tomorrow. Thank you.

* [Whereupon, at 3:31 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, November 1, 2024.]

PUBLIC SESSION

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, November 1, 2024
9:30 a.m.

COMMISSIONERS PRESENT:

VERLON JOHNSON, MPA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
DOUG BROWN, RPH, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
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.]

CHAIR JOHNSON: Good morning, good morning, and welcome to our second day for our October MACPAC meeting. Our first session today will focus on Medicaid managed care external quality reviews, or EQR as we call it, policy options. And so I will turn it over to Allison, our principal analyst, and Chris, our policy director, to tell us more. Thank you.

MANAGED CARE EXTERNAL QUALITY REVIEW POLICY OPTIONS

* MS. REYNOLDS: Good morning. Thank you, Commissioners. Today we'll continue our discussion of Medicaid managed care external quality review from September's meeting.

This presentation will begin with a quick recap of the external quality review process, or EQR as it's known. We'll then review the study we conducted and what this study revealed in terms of limitations and challenges with the EQR process, accounting for the impact of the 2024 Medicaid managed care rule. Next, we'll present three policy options intended to further improve the EQR process

and beneficiary access to quality care. We'll conclude with next steps in light of today's discussion.

Let's briefly review the key elements of the EQR process relevant to our study findings and policy options.

This graphic illustrates managed care quality oversight at a high level, specifically how the regulatory requirements of quality strategies, quality assessment and performance improvement plans, and EQR are interrelated. For the purpose of today's discussion, we will be paying special attention to the part of the cycle where feedback from a state's EQR Annual Technical Report should be used by the state Medicaid agency to inform their review of and updates to their quality strategy.

Of all of the concepts involved with external quality review, our focus today is on two specific elements: one, the role CMS plays through development of EQR protocols for each activity that guide the state-contracted external quality review organization in performing its work, and two, the Annual Technical Reports that states must publish of all EQR activities conducted by their EQRO the previous year.

After the publication of the managed care final

rule earlier this year, CMS has specified four mandatory EQR activities that states with qualifying managed care plans must conduct and seven optional activities that states may choose from. Today we will be particularly interested in opportunities to improve mandatory compliance activity 3, the triennial compliance review.

CMS provides technical assistance to states, EQROs, and managed care plans with EQR protocols. These protocols provide states and EQROs with the purpose of each activity, acceptable methodologies to conduct each activity, and offer practical tips, suggested questions, and best practices. CMS issued the first set of protocols in 2003, and the current versions were issued in February of 2023. CMS is required to review the protocols and make necessary revisions every three years or when new regulatory changes require updates. Therefore, CMS will need to update the protocols in response to the 2024 managed care final rule, and states will have one year from the issuance of the applicable protocol to comply.

Once the EQRO has completed the mandatory and any optional activities for a state Medicaid agency within a calendar year, the EQRO produces an annual technical report

summarizing those activities, each plan's performance, and the state's managed care program overall. For today's discussion we will be highlighting the new requirements to include any outcomes data and results from quantitative assessments from three of the four mandatory activities in the Annual Technical Report. We will also focus on the requirements regarding posting the Annual Technical Reports online.

Now that we've reviewed the EQR process and requirements let's turn our attention to the study we conducted and what it revealed regarding limitations and challenges with the current process.

In our prior review of the EQR process we identified a few limitations and challenges that are listed here. We will discuss these in greater detail over the next few slides.

The first challenge our study found is the EQR process and protocols focus on process, not outcomes. Specifically, the focus has been on validation and compliance with federal managed care requirements and the process elements of the CMS-designed protocols. This leads to findings that report levels of compliance with federal

requirements but does not provide more useful information on actual plan performance and outcomes. Stakeholders we interviewed told us that when EQR activities are focused on outcomes they reveal trends in performance that help inform where to focus resources for improvement.

In the 2024 managed care final rule, CMS partially addressed this concern by requiring outcomes data to be reported for three of the four mandatory activities. However, this requirement does not apply to the triennial compliance review activity.

Second, our environmental scan revealed EQR and state quality strategies are not always aligned. As discussed earlier, the EQR process is supposed to be connected to other quality monitoring and improvement requirements in Medicaid managed care, including the state's quality strategy. However, our study found this connection between EQR activities and the state's quality strategy has been historically limited. Rather than the continuous feedback loop represented by the earlier graphic, one interviewee described the EQR process and the state quality strategy as operating on parallel paths. Interviewees did tell us that they had recently seen

efforts by states to align their EQR activities with their state quality strategies, and this also appears to be a growing area of focus for CMS.

Third, states vary on enforcement of EQR findings. Since state Medicaid agencies are not required by CMS to act on EQR findings, our study found states took a variety of approaches incorporating findings into their managed care oversight process. On the passive end of the spectrum, some states reported simply documenting the EQR findings. Other stakeholders reported states freezing auto-assignment of enrollees to plans that perform poorly on EQR activities, and described this freeze as an effective action to bring about improvement to a plan.

The fourth limitation our study identified is that CMS oversight of the EQR process appears limited. Despite the EQR guidance documents and technical assistance CMS provides to states and EQROs, our study did not reveal evidence that CMS is utilizing EQR findings to directly oversee or bring about improvement in state Medicaid managed care programs. For beneficiary advocacy groups, this could be described as a missed opportunity for CMS.

Our fifth and final challenge with the current

EQR process is that Annual Technical Reports are not always accessible and findings are hard to use. Even with transparency requirements built into the 2024 managed care final rule, Annual Technical Reports, as currently required, do not present their content or findings in a way that stakeholders reported as digestible or useful. The lack of an executive summary or a template for the report's layout or a standardized approach to evaluating plans' performance were noted by interviewees as challenges with Annual Technical Reports.

Now that we've reviewed the challenges with the current EQR process let's discuss some options to make improvements.

Here we've identified the five challenges found by our study, and we have mapped all five challenges to three policy options. Next, we will review the policy options one at a time before coming back to this comparison slide for the Commission to provide us feedback. Overall, these three policy options seek to shift the focus of EQR activities from process and compliance to meaningful outcomes and actionable data, and to improve the usability of EQR reporting through standardization and summarization.

Policy Option 1. Our study found EQR activities focused on process and compliance rather than plan performance and meaningful outcomes. This finding was partially addressed by CMS in the 2024 managed care final rule. CMS indicated its intention to require outcomes data be reported in the Annual Technical Report for three of the four mandatory EQR activities is to make the EQR process more meaningful for driving quality improvement. However, CMS did not require this quantitative analysis for the triennial compliance review activity.

A review of the protocol for the triennial compliance review activity reveals numerous outcomes-based suggested questions and potentially responsive documents containing quantitative data. For example, regarding the availability of services standard, the protocol suggests asking MCOs how often in the last year has your managed care plan had to arrange for services or reimbursements to out-of-network providers. For the coverage and authorization of services standard, a suggested question of utilization management staff is what was the volume of denied claims for emergency and post-stabilization services in the most recent year.

A third example comes from the grievance system standard, where it is suggested to ask what types of services require preauthorization, how does your managed care plan track requests for covered services that the plan or its providers has denied, and what was the volume of denied requests for services in the most recent year.

Similarly, the 2023 protocol identifies several applicable plan documents for the EQRO to review, including measurement or analysis reports on service availability and accessibility, data on enrollee grievances and appeals, data on claims denials, and performance measure reports.

Based on our study findings and our analysis of the 2024 managed care final rule our first policy option is: CMS should amend 42 CFR 438.364(a)(2)(iii) to require the EQR Annual Technical Report include any outcomes data and results from quantitative assessments collected and reviewed as part of the triennial compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

Policy Option 2. We believe our second policy option addresses all five challenges identified by our study. CMS gives states flexibility in the way states evaluate their plans' performance during EQR activities and

how they report those results. Stakeholders reported to us flexibilities in these particular areas make it difficult to identify key findings and place plan performance in context. Stakeholders indicated the desire for an EQR process that balances flexibility with standardization and consistency.

There are several design considerations where standardization could be implemented. For example, identifying KPIs of plan performance and standardizing the reporting of these KPIs. Also, CMS creating a standardized template for an executive summary of key findings and recommendations.

Revisions to the EQR protocols, both in terms of how activities are conducted but also how findings are reported, could improve the usability of the Annual Technical Reports for all stakeholders.

Our second policy option is: CMS should issue guidance and protocols to include more prescriptive and consistent standards for reporting on EQR activities.

Policy Option 3. Stakeholders reported that finding the most recent Annual Technical Reports and compiling those reports from all 50 state websites is

challenging. And while CMS currently publishes summary tables of Annual Technical Reports, those tables do not include findings that would allow stakeholders to use the summaries to assess plan performance. CMS officials indicated to us that it was challenging to post Annual Technical Reports on Medicaid.gov currently as the reports vary from all 50 states and would require resources that aren't currently available to make them 508 compliant.

As we recommended in Policy Option 2, a standardized template for an EQR Annual Technical Report executive summary would allow CMS to post 508-compliant documents for all 50 states. Together, Policy Options 2 and 3 could provide stakeholders access to the key EQR findings across all states in one central location, Medicaid.gov.

Our third policy option is: CMS should improve the accessibility of EQR findings by publicly posting the Annual Technical Reports on Medicaid.gov.

What's next? If the Commission decides to move forward with any of the three policy options, then we will be back in December with recommendations language, and in the new year we would review the draft chapter and vote on

those recommendations.

During this meeting we look forward to the Commission's feedback to the challenges identified by our study and the three policy options presented to address them. Thank you.

CHAIR JOHNSON: Thank you, Allison and Chris. Very helpful. I think that this slide here obviously helps to show us where each of the different areas can address the concerns that we had. But I'm wondering, for the sake of this conversation, if it may be better to go through each of the different options one by one. So let's go ahead and go to the first one.

MS. REYNOLDS: Sure.

CHAIR JOHNSON: Thank you. So I'll open the floor to the Commissioners, but just keep in mind again, based on what you've heard today, we need your feedback on the different options that we potentially would want to advance, that there are suggested modifications to the options as written that will be helpful to you, as well. And again, while we're going through it one by one, it will be really good to hear collectively your thoughts on if there are some that may be well-suited to still be together

or different combinations. So I'll open up the floor right now.

All right. Tricia.

COMMISSIONER BROOKS: Thank you, and I already was planning to talk on all three before you said one, so I might be a little out of range here.

CHAIR JOHNSON: Please do.

COMMISSIONER BROOKS: Thank you for this work. I was not an interviewee, but honestly, you captured everything I would've said to you. I have spent a lot of time trying to help educate the policy and advocacy community about how you engage and understand where quality is and what drives quality in the process.

Your flow chart, I actually have one similar to that but it's got a fourth bucket, and that is the RFP process and procurement, that the quality strategy should drive that, then you have the quality assessment program, then you have the evaluation under EQR.

So, Madam Chair, if you will forgive me to say I am in favor of all three, and I won't have to raise my hand again. Thank you.

CHAIR JOHNSON: Thank you so much, Tricia. All

right. Next up, Angelo.

COMMISSIONER GIARDINO: First, I wanted to say thank you for what was really an elegant policy analysis over the last number of months, and this has really resulted in a real clarity around what the potential options are. So I think this is a real great case study of how we do some work, we look at what the literature is, and then we find an opportunity to perhaps improve the program. So thanks for that investment of time and effort.

