PUBLIC SESSION

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10:01 a.m.

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1 P R O C E E D I N G S

2 [10:01 a.m.]

3 CHAIR JOHNSON: Good morning, everyone, and
4 welcome to our first public meeting of 2025. I hope you
5 are all staying warm. I know we are very chilly here in
6 D.C. and for this January day, and as we continue to do our
7 important work on behalf of the Medicaid and CHIP
8 beneficiaries across the country.

9 Today's meeting not only marks the start of a new
10 year but also takes place in the early days of a new
11 President's administration. And we know that transitions
12 like these bring opportunities to reflect on how we can
13 best adapt new priorities and ensure that Medicaid and CHIP
14 remain responsive, effective, and align with the needs of
15 the people we serve.

16 We do have a packed agenda over the next two
17 days. We will be touching on critical issues such as
18 improving access to HCBS, addressing workforce challenges,
19 and of course, enhancing managed care oversight and
20 accountability. And these discussions, of course, are
21 always going to be very vital as we continue to try to find
22 ways to improve our Medicaid and CHIP programs.

1 So we very much thank you all for joining today,
2 and we do look forward to a very thoughtful, productive,
3 and engaging meeting.
4 We will now dive into our first session on timely
5 access to HCBS, specifically use of provisional plans of
6 care to expedite service delivery for beneficiaries. With
7 that, I will turn it over to Tamara Huson to facilitate and
8 get us started.
9 **### TIMELY ACCESS TO HOME- AND COMMUNITY-BASED**
10 **SERVICES**
11 * MS. HUSON: Okay. Thank you, and good morning,
12 Commissioners. Today I'm going to present the draft
13 chapter on timely access to home- and community-based
14 services to be included in the March report to Congress.
15 Access to HCBS has long been an area of focus for
16 the Commission, and we have engaged in multiple streams of
17 work in order to promote and understand how individuals can
18 access services when and where they need them.
19 States have a number of flexibilities at their
20 disposal to speed up eligibility and enrollment for
21 individuals seeking Medicaid HCBS, and this chapter
22 discusses three such flexibilities, namely (1) presumptive

1 eligibility, (2) expedited eligibility, and (3) use of
2 provisional plans of care.
3 I am going to begin with an overview of these
4 three flexibilities, followed by a recap of our findings.
5 I will conclude with the recommendation language and a
6 discussion of the rationale and implications.
7 In order to be eligible to receive Medicaid HCBS,
8 applicants must meet both financial and functional
9 eligibility criteria. Once determined eligible, designated
10 staff, such as case managers, work with the individual on a
11 person-centered service plan, or PCSP. Enrollees are
12 required to have a PCSP in place before they can receive
13 HCBS. States have up to 90 days to make eligibility
14 determinations for non-MAGI populations, which includes
15 individuals who are determined on the basis of age and
16 disability. Most states take between one and two months,
17 on average, to complete a non-MAGI eligibility
18 determination, but some states take longer.
19 Typically, an applicant cannot begin to receive
20 Medicaid services until their eligibility determination has
21 been completed. Presumptive eligibility, however, allows
22 individuals who have not yet been determined eligible for

1 Medicaid to receive Medicaid-covered services while
2 completing the full application process.
3 The presumptive eligibility period typically
4 lasts up to 60 days, at which time the full eligibility
5 determination must be completed for coverage to continue.
6 And states can allow qualified entities, such as hospitals,
7 to make presumptive eligibility determinations. The
8 Affordable Care Act gave states the option to expand
9 hospital presumptive eligibility to non-MAGI populations,
10 but only one state has done so.
11 There are two options available to states to use
12 presumptive eligibility for non-MAGI populations. The first
13 is which I just mentioned, which is the use of a state plan
14 amendment to expand hospital presumptive eligibility, and
15 then the second is use of a Section 1115 demonstration.
16 And regardless of pathway, providers furnishing HCBS during
17 the period in which a beneficiary is deemed presumptively
18 eligible are reimbursed by Medicaid. However, services
19 during this time must be rendered after a plan of care is
20 established.
21 Expedited eligibility is when an individual's
22 Medicaid application is processed in an accelerated manner

1 for the purposes of making an eligibility determination,
2 but services are not rendered until after the determination
3 has been made. There is not a uniform definition of
4 expedited eligibility, and it is not a term used by federal
5 officials. Instead, it can be used generally to describe a
6 number of state actions to streamline eligibility, such as
7 accepting self-attestation of information or setting
8 specific timeline requirements for Medicaid eligibility
9 approvals.

10 One way that states can expedite delivery of
11 Section 1915(c) HCBS is to use a provisional plan of care,
12 which is a type of preliminary service plan that identifies
13 the essential Medicaid services that can be provided in a
14 person's first 60 days of waiver eligibility. States may
15 call provisional plans of care by other names, such as in-
16 term or temporary service plans or initial plans of care.
17 And provisional plans have been allowed since 2000, when it
18 was described in a State Medicaid director letter, known as
19 Olmstead Letter No. 3, which was issued in response to the
20 1999 Olmstead v. LC decision.

21 The analytic work that went into this chapter has
22 three main inputs. First, we contracted with The Lewin

1 Group to conduct an environmental scan. The scan gave us
2 an initial understanding of state take-up of different
3 flexibilities and policies around the use of presumptive
4 eligibility, expedited eligibility, level of care
5 determinations, and person-centered planning processes, and
6 the full scan is available on our website along with the
7 policy in brief.
8 Second, we conducted stakeholder interviews with
9 officials in seven states, with officials at CMS, and also
10 representatives of four national organizations.
11 And then third, we conducted a review of Section
12 1915(c) waivers for language allowing for the use of
13 provisional plans of care.
14 I am going to give just a high-level overview
15 again of our key findings. To start with presumptive
16 eligibility and expedited eligibility, states most often
17 use Section 1115 demonstrations as the vehicle to
18 streamline eligibility. Section 1115 demonstrations give
19 states the ability to innovate, design policies to meet
20 their specific state needs, and waive certain elements of
21 federal Medicaid authority.
22 States are generally using presumptive

1 eligibility and expedited eligibility for older adults and
2 individuals with disabilities, with a focus on helping
3 individuals transition from hospitals back to the
4 community. In particular, we heard how states can use
5 these flexibilities to help ensure that individuals are
6 able to receive care in the setting of their choice.
7 And states that are using these flexibilities
8 generally accelerate their eligibility determinations by
9 relying on self-attestation, using shortened versions of
10 their level of care assessment, and a limited benefit
11 package. A number of interviewees suggested that offering
12 a limited set of services during the presumptive
13 eligibility period can respond to beneficiaries' short-term
14 needs and prevent institutionalization.
15 To continue, CMS and experts that we spoke with
16 said that states and providers are under no obligation to
17 repay services provided during a period of presumptive
18 eligibility for either Section 1115 demonstrations or
19 hospital presumptive eligibility provided through a SPA.
20 The next finding is that there was no consensus
21 among interviewees about the need for additional CMS
22 guidance on presumptive eligibility for non-MAGI

1 populations. One expert noted that much of the work being
2 done through Section 1115 demonstration authority relies
3 heavily on back-and-forth discussions with CMS and the
4 ability for states to tailor programs to their specific
5 needs. And with regards to hospital presumptive
6 eligibility through a SPA, there is guidance available, and
7 CMS officials noted for us a set of FAQs from 2014 in
8 particular.

9 The complexity of non-MAGI eligibility
10 determinations does not necessarily lend itself to speedy
11 determinations. Both financial eligibility determinations
12 and disability determinations can be complex and time-
13 consuming.

14 And then finally, a few interviewees noted
15 concerns about a "benefit cliff" for individuals who
16 receive services during the presumptive eligibility period
17 but are ultimately found ineligible for Medicaid.
18 Interviewees were concerned that people might not
19 understand why they were able to receive services only to
20 subsequently receive a denial notice and be cut off from
21 services, but many interviewees noted for us that this
22 happens very rarely.

1 Then to turn to provisional plans of care, first,
2 our waiver review found 24 states have language in one or
3 more of their Section 1915(c) waivers that allow for the
4 use of provisional plans of care, for a total of 59 waiver
5 programs across all states.
6 Provisional plans of care are used most often for
7 emergency situations, such as natural disasters or
8 hospitalizations. However, our interviews also indicated
9 that few states are actually using provisional plans. We
10 heard a number of reasons for low state uptake of this
11 flexibility, namely a lack of awareness as well as limited
12 state capacity, administrative complexity, and competing
13 priorities at the state level. We also heard that in some
14 states their operational processes affect decisions about
15 whether or not to use this flexibility. For example, three
16 states shared with us that they complete the level of care
17 assessment and develop the PCSP together in the same
18 meeting, thus negating a need for an interim service plan.
19 And then finally, provisional plans of care might
20 not be feasible or appropriate for all individuals.
21 And as I mentioned just a minute ago, states
22 using Section 1115 demonstrations to offer presumptive

1 eligibility for non-MAGI populations typically provide a
2 limited set of services during the PE period. And the way
3 that they do this, since a PCSP is required to be in place
4 before HCBS can be delivered, is to use a provisional plan
5 of care.
6 And then the last key finding is related to
7 guidance, specifically for provisional plans of care. In
8 our interviews we got mixed responses on the need for
9 additional guidance. Two experts, as well as one state,
10 agreed that guidance would be helpful. Two states that
11 have already operationalized the use of interim service
12 plans said they do not need initial guidance. And then we
13 also received multiple public comments in support of
14 guidance.
15 Okay. So we have one recommendation coming out
16 of this work, and the recommendation reads:
17 The Secretary of the U.S. Department of Health
18 and Human Services should direct the Centers for Medicare &
19 Medicaid Services to issue guidance on how states can use
20 provisional plans of care, including policy and operational
21 considerations, under Section 1915(c), Section 1915(i),
22 Section 1915(k), and Section 1115 of the Social Security

1 Act.

2 As I just stated, interviewees were mixed on the
3 need for guidance, but the apparent lack of awareness and
4 the limited use of provisional plans indicates this need
5 for additional guidance. Interviewees noted that CMS could
6 better describe the intent of the policy and how
7 provisional plans of care could be used, including state
8 examples of how to operationalize the policy.

9 The recommendation also directs CMS to clarify
10 that provisional plans of care can be used for all HCBS
11 authorities. Olmstead Letter No. 3 is specific to Section
12 1915(c) waivers as it predates the other Section 1915 state
13 plan options. There is no guidance expressly stating that
14 this flexibility is allowed for other HCBS authorities.

15 And then finally to talk about the implications
16 of this recommendation. In regards to federal spending,
17 the Congressional Budget Office did not estimate any
18 changes in federal direct spending as a result of this
19 recommendation.