I would also speak in favor of all three options because I think, fundamentally, what you're talking about is the value of standardizing a reporting mechanism that's in place for a very good reason. But by standardizing it we allow stakeholders to really understand the issue much better across the nation, which is very important. And I think fundamentally what you're talking about is basic quality improvement principles, where if you're going to invest time in a monitoring effort you should do it in a standardized way that allows comparisons which then could improvement the program. So aligning what the EQRO is doing with what the state plan is trying to improve is useful locally, and then across the country it's great if

it's standardized, so we can see if the whole program is benefitting.

So I really applaud your effort, and I will take my prerogative and say I support all three directions. Thank you.

CHAIR JOHNSON: Thank you, Angelo. We may as well go to the fuller slide, so let's see that. It looks like that's the way we're going to go. Patti, how about you?

COMMISSIONER KILLINGSWORTH: So I also appreciate this great work. It's a complicated subject with a lot of moving pieces, and I think you've done an excellent job of laying all of it out for us.

I support all three options, but would like to suggest that we consider a slight modification to Policy Recommendation 2, which would make sure that it's clear that as we focus on kind of standardizing some of the things that we're looking at that we make sure that stakeholders are a part of those discussions, that feedback is received from states as well as other interested stakeholder groups in kind of putting that together.

I always worry a little bit about unintended

consequences, and one of the examples that you mentioned, by the number of out-of-network providers that are approved, that can be a sign of an inadequate network. It can also be a sign, though, of plan flexibility and really meeting unique needs and preferences of members. I don't want to sort of create unintended incentives for a plan to not be as flexible in allowing out-of-network options if that sort of becomes an indicator of something that's perceived to be negative. So I just think a really good discussion before we begin to standardize is really important.

And then if you could show the slide that sort of maps the issues to the policy options. It did feel like there's one thing missing, and that is kind of transparency around enforcement, and just making sure that we sort of understand the end of the feedback loop around how when there are compliance concerns that those really get addressed and what that really looks like. And if it's there and I missed it I apologize, but I don't really see that we've captured that well maybe in the policy options.

MR. PARK: Yeah, we can make that clear. I think part of that is trying to standardize that executive

summary. You know, part of the protocol to ask the EQROs to kind of identify the issues, and then in the next year kind of report on how the state may have addressed those issues, state and plans. But sometimes those findings could be buried and it's not always easy to find. I think the goal was to kind of have a more standardized summary that really highlights those key findings, and compliance, and how the plans and states have addressed it would be part of that. But we can make that more clear in the rationale and text.

CHAIR JOHNSON: Thank you. John.

COMMISSIONER McCARTHY: This one's hard for me because I do believe strongly in measurement and using EQROs to oversee our managed care programs. And I did it extensively in the places I've worked with. What I kind of feel with some of our options that we're proposing it's like that email that goes out to everyone at a workplace when people are late to work, and you kind of just send it to everyone, "Hey, it's important that you be on time to work." And the person who is always late doesn't know that they're the person always late.

So when we talk about standardization there can

be good from that, but as Patti said there can also be bad that comes from it. And we say, oh, we want it standardized, but I don't know what that standardization looks like, so it's hard for me to say I agree with that standardization.

And Chris and Allison, this isn't against anything you've proposed. I'm just saying in general this is what we run into. Because if we were to standardize something, obviously I have a bias because being a Medicaid director twice I would be saying, well, we would want any Medicaid director's input on what does standardization look like, not just CMS coming up with a standardization and having people, you know, what is important on some of these things.

So that's where I get stuck on this is right now, I can't support 1 and 2 because of that. Again, it's not that I don't agree that there could be some possibilities in there. But it feels like there are some states that we would be punishing who are doing great things, and their report might be the best, but we would be taking things away because there's standardization. I know that's not what we intend to do, but it's one of those unintended

consequences.

But we do need to get these reports easier to find, so Option 3, which is having a place that they all can be, I think is really important. I've been arguing about this for a long time with CMS of making things easier to find, and I know we had said that one of the issues is they're not 508 compliant. Maybe that's one of the places we start is saying to states you have to make it 508 compliant, and then have it put in a place to say we keep this all in one place.

The last thing I'll say is states are different and programs within those states are different. So just to make a blanket statement that, oh, that all EQRO reports have to be the same for those different programs sometimes just won't catch the nuance.

And I want to go back. We have a lot of standardized reports at CMS. Mike Nardone and I used to fight about these things when he was at CMS, even like a CMS 64 or a CMS 37. Those are all standardized, yet you would almost argue you can't compare them, because when you do try to compare them, the data sometimes shows things that aren't quite true. So it's like then how do you use

that data.

I guess I had one more comment, lastly, and this is just for all the things I said. If we're going to do things like that, to me it just feels like it's not just about standardization but then how do we incentivize states to then do the right thing and make improvements. So again I'm going to go back to is there something in the future we look at as a policy option that says if you're not doing this your FMAP goes down, or if you're doing a good job on this your FMAP goes up, to provide that incentive for states to do things. Because there are incentives already to do EQRO reports, because they're matched at 75/25. So that's why you often see a lot in EQRO reports. Thanks.

CHAIR JOHNSON: Thank you, John.

Heidi and then Dennis.

COMMISSIONER ALLEN: Well, as a researcher, I very much support having data that allows you to compare apples to apples and see how things change over time. Data without that, and especially with weak evidence that it's actually being used in a meaningful way, is really not worth collecting and not worth the investment and energy.

So I support all three policy options based on

the really good reasons that have already been mentioned, and I support working through the issues of flexibility and standardization, so having a mix and having important stakeholders define what would be standardized in partnership with CMS.

And I really like what sounds to me like what could be the next work cycle, which is thinking about how these would be used for contracting and for procurement, and then also how we measure enforcement. So that seems like that could be, you know, a next stage body of work if we do approve these three policy options.

But I'm always wary of saying like, "Oh, well, it's difficult and nuanced, so let's not do it" as a reason, because yes, it's difficult and it's nuanced, but it's also not rocket science. There's some very basic things that we want to know about quality that we should be able to assess across managed care plans and across time, and it doesn't have to be super complicated. If we get a lot of feedback, we can hopefully identify those potential areas of unintended consequences and avoid them, or we could have a trial period where you work through some of these things and see how well they perform. And if they

don't perform, then you go back to the drawing table and come up with other ones. It doesn't have to be a one-and-done.

So thank you for bringing these forward. Thank you for this great work, and I think that this is a very productive example of taking an issue and trying to come up with solutions and then thinking about what the next steps could be to even make it better.

CHAIR JOHNSON: Thank you, Heidi.

Dennis?

COMMISSIONER HEAPHY: Thank you.

I support all three options, and I will say as an advocate working in this space, it's very frustrating to see contract requirements conflated with quality measures and that focusing on outcomes is critically important.

I appreciated John's point about 508 compliance should be a baseline requirement for states in their sharing their information, and also, Heidi's point about the apples-to-apples comparison.

I don't view these as making states all comply with cookie-cutter requirements, but as a baseline that all states would comply with a certain set of reporting

standards on outcomes. And I do think that's really critically important. I think Patti and Heidi both raised this as having stakeholder involvement and all stakeholder involvement engaged in this process to determine what those actual outcome measures, quality measures, will look like that are collected nationally.

So I'm really excited about this opportunity and appreciate the work you put into it.

CHAIR JOHNSON: Thank you, Dennis.

Doug, and then we'll go to Bob.

COMMISSIONER BROWN: Allison, Chris, thank you for the report. Very detailed, very clear.

A comment and then a question. I support the transparency that is required here, and I think several of these, as we dig into them, several of these options, I would be in favor of.

I want to go back and ask a quick question. You mentioned that CMS did not require outcomes as part of the triennial report, if I've got that correct, and the question is, did you go back or have you had any follow-up conversation with CMS as to why they didn't include that in that report and what the concerns were if they shared any

of those with you all?

MS. REYNOLDS: Sure. Thank you so much.

So we -- both in the commentary to the rule, there was no discussion of why they didn't include it, and so we did ask that explicit question in follow-up conversations with CMS. And there was no specific rationale given.

I would say a fair characterization of that conversation might have been perhaps an intimation that maybe those kinds of data weren't available in that activity, and that was one of the reasons that we dug into the protocol so specifically, to pull out just a few of many potential questions where there actually are lots of places already in the protocol that would lend themselves to gathering that kind of data.

MR. PARK: Yeah. Certainly, when you look through the protocol, a lot of the questions are focused on more general policies and procedures and compliance with those. So there's definitely reasons why there may not be a lot of outcomes or quantitative data there.

But, as Allison mentioned, looking through some of the questions, there are places where they are trying to

assess compliance with network adequacy requirements, and they do look at certain things like use of services, how many were denied. So there are places where some of that information could have been reviewed as part of the assessment of compliance, and so that's where we thought it might be useful to at least report 10 percent of people had a denial of service for this area if the EQRO had looked at that as part of their assessment of compliance.

COMMISSIONER BROWN: Thank you.

CHAIR JOHNSON: Thanks, Doug.

Bob?

VICE CHAIR DUNCAN: It's been said, but I'll say it again. Fantastic work, Allison and Chris, on bringing these three options to us. And I always appreciate the view and lens from which our Commissioners bring to the table and their expertise.

To John's statement around what other states may be doing, I appreciated his thoughts on that, as well as I go back to Commissioner Patty Killingsworth's statements around soliciting the feedback from stakeholders. I think by doing that, we can circumvent some of the concerns that John had.

With that stated and making sure we solicit that feedback as we look at creating some standardization, I'm in favor of all three policy options.

CHAIR JOHNSON: Thank you, Bob.

Mike?

COMMISSIONER NARDONE: Hi, everybody.

I'm generally supportive of all these options. I think that I don't like John taking my name in vain, but I do want to really focus on the second one, because I do think that having reviewed several of the ATRs in prep for this, there's a lot of information in those. But I think it's pretty impenetrable for the most part, and trying to understand what is really in those reports would really benefit, I think, from some sort of standardization around what are the key elements.

So I think that that is an effort that's definitely worth it, because I think there is a lot of information that is published on the performance of the plans. I just think it's very difficult to kind of -- at least in looking at some of the reports that I did, to kind of reach what are the conclusions that you would make about the MCOs, because I think -- you know, I share the view

that we need to hold our plans accountable, providing the services that they're intended to provide for our beneficiaries.

I would say, though, that one of the things I'm trying to understand a little bit better and I kind of think is where all of the results and data that we're going to be collecting from the EQROs and the standardization fits into a number of the other things that are kind of coming down the pike here with respect to quality measurement of plans. So we're going to have the -- we have the MCPAR reports that are kind of being submitted. We have the QRS that's in development. We have the access reporting that I think is also mentioned.

And I think kind of, I just -- I think we need to kind of figure out, a little bit, how does this fit into the grand scheme of accountability and holding the accountability for plans? I mean, I hear that there's a feeling that we haven't -- you know, we could do a much better job on that, but I think that there are these other mechanisms that are also coming down the pike.

And I just want to make sure that we're not duplicating efforts, we're just not adding requirements,

because one of the things we don't do a very good job of when we add new requirements is also making sure about how do we rethink a new framework for holding managed care accountable for services.

So I noticed that in some of the analyses that you all did. I appreciate this presentation around how does EQR fit, but I do think if we're looking at standardization, you know, I think we don't want to be duplicating other things that are also kind of in process, because then we just inundate ourselves with too much information, which I know is not the problem now. But I'm just saying, I want to understand how it all fits together.

MR. PARK: Yeah. And, Mike, we can certainly make that more clear in the rationale that as part of this process, you know, CMS needs to take a more holistic look at kind of how it fits in with all these other new requirements that were put in place with the 2024 rule.

CHAIR JOHNSON: All right. Thank you, Mike and Chris.

Jami?

COMMISSIONER SNYDER: Yeah. Mike, I was going to mention the same thing. I think it's just really important

that we look at the overarching quality framework that was advanced in the managed care rule as we look at enhancing transparency and consistency in reporting and in particular the QRS requirement, which I know goes into place in 2028, so just wanted to mention that.

I'm generally supportive of all three policy options. I am sensitive to the state-to-state nuance that John mentioned and the challenges in creating a level of consistency in reporting when states are so unique. I think it's -- as others have mentioned, Bob, Patty, and others, I think it is really important to have stakeholders at the table, and most notably, because there's such -- you know, states are unique in terms of how they approach quality. It will be really important to have Medicaid directors at the table.

And I think the good news is there's precedence for that, right? And the kind of one example I'll give is around the CMS scorecard, and I think the National Association of Medicaid Directors did a really nice job of bringing CMS and Medicaid directors to the table to discuss how to kind of structure that scorecard in a way that really took into account some of the nuances state to

state. And I think you could use that model as you look for more consistency in the EQRO reporting as well.

CHAIR JOHNSON: Thank you, Jami.

John?

COMMISSIONER McCARTHY: I just want to go back to what Mike said earlier, and he said that -- what I was trying to say is what Mike said exactly, which is there's a lot of things coming, and before we start adding more to that, can we look at those other things first? And then with the knowledge of that, build off of what we learned from those, these new pieces, because otherwise I feel like we're just rushing into some of these.

And last, I do want to say -- and again, holding plans accountable and doing all this is really important, but we don't do any of this for fee-for-service, and fee-for-service is still 28 percent of the people who are served and often people who have some chronic conditions. It's not the moms and kids and things like that. So it's people with a lot of health care needs. So there's another question about that of then we're looking at one part of the program, but we're not totally ignoring the other part of the program.

CHAIR JOHNSON: Carolyn?

COMMISSIONER INGRAM: Thanks.

Thank you for putting these forward for us in such a clean way to review them.

I had a couple of questions first. Did we look at the cost associated with implementing any of these yet?

MR. PARK: We have not been to CBO to see if there's a score on it yet. Until we get the official recommendation language, we won't do that.

COMMISSIONER INGRAM: Okay. And then the second question I had, I think, goes a little bit to Jami and John's point, but have we reached out to NAMD at all or the Medicaid directors to get feedback on what they'd like to see?

MR. PARK: No. And we can do that as part of our process.

COMMISSIONER INGRAM: Okay. I think I'll probably hold off on supporting 1 and 2 until we get some of that feedback, but obviously, No. 3, I think, is important. I ran our communications and marketing and branding and those types of things at the health plan I work at, and hitting the 508 compliance is really not that

difficult to do.

I think back to John's comment. States can put things in that format, and we can do a link or something to it or make it in a way that it's not so hard. So I can support that one.

On the first two policy options, I think we need a little bit more information. Back to the point John and Mike are trying to make is there's a lot going on, and having run a health plan right now on the ground and having to submit all these reports to the state, it does become duplicative over time. We have a lot of things that we already produce that show outcomes, and so it's not a bad idea to move to standardization. Standardization of the product, I think, is going to help us be able to compare things nationally, help people like Heidi who's trying to do research out there.

But there is a lot of information already out there, and so that's why I would say let's go back and talk to NAMD and the Medicaid directors and find out what they're interested in seeing, because a lot of this is already available, and maybe it's easy to have our reports go in this fashion or move and make this change because

it's already out there. But I think a little bit more research and talking to them will be helpful.

Secondly, on the ground, each state has its own way and unique way of doing these things, but there is a lot of publication around things where they're trying to compare health plans so that consumers can access those. Sometimes it's report cards and other pieces, and so I just think listening to them a little bit and getting their feedback about what they're already doing on the ground and is there some way we can make this consistent for comparison purposes and align with those other tools will be important.

So thank you for the work.

CHAIR JOHNSON: Thank you, Carolyn.

And just to Carolyn's point about cost, you did do some analysis on impact for CMS, I believe, right, in terms of administrative burden? Is that correct? Are you still working on that one?

MR. PARK: So the way we do our cost estimates is we usually send the recommendations over to CBO, and they estimate the effect on federal spending, because a lot of these are directed toward CMS and they already have

existing authority to develop protocols and such. Historically, CBO has not scored that as an increase in federal spending because it's something that can be done under existing authority.

COMMISSIONER INGRAM: Okay.

CHAIR JOHNSON: Thanks, Chris.

Tricia?

COMMISSIONER BROOKS: Just a quick point. I'm totally in agreement with the comments that have been made about including stakeholders, but I hope, based on some of the discussion, that we aren't talking about limiting it just to Medicaid directors, that it would include stakeholders that use this information that are outside of state government.

Thank you.

CHAIR JOHNSON: Thanks, Tricia.

Angelo?

COMMISSIONER GIARDINO: I would just add that a really good quality improvement effort does focus on alignment. So if there are a lot of things coming our way, part of the design element would be to make the EQR process aligned with all those other wonderful things that we

support. So that doesn't frighten me. I just think that we need to give voice to what the alignment is. So I would just ask maybe you could bring some of that forward.

To the concern that this doesn't apply to fee-for-service, that's always the way. So the 80/20 rule, you fix the bigger part of the problem. So I just don't find that compelling that we shouldn't do it because it doesn't apply to fee-for-service. You could use that for every single thing we look at.

So this needs, I think, some comment on the alignment, but I think it would be fairly straightforward to align some of those other quality improvement efforts with this quality improvement effort, particularly since this is an existing monitoring process that I think your work has shown misses the mark. So if something misses the mark, you don't keep doing it. You fix it.

So thank you.

CHAIR JOHNSON: Thank you, Angelo.

And then Carolyn again.

COMMISSIONER INGRAM: Yeah, I just wanted to go back on the cost issue. I'm not talking about the cost for CMS to put out some regulations. I'm talking about the

cost that it spends down.

So once they put out the regulations and the Medicaid agency has to go out and implement and make those changes, all of the reporting and documentation that has to happen at that level, all of the reporting and documentation that then has to happen at the managed care level, as Angelo points out, that if these things are already going to be going on in another fashion, maybe it's not going to be an increased cost.

But I do think we should look at the cost, not just to CMS, but what does the cost imply that's going to occur as we make these changes, so thank you.

CHAIR JOHNSON: All right. Any other Commissioners?

[No response.]

CHAIR JOHNSON: All right. So I think we've heard a lot of great comments here and -- oh, Sonja. Okay. I missed Sonja.

COMMISSIONER BJORK: Thanks.

I just want to support the comments that were made about attention to nuanced and unintended consequences and, in particular, the measure about out-of-network

services for plans that have responsibility for children with special health care needs. Gosh, there's lots of times when you send kids out of state, even to the Cleveland Clinic or, you know, many other places, and we don't want that to be seen as a negative.

And then time for agencies and plans to set up their systems to properly capture all of this reporting. If it's retro and you find out later, oh, my goodness, the administrative burden is really difficult for putting things in a template that you never used before or expectations, so time for agencies to set things up from the beginning so that you're collecting things correctly and that it's not as big of an administrative burden.

And then, of course, I support all the comments about alignment. You know, we have a lot of reporting. Every health plan, every state does, and so let's try to align with things that are already happening.

Thank you.

CHAIR JOHNSON: Thank you, Sonja. That was a great comment.

Okay. So you've heard a lot from all of us, of course, some concerns generally supportive of the options,

some modifications, but is there anything else that you need from us?

MS. REYNOLDS: I don't think so. Thank you so much for so much robust discussion and feedback. It's very much appreciated.

CHAIR JOHNSON: All right. Thank you, Allison. Thank you, Chris.

[Pause.]

CHAIR JOHNSON: All right. Now we have time for public comments. We will open it up. We, of course, invite the audience to raise your hand if you'd like to offer any comments. We do ask that you introduce yourself and the organization that you represent, and we also ask that you keep your comments to three minutes or less.

PUBLIC COMMENT

* CHAIR JOHNSON: So, with that, first up, we have Eli. Can you please unmute yourself, Eli?

[Pause.]

CHAIR JOHNSON: You're still muted.

Okay. So next, while we wait on Eli, let's go to Arvind.

[No response.]

CHAIR JOHNSON: Arvind stepped away as well.

Let's go to Shawn, then, for right now. If you can unmute yourself, Shawn.

MR. FRIESEN: I have no comments. Thank you.

CHAIR JOHNSON: Thank you, Shawn.

All right. Eli. If you can unmute yourself, Eli.

[Pause.]

CHAIR JOHNSON: All right. I think while Eli is working on his technology, let's go to Monica.

MS. TREVINO: Good morning, everyone. Thank you for this opportunity to speak. I'm Monica Trevino. I'm the Director of the Center for Social Change at the Michigan Public Health Institute.

I really just wanted to echo the comment from the Commissioner related to speaking to other stakeholders about the utility and usefulness of the technical reports. I appreciate thinking beyond just the scope of state employees for that. They are useful for folks who are not employees of the state of the Medicaid agency, especially the folks who do work across Medicaid agencies. So thank you.

CHAIR JOHNSON: Thank you, Monica.

Any other comments?

[No response.]

CHAIR JOHNSON: All right. So if you have future comments, please feel free to go to the MACPAC website, and you can submit your comments there.

Okay. Let me try Arvind one more time before we exit.

Arvind?

MR. GOYAL: Can you hear me now?

CHAIR JOHNSON: We can hear you now. Go for it. Thank you.

MR. GOYAL: Thank you very kindly. My name is Arvind Goyal. I'm a Medicaid Medical Director in Illinois, my 13th year in the running, and previously, I served as Chair for Medicaid Medical Directors Network for various programs.

So I have really learned from this presentation by Allison, Chris, and many Commissioners. However, I wanted to put these thoughts in the mix. Unless we define specific outcome measures, we are really not making a difference, and the clock is ticking. I want to say that

again. While the patients don't get the care or patients don't get the expected or optimal care, we need to take some steps. And since MACPAC is a respected agency in the country for Medicaid purposes, I wish that this would be an opportunity to fix whatever hasn't been fixed as far as managed care is concerned.

As far as the outcome measures are concerned, they need to be very specific. For example, we get a value for where A1C should be for a diabetic patient, not just did you do an A1C. That is not an outcome measure. Did you prescribe or did you -- enough of your providers prescribed opioid MAT is not a measure that will affect the outcomes. But the outcome measure would be, did you reduce opioid deaths percentage-wise in your population?

Similarly, maternal deaths during pregnancy and postpartum period. Again, vaccine preventable illnesses, not just what percentage of your patients got the vaccine, but what percentage of your patients developed a vaccine preventable disease or did not develop a vaccine preventable disease? So outcome measures need to be very, very specific.