20 For states, state Medicaid agencies and operating
21 agencies for HCBS programs may benefit from greater clarity
22 on how to authorize and implement the use of provisional

1 plans of care. Guidance should describe how states can
2 implement provisional plans of care in the least
3 administratively burdensome way possible.
4 For enrollees, if guidance leads to more states
5 using provisional plans of care, the number of new
6 enrollees who have a provisional plan could increase,
7 potentially leading to more timely access to services. In
8 emergency situations, this more immediate access to
9 services could enable individuals to remain in or return to
10 the community as opposed to going to an institutional
11 setting.
12 For plans, an increase in the number of
13 provisional care plans can affect the entities that are
14 responsible for providing them. So in states where plans
15 are responsible for developing PCSPs, staff would need to
16 be trained on how and when to operationalize their use.
17 And then finally, for providers, use of
18 provisional plans of care may allow enrollees to more
19 quickly be connected with HCBS providers. Providers who
20 need to be educated on the difference between a provisional
21 plan of care and a full PCSP and how services authorized
22 could differ between the two versions. Guidance should

1 also clarify that providers are not financially at risk for
2 services provided via a provisional plan of care.
3 So to conclude with next steps, I welcome any
4 Commissioner feedback on the draft chapter, and I am happy
5 to answer any questions. The chapter will be published in
6 the March report to Congress. And then finally, I would
7 like to note that our investigation into timely access for
8 HCBS is ongoing, and I will return at a future meeting to
9 talk about level of care assessments and person-centered
10 planning processes.
11 Thank you.
12 CHAIR JOHNSON: Thank you for all the work you
13 are doing on this, for sure.
14 All right. So let's turn to the Commissioners.
15 Let us know if you have any questions or concerns around
16 the recommendation as we prepare for the vote tomorrow. So
17 I will open the floor to you. Patti?
18 COMMISSIONER KILLINGSWORTH: Thank you so much
19 for this great work. I completely support the
20 recommendation as it is written. In terms of the rationale
21 and sort of the write-up around the recommendation, I just
22 want to be careful that we don't suggest that states don't

1 have the authority but just that it hasn't been clearly
2 articulated by CMS. I think there are a number of states
3 who do provisional plans of care in authorities beyond
4 1915(c), even though clear guidance has not yet been
5 issued. And I think they are doing that in ways that are
6 permitted under the regulations. So I don't want to create
7 a problem, if that makes sense.
8 And I also just want to reiterate, when you
9 talked about for the implications of the policy
10 recommendation you mentioned that the guidance should be
11 written in a way that is least administratively burdensome.
12 So I just want to emphasize that, that the goal is not to
13 create new waiver amendment processes that states have to
14 go through in order to do something that increases or
15 improves access to home- and community-based services, but
16 really include flexible options that will encourage states
17 to use provisional plans of care, when appropriate, to
18 improve the timeliness of access to those needed services
19 and supports.
20 So that's it for me. Thank you so much.
21 CHAIR JOHNSON: Thank you, Patti. Dennis.
22 COMMISSIONER HEAPHY: Sorry about that. I

1 appreciate all the work that went into this. I agree with
2 Patti and support the recommendation.
3 If we could just go back to the benefits. For
4 enrollees, isn't one of the goals to reduce
5 institutionalization? I mean, that list there is
6 important, as well, if it is in fact true. Obviously, one
7 of the reasons why the letter was written was to support
8 Olmstead.
9 And then just a broader comment and also a
10 question, and that is about HCBS for folks with behavioral
11 health needs. When we think about HCBS, it is much broader
12 than just direct services that help people get from
13 hospital to home. It also includes recovery services and
14 those sorts of things. So I don't think we are talking
15 about those services explicitly in this chapter. Am I
16 right on that?
17 But I think more broadly we need to, if we are
18 moving on and talking about HCBS, we have to be much more
19 cognizant of describing HCBS more broadly, and including
20 all the populations and the types of HCBS that are out
21 there, available to the different populations. So the HCBS
22 is actually population specific and not just like broad

1 stroke of folks to it.

2 Does that make sense?

3 CHAIR JOHNSON: She is shaking her head yes.

4 MS. HUSON: Sorry, yes.

5 CHAIR JOHNSON: Patti.

6 COMMISSIONER KILLINGSWORTH: Just to support that
7 comment from Dennis, I do agree that there is, again, a
8 fundamental institutional bias in the current regulatory
9 framework as it relates to institutional services versus
10 home- and community-based services. As we all know, a
11 person can go into a nursing facility, apply for Medicaid,
12 and receive retroactive coverage to the day of admission,
13 whereas a person who wants to receive home- and community-
14 based services has to wait for that eligibility to be
15 approved before services can commence.

16 And while there is, at least, some regulatory
17 flexibility around that, there still remains sort of this
18 institutional bias, and it does result in people going into
19 institutions because they are simply unable to access home-
20 and community-based services quickly enough. So being able
21 to highlight that is a reason I do think is important.

22 COMMISSIONER KILLINGSWORTH: Thank you, Patti.

1 Mike.

2 COMMISSIONER NARDONE: Yeah. I just wanted to
3 ask a question. It is in response maybe to something Patti
4 said earlier. Does CMS view the provisional plans of care
5 as something that you need state plan amendment change, or
6 not a state plan amendment, a waiver change?

7 MS. HUSON: Yes. CMS did mention that if it was
8 not currently in the 1915(c) waiver, that states should do
9 a waiver amendment. So yes.

10 COMMISSIONER NARDONE: Okay. So I am just
11 wondering how would that -- so states would still have to
12 go through a waiver amendment process to move with
13 provisional plans of care, but that would be described in
14 the actual guidance that they put out.

15 MS. HUSON: Correct. Right. So we would think,
16 in this guidance that CMS puts out, they would lay out how
17 states could do that.

18 COMMISSIONER NARDONE: Okay. Thank you. I think
19 the one thing I've been thinking about, and it's kind of in
20 follow-up to some of the comments previously around the
21 bias towards institutionalization is -- first of all, I
22 totally support this recommendation. I guess my question

1 is, what I have been struggling with a little bit is do we
2 also need guidance on presumptive eligibility, because
3 that's also a place where people get hung up in the whole
4 process of actual getting to HCBS.
5 But I am happy to support this recommendation,
6 and I hope to look at the chapter to see how strongly that
7 point is made, that that is a viable option for states to
8 use presumptive eligibility through 1115s and through the
9 extension of presumptive eligibility to hospitals, to
10 prevent people from going from hospitals to nursing homes.
11 MS. HUSON: I definitely welcome your feedback on
12 the chapter. And in regards to presumptive eligibility,
13 just a reminder that there are two pathways, and the
14 hospital presumptive eligibility there is ample guidance
15 available on that. It's really an issue of state take-up
16 of that. And then around the Section 1115 demonstrations,
17 what we heard in our interviews was how each state really
18 has the ability to kind of tailor their PE program to their
19 state circumstances, their goals of the program, their
20 populations in their state, and that there was a lot of
21 one-on-one technical assistance to CMS. So the states that
22 we talked to felt that that was sufficient at this time.

1 COMMISSIONER NARDONE: So the FAQs that I looked
2 at didn't have a lot of description about extension to non-
3 MAGI population. Is there something more than those FAQs,
4 or is it just in that?
5 MS. HUSON: Right. So it's the ACA that allows
6 for the expansion to the non-MAGI population. So that's
7 what CMS pointed us to as the main source of guidance.
8 There is a lot of additional guidance around implementing
9 PE programs more broadly, and my understanding is that
10 applies to non-MAGI populations, as well.
11 COMMISSIONER NARDONE: Thank you.
12 CHAIR JOHNSON: Thank you, Mike. Patti.
13 COMMISSIONER KILLINGSWORTH: Sorry for my third
14 bite at the apple.
15 CHAIR JOHNSON: You are okay.
16 COMMISSIONER KILLINGSWORTH: But my colleagues
17 are just bringing up great points that I want to circle
18 back on. And to circle back on Mike, let's just remember
19 that there is nothing in the statute around provisional
20 plans of care. This is all in regulation and/or guidance
21 from CMS. And so the fact that CMS has incorporated the
22 submission of a waiver amendment for Section 1915(c) into

1 sort of the technical guidance of the waiver application,
2 and perhaps written guidance that they have also crafted,
3 does not mean that they could not create a less
4 administratively burdensome process for effectuating
5 provisional plans of care for Section 1915(c), and much
6 more broadly under other Medicaid authorities.
7 So again, what I don't want to see is guidance
8 which says you can amend your 1115 waiver and ask to do
9 this if that is the authority under which you operate.
10 What I would much rather see is guidance which says you can
11 make these changes and offer provisional plans of care to
12 people, to improve their access to home- and community-
13 based services. And if you are using 1915(c) authority,
14 the next time that you update your waiver you can include
15 these technical changes in your waiver application so that
16 it accurately reflects prior operationalizing plans of
17 care.
18 In Tennessee, for example, under 1115
19 demonstration, we incorporated language into our contracts
20 with health plans to effectuate not using the same term,
21 provisional plans of care, but what it officially was were
22 provisional plans of care. And through sort of the

1 approval of a contract process, that was operationalized
2 and approved by CMS.
3 But we need to focus on the least
4 administratively burdensome way to improve access to
5 people, and this is authority that is within the purview of
6 CMS to do. It doesn't require a statutory change. They
7 can change tomorrow how they operationalize provisional
8 plans of care in 1915(c), and beyond.
9 CHAIR JOHNSON: Thanks, Patti. Dennis.
10 COMMISSIONER HEAPHY: Yeah. I just wanted to,
11 very quickly, second, echo everything that Patti just said,
12 and hopefully if it gets in the next section, Tamara, in
13 the chapter, that would be fantastic. States will
14 automatically think, oh, my God, now we have to do the
15 waiver. No. It's if they have the waiver. They don't
16 have do it if they don't have the waiver. So thanks,
17 Patti.
18 CHAIR JOHNSON: Any other questions, comments, or
19 concerns? Okay. Do you have everything you need?
20 MS. HUSON: Yes. Thank you.
21 CHAIR JOHNSON: All right. Thank you so much.
22 We appreciate it.

1 VICE CHAIR DUNCAN: All right. Now we'll move
2 from timely access to home- and community-based payment
3 options as we look at trying to support the workforce, and
4 so joining us will be Katherine and Emma to walk us
5 through, and we're looking for feedback from the
6 Commissioners on the policy option that they will lay out.
7 So, Katherine and Emma, thank you for joining us
8 and look forward to the discussion.
9 [Pause.]
10 **### HCBS PAYMENT POLICY OPTION**
11 * MS. LIEBMAN: Hey, everyone. It's great to be
12 here.
13 Today Katherine and I will be presenting on the
14 culmination of our work on payment approaches to promote
15 the HCBS workforce, and our goal for the conversation today
16 is to discuss next steps for the work, including a
17 potential policy option.
18 So I will begin by providing an overview of the
19 work that we have conducted to date, and then I'll pass it
20 over to Katherine, who will walk us through the major
21 findings across our work and the key principles that have
22 surfaced through our analyses.

1 We'll then move on to presenting a draft policy
2 option, and we'll end by opening it up to hear the
3 Commission's thoughts and reactions in terms of next steps.
4 So the purpose of this line of work has been to
5 better understand the relationship between HCBS payment and
6 the workforce shortage and to consider opportunities to use
7 payment to address this shortage.
8 In designing this work, we look to the MACPAC
9 provider payment framework, which notes that access and
10 quality are a function of payment rates, which is a measure
11 of economy, and payment methods, which is a measure of
12 efficiency.
13 To achieve a better understanding of workforce
14 and payment dynamics, staff conducted a few different
15 analyses. So, first, to better understand what HCBS
16 payment rates look like and how they're developed, we
17 completed an analysis and compendium of payment policies
18 for HCBS provided under the Section 1915(c) waiver
19 authority.
20 Next, in an effort to better understand the
21 payment strategies that states are pursuing to address HCBS
22 workforce concerns, we completed a series of interviews

1 with state officials, provider associations, unions,
2 consumer representatives, and managed care plans across
3 five states.
4 And then, most recently, we conducted a technical
5 expert panel to home in on the most promising payment
6 strategies that states may use to promote the HCBS
7 workforce.
8 So, with that, I will pass it over to Katherine
9 to synthesize the key findings across all of our analyses.
10 * MS. ROGERS: Thanks, Emma.
11 So, in this section, as Emma just mentioned, I'll
12 review the findings from these two phases of our work, all
13 of those different analyses, including covering a little
14 bit of what we talked about at the last Commission meeting
15 in December.
16 We plan to translate these findings into a couple
17 of payment principles in the report chapter on this work.
18 MACPAC reports, we preview those for you here today.
19 MACPAC reports have previously enumerated payment
20 principles or policy principles; for example, in the March
21 2023 report on nursing facility payment.
22 So consistent with MACPAC's prior work and our

1 current focus on assessing the link between payment and
2 access to Medicaid services, payment rates in a labor-
3 driven Medicaid service like HCBS can be a key influence on
4 workforce and workforce development. They are not the only
5 driver, to be sure, but Medicaid payment is one key tool
6 for states to use in addressing their widely cited
7 workforce shortages.

8 We found throughout our work that payment rates
9 and direct worker wages vary throughout the LTSS and HCBS
10 service systems and, of course, the health care system as a
11 whole. In some cases, this is due to different scopes of
12 services, different staffing ratios, different patient
13 acuities or needs, but it can lead to that metaphorical
14 squeezing of the workforce from one place to another, as we
15 discussed last month.

16 When wages significantly impact workforce
17 participation in one area over another, this can impact
18 access to one service or another, depending where the
19 workforce is going.

20 State Medicaid programs may have those key
21 underlying reasons for strategic variation in payment
22 rates, but they should carefully consider the potential

1 external effects throughout the HCBS, LTSS, and health care
2 systems.
3 Consistent with our earlier findings, our TEP
4 participants had emphasized that comprehensive data-driven
5 rate studies are an effective tool for building rates as
6 well as identified some of the challenges associated in
7 using those to keep rates updated over time. They do
8 require significant time and energy inputs from a variety
9 of stakeholders, and that variety of stakeholders may have
10 varying capacity to participate in the work that's
11 required.
12 And as we discussed last month, budget
13 constraints can impact the implementation of rate studies
14 or may lead to unintended effects from implementation of
15 the findings from a rate study, such as the implementation
16 of a wait list for a program.
17 Our findings did point to indexing and rebasing
18 as less burdensome tools for ensuring that HCBS rates are
19 updated over time, but as we talked about last month,
20 they're not without their limits either.
21 So, throughout this analytic work, our findings
22 have underscored the importance of robust, complete, and

1 available data in rate setting and rate updates. While
2 there are many important data updates in rate models, in
3 HCBS, wage and salary data are a big one, both due to the
4 primacy of wages in HCBS payment models and the multiple
5 inputs into the wage data themselves.
6 One of our central findings has been the lack of
7 a single reliable source for states to use for HCBS worker
8 wages across states and across different types of programs.
9 We found the largest share of states use BLS wage
10 data as a source, but BLS data do not reflect solely a
11 Medicaid professional population, nor do they include
12 distinct job classes for every type of Medicaid HCBS
13 worker.
14 The 2024 Medicaid Access Rule includes several
15 relevant provisions to what we're talking about here, and
16 it requires state reporting on direct-care worker
17 compensation and hourly rates for key HCBS services. This
18 rule may improve HCBS wage data transparency and
19 standardization. The impacts of that rule are yet to be
20 seen, and there may be further opportunity for CMS to
21 improve data specifically for rate-setting purposes in
22 state Medicaid programs, including by disaggregating by

1 worker types and by services.

2 So, ultimately, these findings led us to the
3 articulation here of three payment principles, which are
4 closely, and hopefully, obviously, closely linked to the
5 findings I just went over and will be described in our
6 upcoming report chapter on this work.

7 Most fundamentally, we start with the principle
8 that HCBS payment rates should promote an adequate
9 workforce and efficient use of resources.

10 State Medicaid programs should take a holistic or
11 comprehensive approach to setting HCBS payment rates to
12 ensure that variations across populations, programs, and
13 geographies reflect their policy priorities and beneficiary
14 needs. And HCBS payment rates should be reviewed for
15 adequacy at a regular interval using tools available,
16 including rate studies, indexing, or rebasing as
17 appropriate.

18 The data-related findings led us to a possible
19 opportunity for improved data availability.

20 I'm going to turn it back over to Emma to walk us
21 through a proposed policy option for consideration.

22 MS. LIEBMAN: So, as Katherine just mentioned,

1 one of the main challenges that surfaced through our
2 analysis is the lack of comprehensive wage data that cover
3 all Medicaid HCBS workers. So, in order to support states
4 to achieve HCBS payment rates that promote an adequate
5 workforce, we propose a policy option that would require
6 HHS to make data available on the wages that are paid to
7 HCBS workers.
8 Specifically, we propose to recommend that HHS
9 collect and make public on an annual basis, data across all
10 states on wages paid to HCBS workers providing care under
11 the highest-volume or highest-cost Medicaid HCBS.
12 In order to fill gaps in existing data, we
13 suggest that all the data be disaggregated by Medicaid and
14 non-Medicaid payment source.
15 We also suggest that high-cost and high-volume
16 services be included based on aggregate or per capita
17 costs, adjusting for variation across states.
18 And recognizing that some data may already be
19 available through the access rule, we note that the
20 requirement should extend existing data collection
21 activities as feasible. So, for example, there are
22 opportunities to extend the specificity and transparency of

1 the data that CMS is already collecting through the Access
2 Rule.
3 So wages generally make up the largest component
4 of HCBS payment rates, and our analyses indicate the
5 importance of wage data as a basis for building payment
6 rates that promote an adequate workforce. However, the
7 existing data fall short, as we've discussed, creating
8 challenges for states attempting to understand what current
9 wages look like, how those wages compare within and across
10 states, and how to build more appropriate wage assumptions.
11 As discussed, BLS data are not specific to the
12 Medicaid program, and as a result, they include wage data
13 for some non-Medicaid workers as well as exclude data for
14 some Medicaid-specific service types and worker
15 classifications. For example, BLS data include a variety
16 of nursing and medical support professionals, but there is
17 no code for direct support professionals.
18 Similarly, CMS wage data reporting requirements
19 finalized in the access rule will help close some gaps in
20 wage data reporting, but these data will not all be made
21 public, which restricts states' ability to compare rates
22 and adjust accordingly.

1 Additionally, the CMS definition for HCBS worker
2 is broad, and it includes some classifications that may
3 inflate or distort the data, given that data will not be
4 disaggregated by Medicaid HCBS worker type.
5 And then, finally, the new CMS data collection
6 excludes some services provided to individuals with
7 intellectual or developmental disabilities.
8 So, moving to our next steps, today we would
9 appreciate your feedback on the policy option that we just
10 outlined and thoughts on whether or not to advance it to
11 the draft recommendation stage in the next meeting. We've
12 also included some discussion questions on the slide as
13 well as in your reading materials to help guide the
14 conversation.
15 But I'll now direct us back to the policy option
16 text for the purposes of our conversation, and with that, I
17 will pass it back to the chair to open us up for thoughts
18 and reactions.
19 Thank you.
20 VICE CHAIR DUNCAN: Thank you, Emma. Thank you,
21 Katherine. Appreciate this.
22 As we just came out of a session talking about

1 timely access to home- and community-based services, it's
2 one thing to get timely access, it's another to be able to
3 offer those and have the workforce to provide. So I think
4 this work is critical to identifying what it's going to
5 take to have those services there for our beneficiaries.
6 So thank you for that.
7 Commissioners, questions? Tim.
8 COMMISSIONER HILL: Thanks. And this is terrific
9 work.
10 Just as a kind of non sequitur, I always -- it's
11 always bracing when you read a sentence that says our
12 biggest competitors here for these workforce are retail and
13 food service, right? And it kind of brings it home in
14 terms of how we're caring for such a vulnerable population.
15 But in terms of the recommendation, a question
16 first. Where is CMS going to get the data? Right? If the
17 states don't have the data, are we talking about amending
18 what is being collected under the access rule, or is a de
19 novo collection -- when we're recommending that CMS or HHS
20 make the data available, where do we think they're getting
21 it?
22 MS. LIEBMAN: So I'll start, and Katherine can

1 weigh in as well.

2 I think we have intentionally left some of the
3 specificity open to allow for HHS to make the determination
4 of where is easiest for them to achieve this
5 recommendation. However, some of the data that they would
6 receive through the requirements in the access rule, they
7 may be able to -- the states might need to collect some of
8 that same data, and so it would just be an additional
9 request in terms of some of the specificity of the data
10 that gets reported to CMS, and then some of the
11 requirements that -- or the recommendations that we are
12 proposing here for your consideration also include just the
13 request to make some of the data that CMS is already
14 receiving, to make that public.

15 COMMISSIONER HILL: Got it. That's helpful.

16 So then a reflection on the option and then a
17 question about a different option.

18 I guess I just -- you know, we've talked about
19 this here. I worry about continuing to collect data from
20 states who already have a hard time submitting the data
21 that they're supposed to submit or collecting the data if
22 it's HHS that they're supposed to collect, and I just --

1 like on its face, this is a reasonable thing to do. I just
2 worry that it's just yet another collection activity, and
3 I'm not sure that it's going to be leverageable timely to
4 make it useful just because there's so much else that HHS
5 is collecting and that states are required to submit.
6 I guess the other question I would have is on the
7 rate studies. Like, I'm interested in the conversations,
8 and in your analysis, was there any kind of conversation
9 around HHS providing a tool or an infrastructure to help
10 states do rate studies, given that they're so hard to do?
11 Right? Like, the indexing is easy. You just apply -- not
12 just, but it's relatively straightforward, but doing the de
13 novo rate study is hard. Could HHS provide a tool? Could
14 they provide a standard set of analytics or a standard way
15 to do a study that might help states kind of do that on
16 their own a little easier, given the cost?
17 MS. LIEBMAN: So while that exact suggestion
18 didn't come up, we certainly heard from states an interest
19 in -- or the value of rate studies and an interest in
20 conducting them.
21 We also heard about a lot of the barriers with
22 implementation of the rate study itself and then of the

1 recommendations and some of the barriers that they can feel
2 there.
3 Certainly, we believe that the data collection
4 activities that we're proposing through this policy option
5 would support states to conduct some of those rate study
6 activities, because it would give them some of the data
7 that they need to base rates and to understand what rates
8 currently look like and wages currently look like within
9 their state. So we see this as a tool to support some of
10 those rate study activities.
11 MS. ROGERS: I would just add one thing, which is
12 that we did hear from stakeholders from the state side that
13 they would appreciate guidance and from the CMS side about
14 the guidance that is available. Like, there are, you know,
15 presentations or technical guidance on conducting rate
16 studies for fee-for-service rate setting with some
17 instruments and tools that are part of that.
18 One of the things that came up in the TEP was a
19 question about specific guidance on one specific service
20 and how rates can be adjusted around that. So I think
21 there was this desire for technical guidance and a desire
22 from -- or expressed by CMS of, like, they also want that

1 guidance out to states and provide that.

2 VICE CHAIR DUNCAN: Thank you, Katherine, Emma,
3 Tim.

4 All right. We've got Patti, then Carolyn, then
5 John.

6 COMMISSIONER KILLINGSWORTH: So such an important
7 and challenging issue. Thank you both.

8 I want to start with just a of sort of
9 overarching comments. This is important work, ensuring
10 that the rates we pay are important. Again, I just need to
11 remind all of us that this is one part of a much bigger
12 solution that is needed to address the workforce challenges
13 that are facing home- and community-based services from a
14 provider perspective, a health plan perspective, a state
15 perspective. And so we just can't lose sight of the bigger
16 picture.