The second point I want to make is that you've

heard enough about network inefficiency or network inadequacy. I think there needs to be a central appointment system somehow where the appointments are set by a central managed care portal, and so nobody can say, oh, you're on Medicaid, where your next appointment is in 13 weeks or 6 months. Central appointment system, it cures the issue of adequacy, because now it's in the lap of managed care organizations.

There needs to be a registry for denials. I think the registry issue was discussed, the central registry.

And the last point I want to make is that you've heard enough, not maybe at this meeting, about PA process. And the PA process is really one-sided right now. You've heard from AMA. You've heard from multiple organizations, provider organizations. I think one way to fix it is to require that once you have a PA, that means payment at the level of published fee schedule is guaranteed.

And I would stop there. I would be very happy to connect with the staff offline afterwards if time permits. Thank you very kindly for listening to me.

CHAIR JOHNSON: Thank you very much, Arvind. We

appreciate it.

Again, if anyone else has any comments, feel free to go to our MACPAC website, and you can submit your comments there.

In the meantime, we will be taking a 10-minute break. So we will return here at 10:35 Eastern. Thank you.

* [Recess.]

VICE CHAIR DUNCAN: All right. Good morning and welcome back. We have got Linn and Ava to bring us up to speed on their findings dealing with transitions of care for children and youth. And with that I'll turn it over to Linn, or Ava.

TRANSITIONS OF CARE FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN): INTERVIEW AND FOCUS GROUP FINDINGS

* MS. WILLIAMS: Thank you and good morning, Commissioners. Today Linn and I will be presenting on our interview and focus groups' findings from our work on children and youth with special health care needs transitions of care.

I will start by briefly giving some background on

children and youth with special health care needs and recapping findings from a previous presentation in March. I will then present our findings from the interview and focus groups we conducted over the spring and summer. Then Linn will continue our discussion of the findings, before ending with next steps and questions for Commissioners.

As a reminder, almost 1 in 5 children have special health care needs, and children and youth with health care needs have a wide range of conditions. The majority of children and youth with special health care needs are covered by Medicaid on the basis of income, under an SSI pathway, or an optional disability pathway. Additionally, most Medicaid-enrolled children and youth with special health care needs are enrolled in managed care. Children and youth with special health care needs can also receive services and supports from state Title V agencies.

As discussed in March, there are no federal Medicaid requirements for states to provide transition of care services for children and youth with special health care needs. However, some states have transition of care policies, some documented in home and community-based

1915(c) waivers and MCO contracts. While there are no federally prescribed or endorsed transition of care processes for this population, some organizations have developed frameworks. Examples include Got Transition's Six Core Elements and the American Academy of Pediatrics' Overarching Principles for Transitions. However, there is insufficient evidence to support the use of a particular health care transition approach.

Next, I'll present on interview and focus groups findings. It is important to note for this work we narrowed our definition of children and youth with special health care needs to those covered by Medicaid under an SSI pathway, under the Tax Equity and Fiscal Responsibility Act, also known as TEFRA, and Katie Beckett Authorities.

The goal of the interviews and focus groups was to understand how states and MCOs operationalize their transition of care policies for children and youth with special health care needs, how beneficiaries and families experience transition, and how barriers to transitions can be addressed. We interviewed a variety of stakeholders including state officials from five states. We also conducted four focus groups, two groups of beneficiaries

and two groups of families and caregivers of children and youth with special health care needs who were in the process of transitioning and those who had transitioned to adult care.

Overall, there is variation in how state Medicaid agencies and MCOs identify and notify children and youth with special health care needs who are approaching transition age. There are a number of ways states and MCOs can identify children and youth with special health care needs, including identifying beneficiaries who are enrolled through a disability pathway and tracking when they are approaching transition age. There are also a number of different processes for notifying children and youth with special health care needs of the upcoming transition that vary in how far in advance individuals are informed and who, at the state or managed care plan, is responsible for notification.

For example, notification can vary by waiver program. In our review of state waivers some specified that those enrolled were notified by care coordinator a year in advance of losing eligibility, while some were notified 60 days prior to losing eligibility.

There is also variation in how MCOs notify beneficiaries. Some MCOs' contracts specify for a transition specialist or care coordinator to notify beneficiaries at age 14 or 15 of the upcoming transition. Other contracts are less specific, allowing plans the flexibility to create their own policies.

Some states cover transition services through state plan and waiver authorities, often through targeted case management and care coordination services. Transition services can be provided by clinical or non-clinical professionals and can include services such as transition readiness assessments, identifying adult providers, and developing a transition plan.

For example, some states may task care or service coordinators or require MCOs to develop transition of care plans for this population. In one state, transition specialists from the MCO are responsible for developing a transition plan with the youth around age 15. However, another state indicated that service coordinators for its waiver are not required to develop a plan, and often do not. Providers can also be involved in the transition process. For example, they may engage in provider-to-

provider warm handoffs to support the sharing of beneficiary health information and improve the beneficiary's understanding of the transition to the adult system.

Although state Medicaid programs can cover transition of care services, many states have now neglected to cover transition-related CPT codes and other transition of care services, such as warm handoffs between pediatric and adult providers. Findings from the literature and interviewed national experts and researchers indicate that warm handoffs and joint visits are an important part of the transition process and can help facilitate smooth transitions. However, warm handoffs may require same-day billing by multiple providers, which is generally considered a duplicative service.

CMS has issued guidance on same-day billing for warm handoffs in the context of other types of services, but they have not indicated whether or how this guidance may apply to transitions of care for children and youth with special health care needs.

Most beneficiaries, families, and advocates describe the process of transitioning from pediatric to

adult care as frustrating and confusing. Some expressed that they did not have a designated person from the state Medicaid program or MCO to support them through their transition, and if they did the assigned staff was often uninvolved and unhelpful. The lack of support left beneficiaries and families to feel as if they were responsible for initiating the transition process.

Participants also expressed frustration over the lack of clearly documented information about the transition of care process from the state Medicaid program or MCO, and noted the need for clear, up-to-date, and accessible website that details this process.

Finally, beneficiaries and families had mixed experiences with their state or MCO-developed transition plan. For example, only a few participants had a transition plan, and of those some expressed that the plan became unhelpful as the child aged or moved out of state.

Through our findings, we have identified a couple of key barriers related to transition of care process. The first area is around the lack of clearly documented and communicated state policies for transitions of care. Several interviewees and focus group participants indicated

that in states' documented policies it can be difficult to understand them, which leads beneficiaries and their families to feel ill-informed and unprepared for their transition process. Additionally, families shared that the service or care coordinator that they worked with were often uninformed about the transition process and unable to help them.

The second barrier is the lack of guidance to states on covering transition of care services. The lack of an option for providers and professionals to bill, and guidance on how to bill for transition services can be a barrier to ensuring beneficiaries and their families receive needed transition support and care.

Interviewees highlighted several policy options available to states. States have the flexibility to cover transition-related CPT codes, but some states may not include them in their fee schedule and some MCOs may not cover them. Additionally, existing billing codes that may be related to transition of care do not always account for the added work related to longer visits used to discuss the transition process.

Further, some states' plans and providers may not

understand how or if aspects of the transition process, such as warm handoffs between multiple providers, can be covered. For example, in states where provider warm handoffs occur, state officials and plans were unsure of how or whether both providers are reimbursed for providing the same service, and shared that in many cases providers would conduct joint visits without billing for their time.

Finally, some states use targeted case management for this population, and that may include or overlap with children and youth with special health care needs. The provider services can be transition related, but none of the interviewed states used TCMs specifically to provide transition of care services for children and youth with special health care needs. CMS indicated that states can use TCM for this purpose, but have not provided guidance on the topic.

* MX. JENNINGS: Thanks, Ava. So now moving on to our findings related to the monitoring and measurement of transitions of care, there are no federal Medicaid monitoring requirements for this population and their transitions of care, so CMS does not require state Medicaid programs to collect or report data related to this

population, their transitions, or their health outcomes after the transition.

The state policy scan identified very few states that are currently monitoring these transitions. However, there were some examples from state agencies and MCOs that collect quality data that may capture some information related to this population and their transition of care process. For example, one Medicaid agency conducts a utilization case review to assess if MCOs are correctly assessing beneficiary needs and if their beneficiaries are receiving the needed services, and some of these services may be transition related and detailed in their care plan.

Advocates and researchers have raised the need to develop and collect data about the transition of care process and the health outcomes after the transition to adult care, to understand how this population is served by federal and state policies and if there are gaps in access.

Interviewees raised two primary barriers to measuring transitions of care, one that there are currently very few measures related to the transition of care process and the transition and health outcomes after the transition to adult care, and there are some measures that are

currently collected in survey data, such as the National Survey of Children's Health, that collects some process measures. But there are some limitations with these data as well, due to small sample sizes for subpopulations within the children and youth with special health care needs population and limitations to the fact that these measures really focus on pre-transition process measures and don't have any outcome measures after the transition.

The other barrier is that because there aren't requirements related to monitoring or measurements of the transitions of care for this population, most states are not collecting the data, and from the states that we spoke with, none are collecting metrics that specifically track post-transition outcomes.

Now moving on to our findings related to the role of the state Title V programs. The Maternal and Child Health Block Grant Program funds state Title V programs, and these state programs are required to use 30 percent of their Title V block grant funds to provide and improve services for children and youth with special health care needs. And the role of state Title V programs in supporting these transitions varies with some providing

direct support and direct services, but many provide educational resources and information to families or partner with or fund advocacy organizations that support children and youth with special health care needs and their families through these transitions.

State Medicaid agencies are required to establish an interagency agreement, or an IAA, with the state Title V agency, and the IAA should describe how they coordinate their services and benefits that they provide with their overlapping populations. However, there are no requirements related specifically to the transition from pediatric to adult care.

In our state policy review and our review of the IAAs, we found that very few described specific roles and responsibilities for the state Title V and Medicaid agencies that are related to this transition of care. And in our interviews, as well, advocates shared that they were not aware of many coordinated efforts between state agencies, and that beneficiaries and their families often didn't experience that coordinated effort.

Findings from our interviews indicate that the primary barrier to this cross-agency coordination is a lack

of established roles and responsibilities for each of these agencies. Even if there are some collaborative efforts between these agencies, advocates who support children and youth with special health care needs and their families and caregivers reported that they may not be aware of who is responsible for which pieces of the transition and how this transition process should work.

Another contributing factor to the limited communication and collaboration is that several states that we spoke with noted that the Title V and Medicaid agencies are housed in separate divisions or departments, and so there weren't established working relationships. However, we did hear, in our state interviews, that several state officials and advocates, especially Title V officials, didn't express an interest in working more closely with Medicaid agencies on these transition of care policies.

So now moving on to our next steps and discussions questions for today, the findings from this work indicate that there are several challenges related to the transition process, the monitoring of transitions of care, and coordination with Title V agencies. And so today we would appreciate your reactions to the interview and

focus group findings, and in particular we'd appreciate your thoughts on federal and state policy opportunities to address the identified barriers, which we have on this slide.

And then based on the conversation today we'll return with potential policy options for the Commission to consider as we work towards developing a chapter.

And I'll leave these questions up to guide discussion and turn it back to the Vice Chair.

VICE CHAIR DUNCAN: Thank you, Linn. Thank you, Ava. Fellow Commissioners, Patti, then John, then Angelo.

COMMISSIONER KILLINGSWORTH: Thank you, Linn and Ava. I'm just going to jump right in and say that I do think there is opportunity for improved federal policy here, and I would certainly support a federal requirement that mandates that there is effective transition planning for children, from pediatric care, if you will, to adult care.

And I think that needs to include three specific areas. I think there needs to be transition support related to eligibility or coverage to benefits, since those benefits are different, and also as it relates to pediatric

versus adult care providers. I think that all of those are important areas where assistance is needed really to ensure continuity as much as we can.

I do also think there is a huge difference between notification and assistance, and I think both are important. So I think effective transition planning has to include both really clear education around all of those areas but also support and assistance in all of those areas.

My experience has been that when that responsibility is delegated to a waiver service agency that oftentimes it's not effective because they may not even be aware of all of the implications of transition as it relates to the rest of the Medicaid benefits. It's part of the struggle of kind of the fragmented way that home and community-based services are oftentimes delivered.

So there has to be an entity who sort of owns the primary responsibility and is aware of all of the different impacts that may occur to that child as a result of this important transition. And I think it has to include a requirement for coordination between, in the case of children who are in managed care, the managed care entity.

Certainly if home and community-based services are delivered separately, the entity who is responsible for that, and then the Title V agency. Really, this is a time of coming together and making sure that the individual and the family is informed and supported, to make sure that that child's need continue to be met as they transition to adulthood.

VICE CHAIR DUNCAN: Thank you, Patti. John.

COMMISSIONER McCARTHY: I'm going to say something I normally don't say in these, and this is I don't think we've gone far enough, and I agree with Patti. I mean, to me on this one, one of the things that we should be looking at is a recommendation to Congress to change a law to include the things that Patti talked about, in a requirement. I mean, some of the ones that I'm really passionate about is paying for warm handoffs, and allowing both providers to bill for that.

Because I know that is a huge issue in a number of states, and I had a hard time dealing with it and just how to get your systems to work to pay for those things and get it to happen, but also making those meaningful transitions. So from a legislative standpoint I think

that's really important, that we may need to go to that level.

Then the second part is more for recommendations to states, and this is also an area that we haven't hit on, but where does value-based purchasing fall in on this one, and rewarding providers who do well around this, because it's super helpful. It's very complicated, so how do we reward providers for doing that, taking these cases on and helping the individuals that need help.

So those would be two areas I think we should take a look at.

VICE CHAIR DUNCAN: Thank you, John. Angelo.

COMMISSIONER GIARDINO: Well, this is a banner day for kids, so thank you for addressing this issue. Health care transition is such an important element to pediatric and young adult care, but it needs to occur in a planned way.

So a couple of things I'd ask you to look at as we're trying to build the case for some of these really big changes that we're probably going to recommend, is if you could reach out to some of the clinical literature. So I think there is a growing body of literature that

demonstrates that a planned transition, particularly for conditions like congenital heart disease, diabetes, and it goes from there, that a planned transition actually promotes better post-transition health and well-being, just clinically.

And then also from a health services perspective, when a transition starts to fall apart I believe there might be some literature that shows that these kids then stream into, let's say, an emergency department or to an urgent care with a provider who is not well-positioned to help them. So I think not only does their care get worse but that discontinuous, fragmented care costs more money.

The other thing is, just again, to make the argument, this is a part of development, so we want our teenagers to become productive young adults. So we encourage adequate development on all the domains except this one. You know, we want the kids to get their driver's license. We want the kids to have work-related services so they can either pick employment or go to college, et cetera. This is just one of those transitions, so I think our system has to reflect that.

And then finally, I do think there is a need in

any policy recommendation to recognize that there is a wobble when transition occurs. This is a really big thing. You know, think about it. If you have congenital heart disease you've been seeing the same pediatric provider for, you know, 13, 14, 15, 18 years. Now you're seeing somebody on the adult side. The adult side is a little bit different than the pediatric side. And sometimes the care goes back and forth for a while. So a transition is a process. It's not just a one and done. So somehow the policy has to reflect that we need to kind of have that back-and-forth until it's okay.

And then I guess my last comment would be this idea that you've hit upon in terms of interagency agreements, you know, HRSA and Title V are just so good at training providers and helping systems become capable, and then obviously Medicaid pays for those services and the care management that's so essential. So I would really love to push on that a little bit and see if there are some model programs in certain states that we could highlight where Title V has taken the responsibility of training up the community, and then Medicaid takes responsibility for doing the infrastructure work so that people can get paid

for this.

But this is very exciting. I think you've done a great job, and I just can't wait to hear what the recommendations are that you come forward with. Thank you.

VICE CHAIR DUNCAN: Thank you, Angelo. Heidi.

COMMISSIONER ALLEN: Thank you for this work. I'm very much in support of us digging into this issue.

I like the term you used, wobble, Angelo, and there are some wobbles that are unavoidable, like the transition from pediatric to adult health care. You know, you can't expect somebody to be an expert across the lifespan. So that's an unavoidable wobble.

But we have other wobbles. We have the wobble of changes in eligibility and benefits, and we have the wobble of graduating and leaving high school and moving into whatever is next. And I feel like that's too many wobbles for families to have to manage. And I worry about the instances where the change in eligibility equals a reduction of support, because you've got all these wobbles happening, you have a reduction of support, and all of this is also happening as parents age, and as kids' health care needs often increase. Some of these kids only get sicker

as time goes by. They don't get healthier.

So in other federal programs related to eligibility we have decided that 26 is the age of adulthood. You know, that the case in the Marketplace, where kids could stay on their parents' coverage until 26. I think we have different ages for eligibility for kids coming out of foster care. And I wonder if this might be a population for which we should consider thinking about having the age of transition not happening at the same time as all of these other really intense transitions are happening, to provide a little bit of continuity for families to get their feet under them before they have to transition to different types of benefits and potentially different programs.

And I think that, you know, ultimately, it's all with the goal of trying to help kids maintain their health and their independence and not putting people in a situation where they then end up having to go to some kind of institutional care because their health care needs aren't being met.

And so I think that, you know, I definitely would, you know, be in support of proposals to try to pay

for things like warm handoffs and care coordination, nut I would also be in support of changing program eligibility to 26.

VICE CHAIR DUNCAN: Thank you, Heidi.

Dennis?

COMMISSIONER HEAPHY: I really appreciated Angelo's comments on moving kids from pediatric providers to adult providers, and there's so many. I think we need to hold MCOs more accountable to ensuring that network adequacy includes providers for youth transit. Someone 40 years old is not seeing the same cardiologist they saw when they were 10 years old. It's just -- it's endemic in the system. And so how do we hold MCOs more accountable to that?

And then in terms of the services, children will be available, kids will be available, once they transition out of schools at the age of 22, the turning-22 cliff, do we have to look at medical as broader than just direct medical service and look at other services they have? What's going to happen to these kids?

I remember I went to a graduation of kids in one year, very many complex kids, and was told by the principal

that that day was both the worst and the best day of these kids' lives, the best because there's this great celebration of all the success that they achieved and what the family achieved, but then the worst day of their lives because that was probably the last time those kids interacted with their peers or engaged in the community. They become isolated, and they become alone.

And so I raise this because there's this siloed system between the medical system and the school system, and so how do we ensure that MCOs are working with schools to ensure the IEPs, that the individual education plans that really shape what folks are going to be eligible for after they transition out or included in what the medical teams are actually working on? So that there's not just a handoff but an engagement throughout as these folks are transitioning to ensure that the kids are eligible for all the services they require once they leave and they turn 22, because if they're not in place and the medical folks are not talking to school folks, these kids are not going to get all the services they were ready to get once they turn to be adults.

VICE CHAIR DUNCAN: Thank you, Dennis.

Patti then Angelo, then Tricia, then Mike.

COMMISSIONER KILLINGSWORTH: Super quick additional thought and potentially an area for innovation. This might be an area where peer support would be really, really helpful, both to the young adult but also potentially to the family. And so I'd be interested to know if any state has thought about or would consider offering peer support as sort of a demonstration type of benefit to really support people through the transition process.

VICE CHAIR DUNCAN: Thank you, Patti.

Angelo?

COMMISSIONER GIARDINO: Yes. Since we're using metaphors, so wobble is one. The other one is -- that Dennis had mentioned this, but the policy lab at the Children's Hospital of Philadelphia and University of Pennsylvania has this concept of falling off the cliff. And they have this wonderful report that's in the public domain. It's on the internet. But it has a great graphic, and it really tells the story of what it feels like for these kids from an eligibility perspective and then from where you get your insurance perspective, and they truly

fall off a cliff at 21. So I think we should incorporate that imagery where we can, because it's quite dramatic, and it's well documented that that cliff really has clinical as well as developmental elements.

And then I guess the only other comment I would make is, in your briefing materials, you talked about the AAP and Got Transition. My sense is all those organizations -- and I would include the Society for Adolescent Medicine. All of them, if you had a meeting and they were on a panel, they would all agree to harmonize their plans, and I think we could have a best practice that's consensus driven. I'm not sure you're ever going to have an evidence-based one, but for right now, I think all those organizations that put out transition protocols would be willing to harmonize them because they're all very similar at a very fundamental level, so thank you.

VICE CHAIR DUNCAN: Thank you, Angelo.

Tricia.

COMMISSIONER BROOKS: Yes. Thank you for this work.

I think as a starting point, we absolutely need to recommend that there be a federal definition of children

and youth with special health care needs.

I was actually sort of intrigued by Heidi's suggestion of aligning the upper age eligibility at 26, and I think you could probably look at something like if it's -- the question is, if you do that, are we talking about just the benefits and eligibility, or are we talking about provider services and whether the pediatric community is ready to take on up to age 26 when do you make that transition in that part? Although we know that pediatric dentists often are who actually continues to give services to people with IDD and DD -- you know, the IDD and DD populations.

And so I think you could look at something like extending EPSDT to age 26 for special populations like children with special health care needs, and I would throw former foster youth into that particular group. And then the question is, do you apply the children's eligibility levels in a state to -- the income eligibility to age 26, so there's less of that cliff, little more time to transition in?

So I think there are a lot of ideas percolating here that will be interesting to continue to consider and

research. Thank you.

CHAIR JOHNSON: Thank you, Tricia.

Mike.

COMMISSIONER NARDONE: I was just going to add, to Tricia's point, it would be helpful to have a specific definition of what children and youth with special health care needs are.

I would also just suggest maybe -- I don't have -- I'm supportive of a lot of the things that my fellow Commissioners have said -- well, almost all -- all of them. But I would like to look at that there may be nuances with different groups that make up that larger category around what transition services might be particularly helpful. For instance, for someone who is IDD graduating through the system versus someone with physical health needs versus maybe someone with behavioral health needs, foster care, I mean, it would seem that maybe taking a further dive into not just the broader things that are needed, but also are there specific things unique to some of the populations that are within that grouping that also would be helpful to move policy forward? Because this is something we've been at for a long time.

And I hearken back to when I was in Medicaid in Massachusetts nearly 30 years ago, and we were talking about kids who were turning 22 and the initiative around turning 22. So this has been around for a long time. We have a lot more work to do on this, and hopefully, we can make progress in this area.

VICE CHAIR DUNCAN: Thanks, Mike.

Carolyn, then Verlon.

COMMISSIONER INGRAM: Sure. Thank you.

A lot of folks have listed out a lot of the things that are going to be important to look at, but just to reiterate a couple of those, there are best practices implemented out there in the field around -- sometimes it's around foster care kids that we could look at. And I know we have a method for records and those types of things traveling with the individuals so that when they do move on, that they're able to have access to those things or know about them and how to get them.