17 Second sort of overarching comment is, in sort of
18 in principle, I absolutely agree that we need data. Data
19 allows us to really understand problems and target
20 strategies appropriately.

21 On the other hand, I'm super concerned about the
22 degree of administrative burden and the nuances that will

1 make it very difficult for the data to be meaningful and
2 useful in terms of improving access.
3 So now just a couple of specific comments. We
4 talked about indexing and rebasing as a more streamlined
5 approach. Yes, streamlined, I would say, doesn't take into
6 account sort of the state budgetary pressures and the
7 competing policy goals that states may have, and that may
8 be another important thing to note.
9 I would say on -- when we talk about reviewing
10 payment rates for adequacy using the tools available,
11 instead of saying including rate studies, indexing and
12 rebasing, I would say "which may include," just to be clear
13 that there is an array of options. And some of the tools
14 may not be palatable, if you will, for states for a variety
15 of different reasons.
16 When we talk about data should be disaggregated
17 and we talk about the ways in which it should be
18 disaggregated, you know, as you pointed out, there's not a
19 job class that sort of recognizes the work that we do in
20 home- and community-based services. And so there's sort of
21 some presumption of uniformity or structure that just
22 doesn't currently exist across private companies, across

1 states, and so work that probably is beyond, if you will,
2 even the purview of CMS.
3 I would say other things that can really be
4 important to understanding payment rates in a state. You
5 pointed out, I think, delivery models, geographies. I
6 would add programs and populations, right? We often see
7 that workers are paid a much higher rate to serve some
8 populations than in other populations, driven largely by
9 the level of reimbursement that's afforded for services.
10 Their reimbursement to a worker or payment to a
11 worker should be able to be tied to the level of training
12 and experience that they have, right? We want to reward
13 those things.
14 We have to be careful about comparing the work of
15 a person who delivers personal care, for example, to a
16 certified nurse assistant who may deliver home health,
17 because there is a certification that is required to
18 deliver those services. And it's sort of an infrastructure
19 and oversight that goes along with home health that is
20 sometimes not present in the HCBS world, and so those
21 things just have to be accounted for when we look at
22 differences.

1 And while I say again that we want to leverage
2 existing data collection activities, by the way, some
3 really good work that's been done specifically in the IDD
4 world, using national core indicators to collect wage data,
5 but it is voluntary and not used in all states, I believe,
6 extended to aging and disabled populations recently in the
7 NCI-AD survey.
8 So there are processes in place that could
9 potentially be leveraged as opposed to creating something
10 that's brand-new, but we need to just find the right
11 balance between administrative burden and value in order to
12 really achieve the access goals that we're after here.
13 VICE CHAIR DUNCAN: Thank you, Patti.
14 All right. Carolyn?
15 COMMISSIONER INGRAM: Thank you.
16 I also echo my colleague's feedback that this is
17 really important. It obviously is something that we work
18 on every day in terms of trying to grow the workforce
19 through scholarships and grants and other things, and so
20 I'm wondering, when we ask for some of the information, if
21 you could clarify what we mean by highest-volume or
22 highest-cost Medicaid HCBS, to make sure I'm understanding

1 properly what we're saying or putting forward there.

2 MS. ROGERS: So I think the goal here was to -- I

3 think, conscious of administrative burden, I'll say, to not

4 leave this open and unlimited to every service that every

5 state provides, I think recognizing there's a diverse array

6 of services in the hundreds of 1915(c) programs, et cetera,

7 but to say that the priority is getting data with the

8 maximum benefit, so for services that are serving the

9 largest number of people or a large number of people at a

10 high cost.

11 And I think this is reflective of, you know,

12 choices CMS made in the access rule as well. Like, you see

13 that focus in the selection of services that were included

14 in those provisions, and so we were trying to align with

15 that as well.

16 Anything to add?

17 [No response.]

18 COMMISSIONER INGRAM: Okay. Thank you.

19 VICE CHAIR DUNCAN: Anything else, Carolyn?

20 COMMISSIONER INGRAM: I'll come back to, I think,

21 other questions. Thank you.

22 VICE CHAIR DUNCAN: All right.

1 John and then Jami.

2 COMMISSIONER McCARTHY: So I want to first say
3 this -- as other people have said, this is really
4 important, and delivering services to people in the
5 community, and especially high-quality services, is
6 extremely important to maintain the person at home and to
7 live a life, you know, to the maximum possible extent.
8 Like, that is highly important. And a lot of states focus
9 on this.

10 I'm just a little concerned about our
11 recommendation, which I brought up last time, and it kind
12 of follows some of the things people have already said.

13 So, number one, states are asking for help on
14 this one because it's hard, and how do I know it's hard?
15 Because as a consultant in the past, I used to set these
16 rates. So, for 10 years, like, I did this work helping
17 states do this. I've done it again recently. And when we
18 created these models and did this, we would look at BLS
19 data, and in some states we worked with, we would try to do
20 cost reports. And trying to get this information from
21 providers is difficult because it's also unaudited. So
22 that's a whole other issue.

1 And also, like, how do you report the data? So,
2 if somebody has -- and let's make it super simple, but they
3 have 100 employees, and some are making $20 an hour and
4 some are making $14 an hour and some are making $12 an
5 hour, do you average that all together? And it's based on
6 experience, because the longer somebody's been there, they
7 get raises along the way. And so the number you're going
8 to get, this is back to what Tim was, I think, saying. So
9 now you get this data. Do you get it for every single
10 employee out there, how much their hourly wage is? And
11 then what are the differences in it? How do you calculate
12 it?
13 So I understand why states are like, hey, help us
14 do this, because it is really hard to do. So I've always
15 thought of, like, this is BLS's job, let them do it. If we
16 have a recommendation along this line, to me it's, hey,
17 BLS, you know, break it down a little bit further into some
18 of these different areas. That might be something.
19 Second piece is, why are we stopping at HCBS
20 services? Or, you know, there -- I know the chapter is on
21 that. But it gets into this other issue of, though, we've
22 got shortages in primary care. So should we do the same

1 thing for physicians? Are we going to ask for a physician
2 -- you know, how much physicians are being paid so we can
3 do calculations, because in some states those rates are
4 really low?
5 Staying on the HCBS side, same thing. It's,
6 like, kind of what Carolyn was asking. Do we get into OT,
7 PT, and speech, because that's provided in the community?
8 I saw nursing was in there. So there's a little bit of,
9 like, where do we stop on there?
10 Third, so we get this information. What does it
11 mean? So, again, if it's summed up at some level and
12 you're saying, hey, everyone's getting paid $16 an hour,
13 okay. But the reason they're getting paid $16 an hour is
14 because the rate that the state is paying is -- I'm going
15 to make it up -- $20 an hour. So everyone's getting paid
16 $16 because that's all they can pay. I mean, the rate
17 maybe should be -- I'm going to make it up again -- $35 an
18 hour, but if you're not getting paid that rate, you can't
19 pay the person. So there's this issue of, like, what does
20 this mean?
21 To me, when we were setting these rates, what was
22 more important is what were the other wages paid to other

1 areas like retail and things like that, because then when
2 you're doing your model and you're setting the rate and
3 you're seeing, oh, fast food workers are making $20 an
4 hour, we know in our model we need to set our rate at X in
5 order to compete with those areas. And so at some level
6 when you're actually setting these rates, you're looking at
7 those other rates to figure out how that is.
8 You also have to be realistic that the state just
9 doesn't have the money. Like, you want to set the rate at
10 $22 an hour, but you just don't have it. So you're setting
11 it at some lower level. So that's a whole other issue you
12 run into.
13 To me, and I've said this before on other areas,
14 but if we're trying to incentivize states to do things and
15 getting states to improve health outcomes, it would be to
16 have a recommendation to tie, to tell Congress to tie FMAP,
17 maybe 1 percentage point or something, to some type of
18 outcomes like reductions in hospitalizations or ER
19 utilization or things like that, because that's what would
20 incentivize states to, if we think, would increase those
21 rates.
22 I mean, I think the other thing we do need to

1 look at, which we haven't, would be if you look at states
2 that are paying higher rates, do they have any better
3 health outcomes than the states that are paying lower
4 rates? You may have to adjust that for inflation or
5 something like that.
6 But those are the things for me that I think we
7 need to take a look at.
8 VICE CHAIR DUNCAN: Thank you, John.
9 Jami, then Dennis, Mike, and then Adrienne.
10 COMMISSIONER SNYDER: Yeah. Thank you again for
11 this important work. I would echo the sentiments of my
12 colleagues in that it's incredibly complex work, given the
13 variability state to state in terms of how HCBS frameworks
14 are structured.
15 I had a similar question to Carolyn's question
16 actually around how we're defining highest-volume, highest-
17 cost services. And I guess my question is, do we need to
18 further define that in the policy option statement in order
19 to create some consistency in the data gathering and
20 analysis process? And can we do so? And so just curious
21 to know your thoughts on that.
22 MS. LIEBMAN: Thank you.

1 I think that we had, kind of consistent with a
2 comment I made earlier, wanted to leave some of that a
3 little bit open to interpretation to reduce the burden
4 potentially on CMS and allow them to kind of use a similar
5 methodology to the methodology that they've used in other
6 activities, including the access rule. However, I think
7 that if the feedback is that having a clear definition
8 would be helpful, that's certainly something that we're
9 open to.
10 COMMISSIONER SNYDER: I do think it would be
11 helpful to add a little bit of clarity around what we're
12 talking about when we referenced highest-volume or highest-
13 cost Medicaid services.
14 The other comment I would make more generally is,
15 you know, clearly in the access rule, there was a provision
16 that mandates that 80 percent of all payments made to HCBS
17 providers be passed down to direct-care workers. I think
18 the challenge that we've discussed in prior meetings around
19 that particular mandate is that we don't necessarily have
20 enough data to inform such a mandate.
21 So I do think as challenging as this work is,
22 given the variability state to state, I think it's

1 incredibly important, as long as that particular provision
2 stands, so we can better understand the merit of such a
3 mandate.
4 VICE CHAIR DUNCAN: Thank you, Jami.
5 Dennis.
6 [Pause.]
7 COMMISSIONER HEAPHY: Okay. Sorry that took so
8 long. I apologize for that.
9 So this really is complicated and an important
10 stuff, as everyone was describing, and I get two things.
11 One is maybe somewhat of a non-sequitur, but it's the idea
12 that it's not just wages that drive people's interest in
13 these jobs. It's also benefits, because there are folks
14 who are afraid of actually making more money, because the
15 more money they make, there's a chance of them actually
16 losing benefits. Is that something that you'd like to
17 factor into this conversation? Is it just the dollar per
18 hour, or is it benefits also included in there? There are
19 folks who may be afraid of losing their Medicaid if they
20 make too much money. So it's something to really factor in
21 here.
22 I think there's also the issue of this being a

1 living wage issue, and that the majority of folks who do
2 this work, in-home work, public service, are women of
3 color, and that, historically, this population has been
4 underpaid.
5 But then my question in terms of simply the
6 policy option is -- so we get the data, and what happens?
7 How do we know what the value of the data actually is? How
8 do you measure the value of that data? Is it by states
9 actually increasing the payments made to folks? Is it that
10 advocates have the ability to then look at data nationally
11 and then advocate at different state levels and to support
12 higher wages? How do we know what the value actually is of
13 that data? What makes it actionable? How do we know that
14 it's actually actionable and going to have an impact? I
15 think maybe that's what some of the other folks are
16 thinking about as well. So how do we make it?
17 And someone can put me on mute.
18 VICE CHAIR DUNCAN: Thank you, Dennis.
19 Mike.
20 COMMISSIONER NARDONE: Yes. Thanks for this
21 really important work.
22 Obviously, ensuring that we're adequately paying