Also, looking at are there any innovations or best practices in dealing with youth who may be in rural communities and not as able to access some of the services that they need as they're transitioning out into adulthood

or those with culturally different backgrounds. I think of people in Tribal communities and things like that, where they may have gotten a lot of assistance. Are there best practices to helping link them to services?

I know we have some that we implemented our plan, but there's got to be some other things besides just what we're doing as well. So I think a lot of things to look at there that will be important.

Thank you.

VICE CHAIR DUNCAN: Thank you, Carolyn.

Verlon.

CHAIR JOHNSON: I think this is a very good discussion. I definitely hear your passion and everything that you're saying, and obviously, children are very important to us. We want to make sure that we're always thinking about them and their families.

I do want to remind us, though, that for this cycle here, we had planned on really focusing on more of the transition of care. We're looking at '24 and '25 as the eligibility pieces of it. So I think a lot of the comments that were brought up around the '26 and other things, we want to make sure that as Commissioners, we're

keeping that top of mind as we move into those conversations and the staff starts to do more research around that for the next quarter.

I just want to go on record and say, too, I've heard over and over around the need for national guidance, and that's really important. I mean, if we look at particularly what we're hearing from the beneficiaries and their families and the complications around that, it just feels like if we can really put a stake in the ground and have a national standard of care, that would be really helpful.

And then I think, Patti, you said it early on too. You talked about really thinking about more around the education and piece of it, and more of those holistic approaches are really important, so not just the medical services when you think about that, but also the social, the educational, and of course, the community research supports. I just want to make sure that I highlighted that.

So thank you, Bob.

CHAIR JOHNSON: Thank you, Verlon.

And then I'd also like to add, we've used

"wobble." I'm going to use the word "weeble" as we think about this. And it's been brought up. Michael brought up the -- I can't even say the word -- nuances of all this. And then, Carolyn, I appreciate your comments around both the rural and our Native American population.

But the reality is, I think, from a nuance, what you need to put into the conversation is, some of these are what we consider pediatric diseases, and there is no real true transition to adulthood because some of these kids are living today that didn't live in the past.

Even in the state of Connecticut, a lot of our adult providers do not feel comfortable treating some of the pediatric diseases. So, as a pediatric system, we're seeing patients up to the age of 40 to 70 years of age with some of these. And so as we think about these transitions, having that resource in that community or that state may look very different, and so I think part of this as we think about transition is not only in age, but the disease itself and what is the medical system prepared for.

So they may transition from an age standpoint, but they still may be in the care of a pediatric provider for a majority of their life with a different set of

benefits. So I just want to add that to the mix of all the things we've brought forward.

Angelo.

COMMISSIONER GIARDINO: Just to further add to that, Bob, one of the models that's emerging is that the system could allow that pediatric provider who knows a lot about that very, very specific condition that starts in pediatrics to consult on an ongoing basis with an adult provider, because truly as a trained pediatrician, when you get to be 45 or 50, cardiovascular and cerebrovascular, there's diseases that we don't train in as pediatricians. So we know a lot about that very, very rare condition, but we don't know anything about the adult thing.

So the system would have to have the permissiveness to allow a pediatric provider to, on an ongoing basis, consult on these very unusual cases. But the best practice would really be if they work together, and truly, it is not cool to have a 45-year-old in a bed next to a 2-year-old. We don't want to have a system that does that. That's not good for the 2-year-old. It's not good for the 45-year-old. And it's certainly not good for the nursing staff and the physicians.

VICE CHAIR DUNCAN: Thank you for putting more detail around that, Angelo.

Any other comments or feedback?

[No response.]

CHAIR JOHNSON: Linn, Ava, do you feel like you got enough? Anything hanging out there you need answers to?

MX. JENNINGS: No. This discussion was great. I think we have a lot of good ideas. So we'll be excited to come back and look into some of these things. So thank you.

VICE CHAIR DUNCAN: Thank you. Great work.

Back to you, Madam Chairwoman.

CHAIR JOHNSON: All right. Thank you. I agree, a very good conversation, and thank you to both.

[Pause.]

CHAIR JOHNSON: All right. So we're going to have Asher and Chris join us again -- or have Chris join us again, and Asher coming for the first time, right?

So our final session today will focus on state-directed payments within Medicaid managed care, and so they're going to have some great conversations around some

of the key findings around some of our CMS-approved directed payment arrangements as well as some changes that were introduced in the 2024 managed care rule.

So I will turn it to Asher and to Chris.

DIRECTED PAYMENTS IN MEDICAID MANAGED CARE

* MR. WANG: Hi. Good morning, Commissioners.

Today we'll be presenting on directed payments in Medicaid managed care.

Earlier this week, we had published an issue brief on our review of directed payments, and we'll be sharing some of our key findings in this presentation.

We'll start off with some background information on supplemental payments in managed care and then describe what directed payments are and how states can use them. We'll then share the trends and characteristics of directed payments that we found from our most recent analysis of directed payment preprints, which are highlighted in the slides above. Finally, we'll talk about some major regulatory updates that CMS made to directed payments in the latest managed care rule and conclude with our next steps.

To start off with some background, in fee-for-

service, states can make supplemental payments up to the upper payment limit, or UPL, which is based on what Medicare would pay for hospitals. However, states are not allowed to make UPL supplemental payments for services provided in managed care. This is because managed care rates are supposed to be actuarially sound and sufficient enough to be able to cover the reasonable costs of services, so additional payments wouldn't be needed.

Even so, some states initially used Section 1115 demonstrations to make supplemental payments through uncompensated care pools or DSRIP payments. States also made pass-through payments, which required managed care plans to pass through additional payments to providers.

Over time, CMS has gradually phased out the use of pass-through payments and DSRIP funding and created a new option in 2016 called "directed payments." Since their introduction, the use of directed payments has grown rapidly and evolved as a way for states to make additional supplemental payments in managed care.

The directed payment option allows states to direct managed care plans to pay providers according to specific rates or methods. Under existing regulations,

states must meet certain criteria required to use directed payments. Most importantly, directed payments have to be tied to the utilization and delivery of covered services. They also have to advance at least one goal in the state's managed care quality strategy, and they cannot be conditioned on provider participation in financing arrangements such as an intergovernmental transfer.

Most directed payment arrangements also have to be approved by CMS prior to implementation. In order to get approval, states have to submit a preprint application to CMS for review, which describes the directed payment and projects the amount of estimated spending.

Directed payments are usually approved one year at a time and not automatically renewed. So most directed payment arrangements have to go through the preprint process for each renewal.

We've organized directed payments into three broad categories. First, minimum or maximum fee schedules set the base payment rates that plans pay for specified services. This could be using a state plan rate, Medicare-approved rates, or another alternative fee schedule that the state develops.

CMS does not require prior written approval for fee schedules tied to state plan rates, and under the most recent managed care rule, fee schedules set at 100 percent of Medicare-approved rates will also be exempt from prior preprint approval going forward.

Uniform rate increases require plans to pay a specified uniform dollar or percentage increase in the payment above negotiated payment rates. These payments are most similar to lump-sum supplemental payments in fee-for-service, where there is an add-on or additional payment over the base rate. As we will later show, the majority of directed payment spending goes towards uniform rate increases.

Finally, value-based payment arrangements require plans to implement value-based payment models that tie payment to a specific performance or outcome. These include pay-for-performance models, shared savings arrangements for accountable care organizations, or other alternative payment mechanisms.

As the chart above shows, managed care directed payments are a substantial share of Medicaid payments to hospitals. In 2022, we found that directed payments

accounted for around one-third of managed care payments to hospitals. Directed payment estimates were also larger than other types of supplemental payments for hospitals.

Now we'll move on to discuss the trends and characteristics of directed payments that we observed in our most recent analysis.

For our analysis, we reviewed directed payment preprints approved on or after February 1st, 2023, which CMS has made publicly available online. This does not include minimum fee schedules tied to state plan-approved rates because they are exempt from prior preprint approval.

In total, we included 302 distinct directed payment arrangements approved between February 2023 and August 2024 in our analysis, and in order to use the most recently approved and updated directed payment, we excluded preprints that were subsequently renewed or amended and used directed payment preprints that did not use the old preprint template.

The payment amounts represent annualized amounts for the most recent rating period, which may not be tied to the most recent calendar year and differ from actual final spending.

This analysis updates our previous directed payment analyses where we had analyzed directed payments approved up to February 2023.

This chart represents our directed payment analyses from our separate review periods. Since the first directed payments were implemented in 2017, there has been a substantial growth in the use of directed payments, especially for uniform rate increases.

In 2022, MACPAC reviewed all directed payments approved up to December 2020, and we found 61 distinct arrangements for uniform rate increases. We replicated this analysis in 2013 for directed payments approved between July 2021 to February 2023, and we found 177 directed payments approved for uniform rate increases.

Our most recent analysis found that the number of uniform rate increases approved between February 2023 and August 2024 has grown to 204 distinct direct payment arrangements.

Similarly, we also found a dramatic increase in annual directed payment spending. This increase is again concentrated in uniform rate increases.

This year, we estimated that directed payments

approved between February 2023 and August 2024 totaled $110.2 billion per year, which is nearly 60 percent greater than the $69.3 billion in projected annual spending from our previous review. And while the spending projections is substantial, these numbers should be interpreted with caution because the numbers reported in preprints are spending projections and not actual spending expenditures.

This slide shows the count and spending distribution of different types of directed payment arrangements. We found that about two-thirds of directed payments approved between February 2023 and August 2024 were uniform rate increases. Fifteen percent were minimum or maximum fee schedules discounting those that use state plan rates. Twelve percent were value-based payment arrangements, and 6 percent were more than one type of arrangement.

Uniform rate increases also accounted for a disproportionately large amount of projected spending. Although two-thirds of directed payment preprints were uniform rate increases, they represented nearly three-quarters of total spending.

In contrast, while the value-based payment

arrangements accounted for 12 percent of directed payment arrangements, they only represented 3 percent of the total funding. However, because some arrangements use more than one type of directed payment, it's difficult to allocate the estimated payment amounts for each payment type.

In our review, we also analyzed the ways that directed payment arrangements were targeting providers and their financing sources. For uniform rate increases and value-based payment arrangements, the most commonly targeted providers were hospitals and hospital-affiliated providers, while minimum or maximum fee schedules most commonly targeted behavioral health providers.

Although less common, directed payment arrangements also targeted nursing facilities, home- and community-based service providers, dental providers, and others.

Most uniform rate increases were financed by provider taxes or intergovernmental transfers, especially those that target hospitals, and most minimum or maximum fee schedules were financed by state general funds.

We also found that the targeting of directed payment arrangements appears related to their financing

sources. Directed payment spending often went towards providers who also financed the non-federal share of the payment.

For the 29 largest directed payment arrangements that were projected to spend more than $1 billion a year, 24 of them were targeted to hospitals, and 26 were financed by provider contributions.

Our analysis also found that the methods states used to pay out directed payment arrangements varied based on the directed payment type.

There are two ways that states can incorporate directed payments. They can incorporate them as adjustments to plans' base capitation rates or use separate payment terms, which are separate, typically predetermined pools of funding that states deliver outside of the base capitation rate.

We found that most uniform rate increases and value-based payment arrangements use separate payment terms. Out of the $81.5 billion of annual projected spending on uniform rate increases, separate payment terms accounted for 87 percent of these dollars, although this does not include directed payments that use both capitation

rate adjustments and separate payment terms. There also seems to be a correlation between provider financing and the use of separate payment terms.

We found that provider taxes and intergovernmental transfers financed 78 percent of the uniform rate increases that were incorporated as separate payment terms, while provider contributions only financed 34 percent of uniform rate increases incorporated as base rate adjustments.

Given the common use of separate payment terms, CMS had concerns that separate payment terms undermine the risk-based nature of managed care. So CMS eliminated separate payment terms in the 2024 managed care rule. This elimination will go into effect in July 2027, and directed payments that currently rely on separate payment terms will need to be restructured as adjustments to the base capitation rates.

With respect to quality goals, most directed payment arrangements stated goals relating to access to care, but they did not clearly specify how directed payments would lead to improved access. Directed payment arrangements often did not provide clear nor consistent

measures of improved access. For example, some directed payment arrangements relied on measures of utilization, while others considered the timeliness of care and keeping providers within planned networks. But it wasn't always clear how the additional payments would be tied to these measures of access.

There were some directed payment arrangements that focused on improving access for specific providers or services, such as safety net hospitals, hospitals with a high percentage of Medicaid patients, children's hospitals, and providers of maternal and behavioral health services.

Although states must have an evaluation plan to assess how the directed payment arrangement advances state goals, there is a lack of publicly available evaluation results, and CMS has reported that evaluation results were often incomplete. So it's not clear the extent to which directed payments have achieved meaningful improvements in access.

Finally, we will review recent policy updates that CMS made to the directed payment option.

As we saw from our findings, directed payments have continued to grow rapidly since their initial

implementation. In July 2024, CMS finalized a managed care rule that issued several updates to improve the oversight and transparency of directed payment arrangements.

As mentioned earlier, CMS eliminated the use of separate payment terms, which may have particular implications for hospitals that receive large uniform rate increases from directed payments that use separate payment terms.

CMS also prohibited the use of post-payment reconciliation processes. This means that plans can no longer use historical utilization to make periodic payments and then reconcile to actual service utilization. These provisions will be effective for the first rating period on or after July 2027.

In addition, CMS also issued stricter reporting requirements. States must report provider-level data on directed payments via T-MSIS once CMS releases reporting instructions.

CMS also added more evaluation plan requirements, and states are now required to submit evaluation reports with three-year results for directed payment arrangements that exceed 1.5 percent of total managed care costs.

States must also collect provider attestations that indicate they did not participate in any unallowable hold-harmless arrangement.

While this final rule did partially address some of MACPAC's prior recommendations by requiring states to collect provider-level data, there are still further opportunities to fully implement our recommendations.

We've recommended that states should also be required to report the provider-level costs of financing the non-federal share, so that we can fully analyze the relationship between net provider payments and improvements in access and quality.

For next steps, we plan to update a hospital payment index that will incorporate directed payment data to make payment-level comparisons across states and Medicare, and alongside our payment index work, we'll also review narratives from UPL payment reports and continue to review new directed payment preprints.

Thank you for your time, and we welcome your feedback on our findings and any additional information that you would like us to monitor on directed payments.

CHAIR JOHNSON: Thank you, Asher and Chris.

All right. So we're going to open it up for Commission feedback here. We're looking for some feedback on the findings as it was presented and if there's additional information that will be helpful as we continue the discussion as well. So I'll open up the floor.

All right. Tricia.

COMMISSIONER BROOKS: I just have a question. Could you go back to slide 10? Can't get there, huh? Okay.

So, if I'm looking at these time frames correct, the middle one was for a 19-month time frame, and the one on the far right, the most recent, is for seven months?

MR. WANG: Eighteen months.

COMMISSIONER BROOKS: It says February -- okay. Never mind. Thank you. I can't read that small print.

MR. WANG: No problem. It's a small font.

COMMISSIONER BROOKS: Nice presentation, though. There's a lot of stuff to think about here.

CHAIR JOHNSON: Thank you, Tricia.

Sonja?

COMMISSIONER BJORK: Thank you.

What a great presentation. So much work goes

into these, and we sure appreciate you putting it all together for us like this.

Well, I have several comments. The first is one that I've made before that, you know, that the stated goal is -- one of the stated goals is strong networks and access. So I continue to be very disappointed that CMS removed the requirement that providers be contracted with the managed care plan in order to take advantage of the directed payment program. It turns out that's one of the really big incentives for providers to contract with their local plans.

You know, we continue to encounter pretty big hospital systems, that they don't want enter into a contract, but they sure do want to take advantage of directed payments. And so I just wanted to go on the record that although states are allowed to require that, it was much stronger when it was a CMS requirement for part of the whole program.

Directed payment quality goals. They should very much be aligned with what are required by the states of the managed care organizations. There have been instances where the quality goal was different than the ones that are

being required by the state and the managed care plans, and it sure is helpful when everybody is moving in the same direction on quality issues. So I would advocate for that.

Let's see. The new regulations, as you've noted, the directed payments no longer have the separate terms. That starts in July of 2027. This means that the payments will eventually be included in MCO base rates.

Now, our actuary specialist, Jennifer, can opine on this, you know, if needed. But essentially, what this means is that it goes into the risk of the managed care plans, and if the actuaries don't get the utilization assumptions correct, then it puts the health plans at risk for -- you know, it could be millions or billions of dollars, and we haven't had risk in that way before. So there's a danger of non-alignment with utilization assumptions.

To solve that, we could have a longer phasedown period of the special terms, and that would give the states time to work through the issues.

Additionally, another possibility is that CMS could allow narrow risk corridors, and that would lessen the risk on everyone.

So those are my comments, and I look forward to our next round. Now that I've been a Commissioner for several years, I understand that this is our perennial topic and that we will always be focusing on this. I can see from your chart that the use of directed payments sure is growing, and so we'll need to pay attention to all the things that MACPAC cares about, including transparency, consistency, and topics like that. So thank you.

CHAIR JOHNSON: Thank you, Sonja.

Patti?

COMMISSIONER KILLINGSWORTH: I'll just make a quick comment, and it is one, too, that I have raised before. But, as noted on slides 12 and 13, a significant portion of these payments are funded through provider taxes, provider taxes which heavily favor institutional providers, and thereby have at least the potential to significantly expand access to institutional benefits while inadvertently, perhaps, reducing access to home- and community-based providers who don't have access to those same provider taxes to fund directed payments. And I just think it's an issue that we need to continue to be aware of as we continue our work on this topic.

CHAIR JOHNSON: Thank you, Patti.

Mike?

COMMISSIONER NARDONE: I wanted to ask a question on the Slide 10, Chris and Asher. I was trying to understand where it says the analysis excludes prior versions of directed payments that were renewed or amended. Does that mean that this is actually a low number, in terms of the directed payment arrangements, or am I misunderstanding the notes?

MR. WANG: Yeah. So some directed payment arrangements they have multiple preprints for -- because they submit a preprint for each renewal period. So for example, if they submit a preprint for 2021, they might submit it again in 2022 to renew. But they might have different numbers for their projected spending. So in order to remove any duplicates we would use the latest, most updated directed payment preprint. So older ones that were updated with the new preprint, those were excluded.

COMMISSIONER NARDONE: I see. Okay. And I know that, first of all, this is really helpful to have the understanding of the directed payments, and also understanding -- this is a lot of money, so how do these

expenditures, are they meeting the goals of what they're intending to achieve? So I think the transparency around this is really important in understanding where these dollars are going and how they're being utilized.

I think the one thing that I struggle with a little bit is we don't have, and apparently, we don't have access to this, is what are the resources that are going into funding the provider taxes. So some of these directed payments, at least the way I'm understanding it, some of these directed payments would be offset by the amount of dollars that providers are putting into the provider taxes. And I just note that to say that, you know, just to make that point, and that's, I think, part of putting these dollars in context. I guess we don't really have any sense of that, right?

MR. PARK: Yeah, so we don't have the actual financing amount to individual providers. What we've done in the past, which is rough estimates, is the GAO did a survey of states in terms of how they're using different sources of non-federal share financing. And so that is what we did with our previous hospital payment index, and these are pretty rough buckets of managed care, DSH

supplemental payments, non-DSH supplemental payments, and fee-for-service. It's very rough. The data are older. The most recent one is from 2018.

So that's really the best source of information that we have in terms of non-federal share contributions to different types of payments. You know, certainly in our last report cycle we had made recommendations that this information is important to really understand what individual providers are getting, because these payments are targeted for specific providers, for specific reasons, and we really do need all that information to really understand if they're meeting the stated goals.

COMMISSIONER NARDONE: And I guess I just want to also understand separated payment terms, what the impact of that is. Even though the dollars -- this is my assumption so I just want to ask the question -- even though the dollars are put into the base rates, would there also be some provision elsewhere in the contract that said the expectation was that the plans paid a percentage increase over their rates or additional money, whatever the requirements were of the directed payment?

MR. PARK: Yes. So there's nothing prohibiting

these uniform rate increases in terms of saying, you know, hospitals would get a 20 percent increase in their payment rates or the exact dollar amount, the $100 per admission, however the state went and set that up. As Sonja mentioned, the separate payment terms is allowed to kind of sit outside of the per capita capitation PMPM that the state pays to the plan. So these are more like the fee-for-service supplemental payments that can be paid on a lump sum basis. So it might be paid out on a quarterly basis, based on the utilization, like the actual admissions to a particular hospital.

When it gets incorporated into the capitation rate, as Sonja mentioned, the plan does have that risk in terms of over or under utilization. So then also depending on how -- all the dollars are going to the plan, but then depending on the utilization to different providers, the providers may not get the same amount they would've gotten under the separate payment term, necessarily.

So the amount of dollars could still be the same, but the effect and how the dollars are flowing may look differently.

COMMISSIONER NARDONE: Okay. Thank you.

CHAIR JOHNSON: Thank you, Mike. Sonja.

COMMISSIONER BJORK: Verlon, I didn't quite hear you. Did you call on me?

CHAIR JOHNSON: I did. I'm sorry, Sonja.

COMMISSIONER BJORK: No, that's okay. I just had a follow-up to Patti's comment about what's covered and what's not and who participates. It reminded me of the possible unintended consequence where we say in our paper that we want to promote other models, like value-based purchasing or capitation, but when only certain services are subject to these rate increases through directed payments, you know, this has all been retroactive, so can you imagine the amount of administrative work to go back and parse out, in a capitated arrangement, which services, you know, first figuring out the value and then making sure that those services or service providers get the increase.

So I just want to make note of that, and Chris, you and I have probably talked about that before, but I just want to make sure it's on the radar. Thank you.

CHAIR JOHNSON: thank you. Heidi.

COMMISSIONER ALLEN: Thank you for this work, and, you know, I think it really underscores how helpful

transparency would be for everybody. Like we're assuming nothing untoward is going on here, but if it's transparent then everybody can see the way that it's being used and why. And I think that benefits every stakeholder.

One thing I want to mention about the way, though, that it's happening, is I don't think it does anything or enough to reduce the stigma of treating the Medicaid patient, because it is so back door, because it happened after the encounters. You know, so many providers say, "I don't want to accept Medicaid because I don't get paid enough," and so many providers won't even contract with Medicaid because they say that they don't get paid enough. And you go onto these state websites and you try to understand what the base rate is, and you're like, oh wow, that's really, really low. But it's not actually what providers are getting.