1 the workforce is critical to deal with the workforce
2 shortage that we're facing in this country, and many of us
3 live it day to day with elderly parents, and it's equally
4 of concern in the Medicaid program.
5 I don't have the expertise that I think John has
6 on developing rates at the granular level that I think he
7 does. So, to me, this seems like an incredibly complex
8 topic.
9 And, you know, I think I want to make sure that
10 if -- and I don't really have a sense of what the burden
11 would be to collect this data. I mean, I think Tim
12 mentioned, like, what does it mean to states? What does it
13 mean to providers? Where does it come from? I guess what
14 I would like to ensure is that if we're going down this
15 road, that we're collecting this information, that it
16 really be the most critical information that states need to
17 build the rates.
18 And so I don't know if you envision a process
19 that HHS would go through to really kind of hone in on what
20 is the data that would be most important to states in
21 building these rates. I don't know that I have the
22 recommendations around what those things would be, but I

1 hope that there would be, you know, some sort of
2 conversation or effort to really -- by working with states
3 providers, what would be the information that's most
4 important.
5 I, too, am getting hung up on the high-cost and
6 high-volume services. I don't -- I'm trying to understand
7 maybe how the mechanics of how that would work. So you
8 would identify a service in the taxonomy of services that
9 says, you know, this is the highest volume or highest per
10 capita, and then you would figure out who was providing
11 that service, and then what the rate should be for that?
12 I'm trying to understand it, just because I don't --
13 because I think of the rates as you're paying a provider
14 rate, but that, you know, you also have to get down to,
15 well, how much of that is actually going to a wage, and who
16 are the people that are actually providing the service? So
17 I'm getting a little kind of hung up on that. So I think a
18 little more, maybe, clarity around that would really be
19 helpful to me.
20 And I really do -- as being relatively new to
21 MACPAC, I also would like to understand maybe -- Patti
22 mentioned the broader context of the workforce shortage and

1 some of maybe the non-rate activities that are going on.
2 There's a lot going on in Tennessee, for example, around
3 dealing with workforce shortages and creating ladders. And
4 I'm not sure what the context is for also understanding
5 those issues, because that's really important.
6 And then also, you know, a lot of states use the
7 ARPA funds to try to figure out creative ways to maintain
8 the workforce. And I know that's been kind of an ongoing
9 discussion that's been had here, but I would like to be
10 able to maybe use or have some exploration of whether there
11 were examples of best practices there that really need to
12 be considered to helping build the workforce, because as
13 John said, you know, the problem for states is they're
14 strapped, right? And so we have to look at a combination
15 of things, including the rates, as well as maybe other
16 activities that would help to support the workforce.
17 VICE CHAIR DUNCAN: Thank you, sir.
18 All right. Adrienne, then Tricia, then Angelo.
19 COMMISSIONER McFADDEN: So I'm going to add to
20 the chorus of how important this work is. So thank you for
21 this work.
22 And I do appreciate the sentiments of my other

1 co-Commissioners on the complexity and nuance of this,
2 especially with the particular details and frequency that
3 would be informative and actionable for this data
4 collection.
5 I think it was Patti that mentioned that there's
6 existing mechanisms and entities that are collecting these
7 data already, and so that sort of made me think about some
8 other sort of corollary data collection sources that we
9 have for health care service providers out there.
10 And, John, I think you mentioned why stop at
11 HCBS, why not primary care doctors? There's a plethora of
12 folks that are collecting those data already, so it would
13 be redundant, I think. But there's also the advantage of
14 licensed clinicians having sort of mechanisms like
15 licensure surveys, where they can collect those data
16 frequently and have a sort of mechanism to do that. That's
17 sort of reliable and sort of audited.
18 So, when I'm sort of collecting all this in my
19 mind, I go back to, I think, Emma. You made the comment
20 with the question that you intentionally wanted to build
21 some flexibility and not be so prescriptive in how this
22 collection happens, and so to go back to the original

1 question on the policy option, I think I'm of the opinion
2 that what's really important here is not HHS or CMS
3 collecting the data themselves but assuring that the data
4 is collected and that it's adequate and detailed enough so
5 that it informs the states when they're trying to make
6 their rate decisions.
7 VICE CHAIR DUNCAN: Thank you, Adrienne.
8 Tricia.
9 COMMISSIONER BROOKS: Yes, agreed. This is great
10 work.
11 I, too, was hung up on the high cost, high
12 volume, or -- yeah, highest volume, high cost. And if this
13 were to hold, you know, in any descriptive materials, I
14 think at the very least, we should offer some thoughts on
15 such as ABC, right, so that it gives some parameters there.
16 But I am also struck -- I mean, it's sort of
17 easier for us to get focused on payment when you think
18 about seniors rely more on Medicaid in rural areas than
19 proportional to the population, and the workforce just
20 isn't there. And so it just feels like that no amount of
21 payment is going to necessarily help provide home- and
22 community-based services in rural areas if the workforce

1 just physically doesn't exist. And what more can we do to
2 assess how to boost home- and community-based services in
3 rural areas?
4 VICE CHAIR DUNCAN: Thank you, Tricia.
5 Angelo, then Verlon.
6 COMMISSIONER GIARDINO: Again, I'll echo this is
7 really important.
8 So I think we've gotten the framing of the
9 problem correct, but one of the principles of high
10 reliability is that you don't proceed in the face of
11 uncertainty. And I think there's too many unknowns for me
12 with this policy option. So I think I'd need to understand
13 more of the details.
14 And I understand the desire to give flexibility,
15 but I'm not convinced that this policy option solves the
16 problem. In fact, I think it might make it worse.
17 And I'll just give you an example. You know, I
18 could imagine collecting data, and it says a first-year
19 frontline service worker. And someone who's a first-year
20 frontline service worker might be someone who worked for 20
21 years in a related industry, but in that company who will
22 be submitting the data, they're a first-year worker. So

1 they have 20 years' experience, and then someone right out
2 of high school could be that frontline worker. And they're
3 a first-year worker.
4 So I feel like this could be used to really de-
5 emphasize all that experience that someone who's a
6 frontline worker brings to their work. So I would really
7 need to understand the granularity of the data before I
8 could say this would actually help solve the problem.
9 In clinical work, you always say, what's the
10 worst thing that could happen if I proceed and de-
11 emphasizing experienced people working at the frontline?
12 So I could see that 20-year worker going to their boss
13 saying, you know, I should get $20 an hour. But the data
14 that CMS is putting out says it's only worth $14. So
15 you're going to pay me $14. So then I'm going to go get a
16 job as a barista.
17 So I think we have to understand the data before
18 I could feel comfortable going forward with this. I am not
19 convinced that this option solves the problem. I agree
20 with your framing of the problem, but I don't think this is
21 solving it.
22 VICE CHAIR DUNCAN: Thank you, Angelo.

1 Verlon.

2 CHAIR JOHNSON: Thank you, Angelo, too.

3 All right. So, again, this is lots of good work.
4 I just keep echoing that as well. And I think we had some
5 really good feedback, too, as we thought about these
6 options.

7 But I just want to go back to kind of two themes
8 that I think -- that I'm thinking about as we're putting
9 together recommendations, and the first is around the
10 feasibility and implementation of this, right? You know,
11 are there going to be additional barriers to implementing
12 this from collecting the data, the reporting requirement
13 from states and CMS? You know, could it be technical
14 infrastructure, resource constraints, things like that that
15 could really prohibit it?

16 And then also, I think what was already
17 articulated by, I think, several Commissioners, you know,
18 to what extent can leveraging existing data collection
19 activities actually reduce administrative burden, or will
20 it increase it? Right? So really thinking about that from
21 that perspective.

22 And then the second theme is around the

1 stakeholder use. As we're thinking about collecting this
2 data, how can we make sure that it's going to be actionable
3 for states, CMS, and others? It's not just -- again, I
4 think we've heard this from other Commissioners, just the
5 thought about having the data in front of us, but what are
6 we going to do with it afterwards, too, as well?
7 So as I think about this work and importance of
8 it, I just want to make sure that what we're doing here
9 really can move the needle forward in a really meaningful
10 way.
11 So thank you for the work, though, again.
12 VICE CHAIR DUNCAN: Thank you, Verlon.
13 Anyone else?
14 [No response.]
15 VICE CHAIR DUNCAN: So I think just from the
16 dialogue -- and I want to thank my fellow Commissioners for
17 weighing in -- I think you heard the importance of this
18 work. I think you heard some of the concerns, and I also
19 think you heard several suggestions of ways to address some
20 of that.
21 I'd like for you to hear how much I appreciated
22 both the flexibility built into this because, as

1 highlighted by John, we could expand this. We can't boil
2 the ocean. So let's get a start, and I appreciate how you
3 tried to narrow and focus on at least a couple of
4 populations that data may already be collected.
5 I think understanding what that data is and, to
6 Verlon's point, what is actionable from that will be
7 critical, but I do appreciate how you've framed this up so
8 that we're not trying to boil the ocean and put more
9 administrative burden on CMS or the states, but utilizing
10 information that is already being collected or could be
11 collected in a different manner in moving forward. So
12 thank you for that.
13 Any questions or things you need clarification
14 on, or do you feel like you have enough to move forward?
15 MS. LIEBMAN: I think we got what we needed.
16 Thank you, all.
17 VICE CHAIR DUNCAN: Thank you.
18 And then next we will be moving into a topic that
19 we have been working on for a while, which is the
20 Utilization of Medications for Opioid Use Disorder.
21 Melinda will be joining us to bring us up on the latest, as
22 we prepare for a chapter in June.

1 So welcome, Melinda.

2 **### UTILIZATION OF MEDICATIONS FOR OPIOID USE**
3 **DISORDER IN MEDICAID**

4 * MS. BECKER ROACH: Good morning, Commissioners.
5 At the Commission's October meeting we presented background
6 information on medications for opioid use disorder,
7 including federal policies and other factors that affect
8 access to MOUD.

9 Today's session builds on that discussion by
10 describing utilization of MOUD in Medicaid based on an
11 analysis of Medicaid claims data. I will begin by
12 providing background on changes in state MOUD coverage
13 policies, which informed our claims analysis. I will then
14 present national and state-level estimates of MOUD use,
15 highlight variations in the receipt of MOUD among certain
16 groups of Medicaid beneficiaries, and discuss how the
17 benefit mandate, additional coverage of methadone
18 specifically, affected utilization of MOUD. The
19 presentation will conclude with a summary of key takeaways
20 and next steps, which include incorporating these findings
21 into a descriptive chapter for the June report.

22 Federal law requires state Medicaid programs to

1 cover all forms of FDA-approved MOUD -- methadone,
2 buprenorphine, and extended-release injectable naltrexone,
3 as well as related counseling and behavioral therapies.
4 When the mandate took effect in October 2020, states could
5 apply for an exception to the coverage mandate if
6 implementing it was not feasible due to a shortage of
7 qualified MOUD providers.
8 CMS approved exceptions for provider shortage in
9 three states and four territories, primarily due to a lack
10 of opioid treatment programs, or OTPs, providing methadone.
11 While Medicaid must cover all types and formulations of
12 MOUD, states and MCOs can and do apply utilization
13 management approaches, such as prior authorization, as part
14 of their efforts to ensure the appropriate use of those
15 medications.
16 In 2018, before the mandate took effect, all
17 states covered some sort of buprenorphine and naltrexone,
18 whereas 9 states did not cover methadone, and 18 states did
19 not cover extended-release injectable buprenorphine. As
20 you can see here, by 2023, methadone was covered by all
21 fee-for-service programs and nearly all managed care
22 organizations. Coverage of extended-release injectable

1 buprenorphine also increased, though it is still not
2 covered by a handful of states and MCOs.
3 This coverage data on the slide comes from a
4 SAMHSA study, which relied on publicly available
5 information to assess state and MCO coverage policies. The
6 authors note that it can be difficult to identify MOUD
7 coverage policies in some states, which can create
8 obstacles to treatment by making it difficult for providers
9 and beneficiaries to identify which forms of MOUD are
10 covered and what, if any, utilization management criteria
11 apply.
12 Documented coverage of MOUD doesn't necessarily
13 mean that access to medications is widespread. The next
14 section details findings from an analysis of T-MSIS data,
15 which shows that use of certain medications is extremely
16 low or nonexistent in some states, despite those
17 medications being covered.
18 MACPAC contracted with Acumen to examine MOUD use
19 among Medicaid beneficiaries, using T-MSIS data from fiscal
20 years 2017 to 2022, supplemented by CMS's Race and
21 Ethnicity Imputation File. The study population included
22 full-benefit, non-dually eligible Medicaid beneficiaries

1 between the ages of 18 and 64. We used methodology from
2 the CMS Chronic Conditions Data Warehouse to identify
3 beneficiaries with an opioid use disorder.
4 MOUD use was defined broadly to include
5 beneficiaries who had at least one MOUD claim in a given
6 year for methadone, buprenorphine, or extended-release
7 injectable naltrexone. Oral naltrexone was not included in
8 estimates of MOUD use, because it is not indicated for the
9 treatment of OUD. However, utilization of oral naltrexone
10 was examined separately, to provide insights into its off-
11 label use.
12 Acumen used multivariate logistic regression to
13 assess whether MOUD use varied by beneficiary
14 sociodemographic and health-related characteristics. A
15 synthetic difference in differences model was used to
16 compare MOUD use in states that added methadone coverage to
17 similar states that previously covered all forms of MOUD.
18 The share of beneficiaries with OUD receiving
19 MOUD has increased in recent years, rising from 63 percent
20 in fiscal year 2017 to 71 percent in fiscal year 2022.
21 Access to MOUD was likely affected by a number of factors
22 during this period, including federal and state initiative

1 to improve the availability of MOUD provides and the onset
2 of the COVID-19 public health emergency in 2020.

3 In fiscal year 2022, the share of beneficiaries
4 with OUD receiving MOUD varied considerably by state,
5 ranging from 42 percent in Iowa to 84 percent in Vermont.
6 This is consistent with other studies that found wide
7 variation in MOUD treatment across states and likely
8 reflects differences in the availability of MOUD providers,
9 among other factors.

10 In fiscal year 2022, Medicaid beneficiaries with
11 OUD most commonly received an oral formulation of
12 buprenorphine, followed by methadone, extended-release
13 injectable naltrexone, and extended-release injectable
14 buprenorphine. Roughly 16 percent of beneficiaries with
15 OUD had a claim for oral naltrexone, which is not FDA
16 approved for the treatment of OUD. Off-label use of oral
17 naltrexone was particularly common in certain states, where
18 in some cases roughly half of beneficiaries receiving MOUD
19 were treated with oral naltrexone.

20 In fiscal year 2022, use of extended-release
21 injectable buprenorphine and naltrexone was low overall,
22 and particularly low in certain states. For example, six

1 states each had 10 or fewer beneficiaries with claims for
2 extended-release injectable buprenorphine. Low use of
3 injectable formulations is likely the result of several
4 factors, including limited availability of providers
5 administering these medications, patient preference, and
6 utilization management policies intended to steer patients
7 toward less costly oral formulations.

8 We also observed relatively low use of methadone
9 in some states, which may reflect limited availability of
10 OTPs and the fact that patients generally have to travel to
11 an OTP on a daily or near-daily basis to receive their
12 medication, which can be a substantial barrier to access.

13 Acumen's analysis produced odds ratios, which
14 allow us to observe variations in MOUD use among Medicaid
15 beneficiaries with OUD by sociodemographic characteristics
16 and health status. This slide shows a subset of that
17 analysis, where we saw some of the largest variations in
18 the receipt of MOUD.

19 In fiscal year 2021, white beneficiaries were
20 more likely than any other racial or ethnic group to
21 receive MOUD. Rates of MOUD use were lowest among Black
22 and Asian American and Pacific Islander beneficiaries, who

1 are about half as likely to receive MOUD compared to their
2 white counterparts.
3 There were also notable disparities in MOUD use
4 by age, with beneficiaries aged 18 to 24 being roughly two
5 to three times less likely to receive MOUD than other non-
6 elderly adults.
7 The last part of our analysis examined the effect
8 of the federal MOUD benefit mandate on utilization of MOUD.
9 When Congress approved the benefit mandate in 2018,
10 methadone was the only type of MOUD not covered in all
11 states. Based on their analysis of claims data, Acumen
12 identified 11 states that had not covered methadone prior
13 to that time, and subsequently added methadone coverage.
14 Using a synthetic difference in differences analysis, we
15 found that the percentage of beneficiaries with OUD using
16 any form of MOUD increased more in those 11 states that
17 added methadone coverage compared to states that had
18 already covered all forms of MOUD.
19 Overall, expanded methadone coverage was
20 associated with an increase in MOUD use that was nearly 6
21 percentage points higher than the increase in MOUD use in
22 states that already covered methadone. That is to say, the

1 addition of methadone coverage increased overall MOUD use
2 and narrowed the gap in treatment rates between states that
3 previously had not covered methadone and those that had.
4 To summarize the key takeaways from our analysis,
5 we found that MOUD use among Medicaid beneficiaries with
6 OUD increased in recent years and is relatively high
7 nationally, though there is substantial variation in
8 treatment rates across the states. Use of extended-release
9 formulations is low nationally, and in some states few
10 beneficiaries receive methadone.
11 Rates of MOUD use vary significantly by race and
12 ethnicity and age. MOUD use is lower for non-white versus
13 white beneficiaries, and younger versus older
14 beneficiaries.
15 Finally, the MOUD benefit mandate, specifically
16 the addition of methadone coverage in some states, led to
17 an increase in overall rates of MOUD use in those states.
18 As far as next steps, these findings will be
19 incorporated into a descriptive chapter for the
20 Commission's upcoming June report to Congress. We welcome
21 your clarifying questions and thoughts about particular
22 findings you would like to see emphasized in that chapter.

1 In addition to the data on MOUD use presented
2 today, the chapter will describe the federal policy
3 landscape, which we discussed in October, and findings from
4 stakeholder interviews, which I will return to present at
5 the Commission's February public meeting.
6 Lastly, in response to Commissioner feedback, we
7 are developing a new project that will more closely examine
8 the use of prior authorization for MOUD in Medicaid and
9 potentially result in the Commission's consideration of
10 policy options.
11 That is it for me. I look forward to the
12 discussion, and thank you.
13 VICE CHAIR DUNCAN: Thank you, Melinda. I
14 appreciate that. So Commissioners, any thoughts on the
15 analysis that was done as well as any of the findings that
16 you find particularly interesting or something to be
17 highlighted.
18 With that, Doug.
19 COMMISSIONER BROWN: Thank you, Melinda. Great
20 job. Lots of great information in here. I do have some
21 comments and then a recommendation, specifically on Slide
22 5, where you indicate product not covered.

1 I kind of take issue with that, because I think
2 is it not covered without prior authorization or is it just
3 NDC-blocked and excluded from coverage? And I don't think
4 that is the case.
5 As I mentioned at a previous meeting, prior
6 authorization for safety or quantity limits is appropriate
7 I think for this class, because these products are not free
8 of misuse, abuse, and diversion. Prior authorization I
9 don't think is more restrictive in this class than it is in
10 other classes of specialty, given the light of the act that
11 maybe products available.
12 Just to kind of level set, when we look at data
13 based on publicly available information, I know that's a
14 limiting factor that you all had here. But from a
15 preferred drug list sampling, and kind of looking at that
16 as coverage, commercial plans tend to have formularies and
17 then they have drugs that are excluded or exclusion lists.
18 In Medicaid, all drugs are available as long as the
19 manufacturer signs the agreement with HHS and agrees to pay
20 a federal rebate, the drug is covered by Medicaid. States
21 are allowed to use prior authorization around that.
22 A subset of all these covered drugs is a

1 preferred drug list that many states use today, and in
2 those preferred drug lists they are designed in a way that
3 you take products with similar indications, you put them in
4 a bucket, and then states can look at them and solicit
5 supplemental rebates. And they look at them both
6 clinically and financially and then make decisions for
7 preferred and non-preferred agents within those therapeutic
8 classes.
9 Many states review these drugs within a
10 therapeutic class and post them on their preferred drug
11 list, but not all states. After the SUPPORT Act, some
12 states removed this therapeutic class from the preferred
13 drug list, and so it is not publicly available in the sense
14 that these drugs are available without prior authorization.
15 And the other element here, I think, that goes
16 on, so I think as a recommendation, when you are looking at
17 non-preferred or non-coverage here, it may be that the data
18 isn't publicly available in the space from folks that are
19 looking at it from outside, but to providers who long into
20 a provider portal, the information may be there, kind of
21 behind the wall. And perhaps outreach to the 10 states, to
22 the Medicaid pharmacy director at those 10 states, or half

1 of those states to say, are these drugs really not covered
2 in your state, and get the data effectively. Because I
3 suspect that these drugs are covered. They are just not
4 out there publicly. And again, it creates the perception
5 that it might not be covered, but in actuality, with the
6 providers who are prescribing these products, the products
7 are probably available.

8 The other piece I have a concern with is the idea
9 that low volume is equal to not covered. In this category,
10 patients are working through their opioid use disorder.
11 They are taking medications for a period of time. You are
12 working to get these patients stable on oral therapies.
13 And then once those patients are stable you could convert
14 them to long-acting injectable agents or extended-release
15 products.