So I feel like if it's not going to be integrated into the capitation and to the base rates, then there has to be some way, though, to be able to quantify how it's impacting provider rates in a meaningful way, so that we can actually say, oh, a provider here who sees Medicaid patients for this kind of thing gets paid this much. And I

think that's such a simple outcome.

I mean, why is it a mystery? Why can't we just know how much providers are getting paid to serve a Medicaid patient, so that we can really have a conversation about whether it's enough or it's not enough? And these kinds of payments, I think, make that really, really difficult. So I hope it continues to stay on our radar. I hope we can improve transparency and really make our voice towards ensuring that this significant portion of the Medicaid budget will be used for access and quality and the things that we really care about.

CHAIR JOHNSON: Thank you, Heidi. Jenny.

COMMISSIONER GERSTORFF: First, I want to say how excited I still am about the hospital index that you guys are updating. I think that will be great.

But I also wanted to ask here on Slide 10, when you deleted the duplication of preprints, was that within each period or was that across all time?

MR. WANG: This was within each period.

COMMISSIONER GERSTORFF: Within each period. Okay. Perfect. Thank you.

CHAIR JOHNSON: Any other questions? John.

COMMISSIONER McCARTHY: Yeah. I want to hit on what Heidi said. I think a part of what we run into on some of these things is because there's non-transparency on some of it then people will fill in ideas around what's going on in some of these. So as we voted last time, to be a little more transparent on this, I think it would be quite helpful.

The second point I want to make is there is a lot of nuance in this, and I know in your analysis you're breaking some of these things out. And I think we'll keep pressing you on some of these different pieces, just from the standpoint of what provider types are we looking at for these payments. Are we looking at hospitals? Are we looking at physicians? Are we looking at nursing homes? Like whoever it is, to get a better understanding of those.

Lastly, I think it is also hard in some of these when you're looking across the country -- and I'm making this one up, and I'm not saying there's directed payments around this -- but you're looking across the country and you see rural hospitals closing. And we know that's a fact. I mean, that's not happening. It is happening. And so if a state puts in a directed payment, for instance, for

rural hospitals, and they're using either a tax or an intergovernmental transfer, whatever they're using, and we say we're measuring access, well, the access might be that the hospital stays open, but they're not going to see more people. So how do you measure that, because it's hard to measure, well, the hospital would've closed or not closed.

There are things that we still have to keep in the back of our heads, and the nuances, as we talk about these, and because of the words we use, if they've got negative or positive connotations on some of these, because I think there are a lot of different problems, people we are trying to solve. And the biggest one is probably just payment rates that aren't adequate, and I think that can become an issue.

Even like Sonja said, I get what Sonja said around making a requirement to contact with the plan in order to get the payment. And that, at the service level, makes sense, and I have done that in the past. But I think one of the problems that you come into is what if a plan says -- and I'm not saying Sonja's plan does this, but I'm saying if a plan said something like, "Well, okay, we're going to offer you 25 percent of fee-for-service because

you have to contract with us in order to get this other payment," well, that's not a good way to do this either.

So there are a lot of different pieces and a lot of different nuances around these things, so it will be interesting, as we move forward, how do we look at that and break down maybe specific policy questions for different areas of this.

CHAIR JOHNSON: And as he does when he talks, we have thousands of people wanting to respond. So I will turn to Mike Nardone.

COMMISSIONER NARDONE: I was just going to say, just to reflect on John's point about some of the nuances here, when I reflect back on my time as a Medicaid director, we initiated I guess what now would be a directed payment to hospitals. That was funded by a hospital tax. And it was taking place during the period of the Great Recession. And it also allowed us to generate additional revenues to the program as well as supporting the hospital, increased resources for hospitals.

So it's hard because we're looking at one side of this, the payment side, and we don't have the same level of transparency or understanding around the financing side.

So I applaud these efforts to get there, but I just also want to make sure that these are put in the appropriate context.

CHAIR JOHNSON: Thanks, Mike. Sonja, I thought I saw your hand up.

COMMISSIONER BJORK: Well, you did. John's comment just made me want to mention that I see usually the exact opposite of what John said in that the hospitals or big systems say Medi-Cal base rates and what you're offering as a Medi-Cal plan, they're way too low so we're not contracting with you. And they do not, at all, have a willingness to acknowledge that the directed payment program, you saw on the pie chart, my goodness, that increases the reimbursement by about 30 or 40 percent. That is substantial. And they'll say, "Well, we're not going to count that as part of contracting or as part of your offer."

So we usually see the exact opposite, but John's point is taken. Thank you.

CHAIR JOHNSON: Thank you, Sonja. And then Carolyn.

COMMISSIONER INGRAM: Yeah. I just have to chime

in with Sonja. I appreciate John's comment, as well, because he's great about being skeptical about these things. But the directed payments, at least in the states that we operate in, are used to increase access to care, and they're used as a way to ensure that we've got providers who want to participate in programs because they end up increasing the rates to those providers on the ground.

So I guess it could happen somewhere else, but Medicaid, as we all know, because there are a lot of us on here who have dealt with these budget issues besides just Medicaid directors, the legislature and the governor's office gives you the money as a Medicaid agency, that they're going to give you. Sometimes you'd really like them to give you increased amount for rates.

And I'll just do a shout-out to New Mexico. Our legislature has done that. Our rates are going up to 150 percent of Medicare in New Mexico. Thank you, governor and legislature, for doing that. So it's going to be amazing in terms of increasing access to care in the state because they've put that funding behind the program.

I think not all states are able to do that. So

some states are creative and come up with other ways to increase the rates because they want to increase access to care. They can't all come up with that state general fund to do that, or the mechanism there. So I'll just throw that out there for us to think about.

I still agree with Heidi and others that we need more transparency in this process so that we can see what's actually going on. Especially as this managed care rule gets put in place, that will be the more important. Thank you.

CHAIR JOHNSON: Thank you. Anyone else?

All right. Well, Asher and Chris, this is a definitely a very good conversation. I think we had a lot of key points that came out of it. I will just say, too, that as I initially read the report and looked at some of the numbers, particularly around the uniform rate increase, it was a little like, hey, is this really achieving what we're supposed to achieve with this? And I think you all did a nice job of at least reminding us of the key principles we're looking for in transparency, quality, and access.

But what I also heard, I think, from my fellow

Commissioners, is that we want to continue monitoring and really be able to evaluate those longer-term impacts as we move forward.

But I just wanted to pause and see if you all heard anything differently or if there's anything else that you feel that you need from the Commissioners at this time?

MR. PARK: Nothing else at this time.

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

CHAIR JOHNSON: All right. So with that, that was our last session, but we do have time for more final public comments. At this time we'll ask that people raise their hand if they would like to offer comments. Remember to introduce yourself and also the organization that you represent. And as always, we ask that you use keep your comments to under three minutes.

All right. So we have Chelsea.

PUBLIC COMMENT

* DR. FOSSE: Yes, hello. Thank you so much. I want to thank the MACPAC staff and the Commissioners for such an important conversation around the transition from pediatric to adult care for children with special health

care needs.

My name is Chelsea Fosse. I'm on staff at the American Academy of Pediatric Dentistry. I'm a general dentist, and when I worked clinically, I worked primarily with adults with disabilities, so that population that would definitely benefit, and hopefully we'll see more providers for adults in the clinical environment doing this care.

I believe Commissioner Brooks stated in dentistry it's all too common, as I'm sure many other segments of health care, for people with special health care needs, people with disabilities to be seeing their pediatric providers while into adulthood. That is absolutely the case in dentistry where we have pediatric dentists doing a lot of this care.

Right not at AAPD we're fortunate to have the support of the CareQuest Institute as we dive into figuring out the clinical transition in dentistry, how we can guide and advise pediatric dentists and general dentists to work together in this space. We'll turn to many of the resources you've all mentioned, Got Transition, AAP, looking at best practices in foster care, and we've

established a transition advisory group of pediatric and adult dentists to help us roll this out.

I'm grateful for the conversation on the definition of special health care needs, as well. We've thought a lot about that too. I believe one of the recent CMS state health official letters rephrased this a bit to children with disabilities and other complex conditions. We're looking at that sort of terminology, as well, and making sure it's defined well, comprehensive enough.

So I thank you all for this conversation. It's extremely important. We'll be sure at AAPD to share our work with the Commission when it becomes available. And thank you for your incorporation of dentistry in these conversations, as well. So thank you so much, and we look forward to hearing how the Commission moves forward with this.

CHAIR JOHNSON: Thank you so much, Chelsea.

Julie, would you like to make a comment?

MS. KOZMINSKI: Yes, thank you, and good morning, everyone. My name is Julie Kozminski, policy manager at America's Essential Hospitals. Thank you for your work on directed payments and the opportunity to provide comments.

We submitted written comments for the record, but I wanted to highlight what we've heard from our members on the important role of state-directed payments in improving access and about some new barriers to implementing directed payments that were added by the new managed care rule.

America's Essential Hospitals is a leading association for hospitals dedicated to equitable, high quality care for all, including those who face social and financial barriers to care. Our more than 300 members provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid.

First, I wanted to highlight the fact that the ability for states to pay Medicaid providers the same rate as other payers has been truly transformational for many of our members. Not only do these payments help offset low Medicaid payment rates but they also help to fund investments in quality and access.

We recently published a new policy brief highlighting many of these successes, and we urge MACPAC to consider the important role directed payments play in improving access to care as it monitors the implementation

of the new access rules.

Second, we also recognize that the Commission has an important role in monitoring spending associated with state-directed payments, and we appreciate the new analysis that the Commission shared today. However, we are concerned that the Commission's report on state and federal spending do not consider the costs of intergovernmental transfers and provider taxes that reduce the net payments that hospitals receive.

Lastly, we are concerned about two barriers in the managed care rule, the elimination of separate payment terms and the prohibition on interim payments based on historical utilization. These provisions do not change the amount of directed payments providers are eligible to receive, but they will add administrative costs to states, health plans, and providers with no meaningful benefit for patients, and will reduce payment transparency.

Eliminating separate payment terms will disproportionately harm essential hospitals because it will make it more difficult for states to target directed payments to safety net providers. Further, interim payments help states make more timely and predictable

payments to providers, which is important for maintaining cash on hand at essential hospitals.

We have shared with the Commission a letter we sent to CMS detailing these concerns, and we hope that we can continue to be a resource to MACPAC as it seeks to learn more about how directed payment policies are working on the ground at essential hospitals.

Thank you for the opportunity to provide comments.

CHAIR JOHNSON: Thank you so much, Julie. Thank you for all the comments.

I do want to remind others, if you have additional comments that you'd like to submit you can definitely go to our MACPAC website and submit the comments there.

And with that, as we conclude these two days of, I think, very important discussions that we've had, I just want to thank the staff for their in-depth analysis and their research. It was very helpful. I also want to thank my fellow Commissioners for your thoughtfulness, of course, and the contributions and engagement that you made, as well. And, of course, the public for your support and your

input is always valuable.

And we are looking forward to our next meeting which will occur on December 12th and 13th. And let me just get a nod that that's correct. Okay. We're looking forward to seeing you all there.

So thank you very much, and enjoy your weekend.

* [Whereupon, at 11:57 a.m., the meeting was concluded.]