16 Physicians will make the determination whether
17 the patient, and the patient will also make the
18 determination whether those products are appropriate for
19 them or not. And in some cases, patients may prefer to
20 just stay on the oral meds because they are stable and they
21 prefer to do that. And I think, for me, I think when we
22 look at this, it may be a differential of the demand for

1 services exceeds the provider capacity, in some cases, and
2 that's why you're not seeing the uptake in use. So some of
3 those states that we saw on the map have a lower profusion
4 or treatment course than some of the other states.
5 Thank you.
6 VICE CHAIR DUNCAN: Thank you, Dong. Sonja,
7 then Adrienne.
8 COMMISSIONER BJORK: Thank you. Melinda, can you
9 say a little bit about the plans for the stakeholder
10 interviews?
11 MS. BECKER ROACH: Yes. We completed the
12 stakeholder interviews. We spoke to a variety of
13 stakeholders in five states, Medicaid officials, behavioral
14 health agency officials, managed care plans in a few of
15 those states where that was relevant, and we also spoke
16 with beneficiary representatives and advocates, as well.
17 COMMISSIONER BJORK: Did any issues come up about
18 physician comfortability in utilizing these drugs and the
19 impact of some training programs that are out there? For
20 example, some of the big universities, they will do
21 trainings for primary care physicians so that they feel
22 really well-supported in using these medications. And then

1 sometimes a physician might not want to be known as the
2 person at their practice who is really great at this,
3 because then they get all the patients that need that type
4 of treatment, and that might not have been the whole reason
5 they went into medicine. So it's always that balance of
6 how do you support the physicians right there on the front
7 line doing the work.
8 MS. BECKER ROACH: Yeah. Some of that did come
9 through in the interviews, so we will make sure to
10 highlight that at the next meeting.
11 VICE CHAIR DUNCAN: Thank you. I was going to
12 say, this is, when we meet next time, what she is bringing
13 back is from those interviews, so we will look forward to
14 learning that.
15 All right. Adrienne, then Verlon.
16 COMMISSIONER McFADDEN: Melinda, thanks for this
17 work. Just a real general comment that may not be
18 appropriate, or may be out of scope for this descriptive
19 chapter. But as I was reading through this content it was
20 really informative to see sort of the mandate and how it
21 sort of translated into utilization.
22 I think my clinician brain wanted it to go a step

1 further to understand the impact, to see what the
2 reductions in overdose rates, hospitalizations, or overdose
3 deaths would be as a result of this policy. So if there is
4 an opportunity in future work to be able to infuse that or
5 even to have some of that in the descriptive chapter, I
6 would love that.
7 VICE CHAIR DUNCAN: Thanks, Adrienne. Great
8 point. Verlon, then Jim.
9 CHAIR JOHNSON: Thank you. This is great work,
10 Melinda. I really appreciate it.
11 I am excited about this work overall but also
12 about the prior authorization that we are going to talk
13 about and continue to go forward on, and of course the
14 stakeholder interviews will be really good.
15 The question I have is, is there a way to learn
16 more about the factors contributing to the significant
17 disparities in MOUD utilization along racial and ethnic
18 groups at all? Can you go a little bit deeper on that one?
19 MS. BECKER ROACH: Yeah. I think it's something
20 that we can dig into further and try to include more detail
21 on when we are drafting the chapter. I think there also
22 may be some relevant findings from the stakeholder

1 interviews that we can be sure to highlight for you all at
2 the next meeting.
3 CHAIR JOHNSON: Perfect. Thank you. I
4 appreciate it.
5 VICE CHAIR DUNCAN: Thanks Verlon, and I
6 appreciate you helping me feel better that I couldn't say
7 analysis a while ago. Thanks. Jenny.
8 COMMISSIONER GERSTORFF: As we discussed on this
9 topic before, current opioid use is heavily fentanyl, and
10 that is kind of a newer development. And studies are
11 showing that the long-acting injectables may be more
12 effective for fentanyl users.
13 So looking at the table that you had by state,
14 showing the percent of people who were identified as having
15 an opioid use disorder, who had the long-acting treatment,
16 it's very small for most states. But there were two or
17 three where they had 5 to 10 percent of beneficiaries using
18 that treatment.
19 I was wondering if we could look into those
20 states to see if there are certain policies they may have
21 that are influencing that.
22 MS. BECKER ROACH: I don't recall offhand which

1 states those are, but that's something we can take back in
2 and look at.
3 VICE CHAIR DUNCAN: Thanks, Jenny.
4 Carolyn, then John.
5 COMMISSIONER INGRAM: Thank you.
6 If you could add -- and thank you for the work on
7 this, but if you could add to the list, challenges in rural
8 communities, especially Tribal communities, with delivering
9 these services, and if there's any creative ideas or things
10 that you've been able to pick up in rural communities that
11 we could talk about, I think, that could help spread to
12 other areas, that would be helpful. When you're doing your
13 interviews, if anybody's seen anything, that would be good
14 to know.
15 MS. BECKER ROACH: Yeah. We did complete the
16 interviews already, but there were some, you know, sort of
17 promising practices that were highlighted, and so we can
18 try to bring those forward.
19 VICE CHAIR DUNCAN: Thank you, Carolyn.
20 John.
21 COMMISSIONER McCARTHY: I may not be exactly
22 right on this, and Doug may know better, but I believe with

1 the injectable extended-release options, the person has had
2 to have gone through withdrawal already, whereas with the
3 other ones, you don't. And so sometimes that's the barrier
4 to that, because people don't want to go through
5 withdrawal. So sometimes that is an issue.
6 MS. BECKER ROACH: I believe that's the case for
7 naltrexone but not for the extended-release buprenorphine.
8 But, others, please correct me if there's some nuance
9 there.
10 COMMISSIONER McCARTHY: Yes, that sometimes
11 causes it.
12 The second thing is, can you go back to the map
13 page? And since we just talked about provider rates, what
14 I'd really like you to do is look at what are the provider
15 rates in these states and look at those percentages. When
16 I say provider rates, not what is paid for the medications,
17 but what are providers paid to treat those patients? And
18 I'm wondering if we would see a strong correlation between
19 those percentages and that.
20 The third piece -- and Adrienne hit on this -- is
21 -- you know, I'm going to harp on this again, and in any of
22 these policies we have, it's just because you have higher

1 utilization, that doesn't matter if we don't see better
2 outcomes. And so, again, is there something we can look at
3 as we go forward saying if you're looking at these
4 percentages, do we see better outcomes in states with, you
5 know, the reduction in overdose deaths or reductions in
6 hospitalizations and ER utilization?
7 Thanks.
8 VICE CHAIR DUNCAN: Thank you, John.
9 Anyone else? Okay. Jen and Heidi.
10 COMMISSIONER GERSTORFF: I just had one more
11 thought. I really loved your table of the differences by
12 the demographics, but I was wondering if you could also
13 create a table like that that shows us the percent of
14 beneficiaries with OUD who are identified with OUD as a
15 percent of the population groups to show kind of what
16 populations might be more impacted by that diagnosis
17 overall.
18 MS. BECKER ROACH: Sorry. Just to clarify. So
19 the characteristics of the population that's receiving
20 MOUD?
21 COMMISSIONER GERSTORFF: Yeah.
22 MS. BECKER ROACH: Okay.

1 CHAIR JOHNSON: Thank you, Jenny.

2 Heidi?

3 COMMISSIONER ALLEN: Thank you for this work.
4 It's great to see this research, and particularly, I really
5 appreciated seeing that the policy efforts to increase use
6 of methadone were effective. That was a great analysis.

7 I want to respond to John's comment, though,
8 about outcomes. I think that it's difficult to look at
9 things like overdoses and outcomes like that and compare
10 them to these kind of efforts because states that have the
11 worst situation are probably being the most aggressive,
12 potentially.

13 Like, if you look at the map, if you go back to
14 the map, I think you see that there's a lot of efforts in,
15 like, Kentucky. So what you don't want to do is end up
16 inadvertently saying, like, oh, really high overdose rates
17 there, and they're doing this thing, and, you know,
18 therefore, it's not helping, because they may have an even
19 worse situation if they hadn't been doing these things. So
20 I just think that that kind of analysis needs to be thought
21 of in a more sophisticated way.

22 But I do think that really showing, you know,

1 where there might be gaps in treatment -- the rest of this,
2 I think, is really, really helpful.
3 And there was a table in the materials that
4 looked at the different state, listed the states and the
5 different percent of utilization across the types, and I
6 would just love to see a total at the end as a last column
7 so that you can suss out a little bit, because it -- you
8 know, when you're trying to look at something like that,
9 you know, it's helpful to see if, like, one state is just
10 doing one thing really well, and therefore, there's less
11 people going into other categories, but, like, what the
12 total penetration is.
13 And you could get there by comparing with the
14 map, but I think that just having it side by side would be
15 helpful.
16 MS. BECKER ROACH: Sure.
17 COMMISSIONER ALLEN: Thanks.
18 VICE CHAIR DUNCAN: thank you, Heidi.
19 Michael, then Adrian.
20 COMMISSIONER NARDONE: Thanks for this work,
21 Melissa. I want -- Melinda. I'm sorry.
22 Just following up on the map, you kind of

1 mentioned that, you know, obviously the rural nature of
2 those states. and I was wondering if in your interviews --
3 and maybe this is for the next time -- you learn more about
4 what might be causing the variability in those states.
5 John mentioned rates. I'm sure there are other
6 things like transportation policies, you know, the provider
7 capacity. But, I mean, maybe if you could provide a little
8 more background on that than at least I saw in the memo or
9 that we talked about today.
10 And I was wondering -- I would imagine this data
11 is from FY 2022, so some of the impacts of our policy
12 changes -- I mean, this is just for the record, right? It
13 will take a while for those to get incorporated into actual
14 data that's coming from -- that's being reported. So I
15 just -- I wanted to -- I assume that the case is that, you
16 know, those trends could potentially be going up as we look
17 at more recent data.
18 MS. BECKER ROACH: Yeah, I think that's certainly
19 right. You know, just because of the data limitations, FY
20 2022 was the --
21 COMMISSIONER NARDONE: Right.
22 MS. BECKER ROACH: -- you know, sort of as far as

1 we could go.

2 COMMISSIONER NARDONE: I'm not being critical.

3 MS. BECKER ROACH: Yeah.

4 COMMISSIONER NARDONE: I would say that just in
5 understanding the data, that that's an earlier point in
6 time, and the actual requirement was 2020. So it might not
7 yet be reflected.

8 And then is the information also being reported
9 for MCOs? I assume the data also includes MCO data in the
10 T-MSIS?

11 MS. BECKER ROACH: It does, yes.

12 COMMISSIONER NARDONE: Could any of this
13 variability be due to T-MSIS reporting variability?

14 MS. BECKER ROACH: It's certainly possible.
15 Acumen did exclude states where they had identified data
16 limitations or quality issues.

17 COMMISSIONER NARDONE: Okay. I'm just curious.

18 MS. BECKER ROACH: Yeah. I can definitely think
19 about, before I come back in February, you know, if we can
20 provide more context about some of this variation, drawing
21 from the stakeholder interviews that we -- and the
22 conversations we had.

1 COMMISSIONER NARDONE: Thank you, Melinda.
2 VICE CHAIR DUNCAN: Thank you, Michael.
3 All right. Adrienne.
4 COMMISSIONER McFADDEN: So not to sound a little
5 bit like Switzerland here, but I actually agree with John
6 and Heidi. I think there's a level of sophistication and
7 elegance that would have to happen with reporting outcomes.
8 But I think we have this really interesting time frame
9 where we can see a change in policy with the allowance or
10 mandate of methadone coverage, and so it would be nice to
11 see if there's even a delta in changes in those outcomes
12 that are responsive to overdoses in a particular state. It
13 doesn't have to be compared to other states.
14 VICE CHAIR DUNCAN: Thank you, Adrienne.
15 Anyone else?
16 [No response.]
17 VICE CHAIR DUNCAN: So, Melinda, I think you see
18 the appreciation in the work to the state. I think you can
19 also hear the excitement in the questions as we await the
20 stakeholder interviews for next month. But do you feel
21 like you've got everything you need to move forward with
22 this descriptive chapter?

1 MS. BECKER ROACH: I do, yes. Thank you very
2 much.
3 VICE CHAIR DUNCAN: Thank you.
4 And with that, Chair, I'll turn it back over to
5 you.
6 CHAIR JOHNSON: Thank you so much. Great
7 conversation.
8 All right. So now is our time. We're going to
9 open it up for public comment. We invite people to raise
10 your hand in the audience if you'd like to offer a comment.
11 Please make sure you introduce yourself and your
12 organization that you represent, and we also ask that you
13 keep your comments to three minutes or less.
14 So, with that, let's see. Okay. Arvind? You
15 want to go ahead? Arvind?
16 **### PUBLIC COMMENT**
17 * DR. GOYAL: Can you hear me all right?
18 CHAIR JOHNSON: We can hear you, yes.
19 DR. GOYAL: Yes. My name is Arvind Goyal. I'm
20 Medical Director for Illinois Medicaid Program, and I'm
21 also a previous Chair of the National Medicaid Medical
22 Directors Network. This is one of my acquired specialties,

1 if you will.

2 And I wanted to start by saying that -- somebody
3 touched upon it -- there is not only a continuing stigma
4 for the user of opioids, but there is also some stigma that
5 persists over decades, decades for prescribers as well.
6 People who used to prescribe MOUD of any kind, when I was
7 in practice not too long ago, those people have been put
8 out of practice either for overprescribing or they got in
9 trouble due to their policies that were not in line with
10 their licensing or other requirements.

11 I also want to say that the capacity limitation
12 for providers is significant, but it is the provider
13 hesitation as well that creates that capacity issue. Not
14 many people are educated, trained, or comfortable
15 prescribing. I think it's more than just the reimbursement
16 issue, but there is a continuing capacity issue.

17 Just to highlight that example, we are currently
18 discussing ED prescribing, and ED prescribing for methadone
19 as well as buprenorphine is available at this time.
20 However, the federal guidance on how long that prescription
21 should be is mixed.

22 The DEA rule, which I can cite for you, indicates

1 three days of dispensing in the ED, in the emergency
2 departments, when an overdose patient shows up, and that
3 would be a very likely place where they'd be initiated on
4 buprenorphine or methadone.
5 However, another problem, you know, three days
6 and if somebody needs to follow up in the interim and the
7 follow-up provider, prescriber is not available to change
8 anything or to help them, then they'll go on street drugs.
9 And the final thing is that -- think about
10 community follow-up within three days and some guidance,
11 some guiding organizations, especially NIH, allows for
12 seven days for buprenorphine in communities that do not
13 have enough prescribers. However, if a community provider
14 is not available to take them, where do they go? So that
15 confirmed appointment, that connection becomes important.
16 And I think it needs to be a multifaceted approach where we
17 provide education, training, take the stigma off of the
18 prescribers as well as the users. And then, very clearly,
19 the disparity between methadone only available through OTPs
20 and buprenorphine now being available for prescriptions by
21 anybody who's allowed to prescribe with a DEA schedule
22 ability, that is a problem. And I think all of these are

1 global issues which need to be straightened out.

2 And one other comment I would make is, think that

3 a prescriber can use buprenorphine or methadone for a

4 patient when they're prescribing it for pain, but they

5 can't use it when they're prescribing it for addiction.

6 And I think those are all the issues we need to handle.

7 And I'm very happy that MACPAC decided to address

8 this issue today. Thank you.

9 CHAIR JOHNSON: Thank you. Thank you so much,

10 Arvind.

11 Next, Kacey Dugan.

12 MS. DUGAN: Hi. This is Kacey Dugan. I'm here

13 on behalf of the National Academy of Elder Law Attorneys.

14 and I just wanted to comment on the timely access to home-

15 and community-based services chapter and express our

16 support for the recommendation and our appreciation for

17 your work on this issue.

18 CHAIR JOHNSON: Thank you so much. We appreciate

19 that.

20 Any other comments?

21 [No response.]

22 CHAIR JOHNSON: All right. Well, thank you for

1 the comments that we received. I do want to remind the
2 audience that you can also submit comments on the MACPAC
3 website as well if you think of additional comments that
4 you'd like to make.
5 But before we adjourn for lunch, I just want to
6 highlight that on January 1st, GAO published a request for
7 MACPAC Commission nominations. Letters of nominations and
8 résumés are due on January 28th, which is coming up. And
9 we do want to encourage you to consider applying if you're
10 interested.
11 I think you can tell from the excitement from our
12 meetings and our discussions that we all enjoy serving as
13 Commissioners and would welcome opportunity to work with
14 you as well.
15 So with that, we'll adjourn and go to lunch.
16 We'll see you back here at one o'clock.
17 * [Whereupon, at 11:49 a.m., the meeting was
18 recessed for lunch, to reconvene at 1:00 p.m. this same
19 day.]
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1 AFTERNOON SESSION

2 [1:00 p.m.]

3 CHAIR JOHNSON: Good afternoon. Welcome back
4 from lunch.

5 To kick us off this afternoon, we're excited to
6 engage in a panel discussion moderated by Melissa, our
7 principal analyst, which offers us an opportunity to deepen
8 our understanding of residential services for children and
9 youth with behavioral health needs.

10 So, with that, I will turn it over to Melissa to
11 kick us off with the panel.

12 **### PANEL: APPROPRIATE ACCESS TO RESIDENTIAL SERVICES**
13 **FOR CHILDREN AND YOUTH WITH BEHAVIORAL HEALTH**
14 **NEEDS**

15 * MS. SCHOBER: Thanks very much.

16 Good afternoon, Commissioners. We're having this
17 panel today to continue our exploration of appropriate
18 access to residential treatment services for Medicaid-
19 enrolled youth that began in September 2024. Through our
20 conversation with panelists, I plan to obtain insights on
21 the experience experts, clinicians, beneficiaries, and
22 states face in developing, implementing, and sustaining

1 access to residential treatment services for youth with
2 behavioral health needs.
3 To that end, we have invited four panelists to
4 today's session. We're joined by Dr. Gary Blau, the
5 Executive Director Emeritus of The Hackett Center for
6 Mental Health and a Senior Fellow for the Children's Mental
7 Health for the Meadows Mental Health Policy Institute.
8 We're also joined by Maureen Corcoran, Director of Ohio
9 Medicaid. Our third panelist is Dr. Steve Girelli,
10 President and CEO of Klingberg Family Centers, and our
11 fourth panelist is Ivy-Marie Washington, a project
12 associate for Youth and Transition Services at the American
13 Public Human Services Association and a beneficiary with
14 lived experience.
15 Thank you all for joining us today.
16 And with that, my first question goes to Dr.
17 Blau. Dr. Blau, to help the Commission understand why
18 Medicaid-enrolled youth might need access to residential
19 treatment services, could you describe some of the
20 characteristics of these youth?
21 * DR. BLAU: Great. So, first of all, thank you so
22 much for having me and allowing me this opportunity to be

1 here with you all today and share some of our thoughts
2 about residential centers and strategies to, hopefully,
3 look at issues regarding quality of care and effectiveness.
4 I am here in my role now as the Executive
5 Director Emeritus for The Hackett Center and a Senior
6 Fellow for the Meadows Mental Health Policy Institute. But
7 prior to this, I worked for SAMHSA for over 17 years, first
8 as the Chief of the Child, Adolescent, and Family Branch,
9 and then as a Senior Advisor for Children, Youth, and
10 Families. And in that work, in that capacity, I was
11 working very closely with residential treatment centers and
12 their state and national organizations to build bridges
13 between residential and community providers, families, and
14 youth, and then also to address these critical issues
15 related to residential interventions.
16 Today my role here, I'm going to provide a little
17 bit of overview and context related to what is nearly
18 23,000 young people in residential treatment centers today.
19 We already know -- and that's just a very small subset of
20 young people who are experiencing mental health challenges
21 in this country. We already know that about one in five of
22 our young people have a mental health challenge, which was

1 exacerbated by COVID-19, et cetera, and that one in ten has
2 a serious emotional disturbance. And again, we're really
3 talking about a smaller subset of those young people.
4 And what kind of this issue? So what I'm going
5 to talk about a little bit is this idea of medical
6 necessity reasons for this level of care. I also, in my
7 few minutes, want to provide some resources and tip sheets
8 or where to go to get further information and then
9 similarly to focus on some of our work to improve quality
10 and thinking about measurement approaches to this. So
11 that's sort of where I'm headed.
12 Again, these will be created into a slide deck or
13 resources for you, so you don't have to be busily taking
14 notes. We'll get this information to you.
15 I think most of us know and certainly understand
16 that a young person that requires or is medically necessary
17 requirement for a residential treatment center have very
18 serious mental health and or even substance use disorder
19 challenges, and we're talking about the kind of youngster
20 that really is sort of butting up against whether they
21 should go to a hospital or a longer-term treatment setting.
22 And they still may have needs because of suicidal ideation

1 or attempts and may not be as acute at that moment, but
2 certainly, certainly those issues are self-harm.
3 We also know that RTCs are used when young
4 people, particularly in juvenile justice arrangements and
5 things where there's a homicidal ideation or even attempts.
6 And then we're talking about young people that
7 have very severe kinds of behavioral challenges and
8 emotional issues, such as severe depression, severe anxiety
9 disorders.
10 We also certainly know that young people that
11 have severe eating disorders, when you're thinking about
12 things like anorexia, bulimia, binge eating and things,
13 that that can become very life-threatening, and residential
14 treatment can offer a specialized care, a structured
15 environment to address these kinds of issues.
16 Similarly, young people that may have on and off
17 or psychotic types of disorders where they are maybe
18 experiencing a step down from a hospital setting after
19 experiencing hallucinations or delusions or things, and so
20 we know that residential treatment centers are dealing with
21 some of these very challenging youngsters, bipolar
22 disorders.

1 And then, of course, probably one of the biggest
2 reasons that a young person will end up, especially a
3 younger person, end up in a residential center is because
4 of out-of-control types of behaviors. And we're talking
5 about when a young person exhibits behavioral problems,
6 aggression, running away that may pose a danger to
7 themselves or to others.
8 The other piece -- and I always try to weave this
9 in because I think it's important to recognize that we're
10 not just talking about these severe mental health
11 challenges, that there may also be severe addiction or
12 withdrawal symptoms, and that there can be a residential
13 requirement when a substance use disorder is interfering
14 with a lot of aspects of life and outpatient treatment is
15 not working or has failed to some extent, or if the
16 youngster needs to have monitoring for, say, a withdrawal
17 situation that could be life-threatening.
18 So, again, these types of behaviors -- and really
19 most residentials -- and Steve can talk about this --
20 really do look at these requirements as ways in which that
21 they will allow a person to come in to the facility.
22 I also think it's important that while perhaps

1 not specifically medically necessary, there are a lot of
2 other factors that go into admission decisions, things like
3 lack of response to outpatient treatment, family settings,
4 and family instability that maybe needs to be addressed as
5 part of this process.

6 We know that young people that have co-occurring
7 disorders, especially intellectual disabilities, may also
8 pose a significant challenge and may be another reason why
9 a placement could be medically necessary. There's not a
10 support system. There's a high risk of relapse into other
11 challenges, so a lot of details that go into a decision
12 about whether or not a young person is in need of a
13 residential treatment center.

14 MS. SCHOBER: Thanks, Dr. Blau.

15 Ms. Washington, as a former foster care youth and
16 current advocate, could you help the Commission understand
17 more about why former foster youth might be placed in
18 residential treatment settings and any concerns you have
19 about current placement processes?

20 If you could take yourself off mute.

21 * MS. WASHINGTON: I thought I did.

22 Absolutely. So I am coming to you from my lived

1 experience. I have over 12 years of lived experience in
2 the foster care system with an additional 10 years of
3 professional experience working in multiple aspects, so
4 from policy all the way to child care placement for the
5 state of Texas as well. You name it; I've done it all.
6 So some of the reasons that some foster youth may
7 be placed in RTC range from severe behavioral and mental
8 health needs. So youth with significant emotional or
9 psychological challenges, such as trauma-related disorders
10 or substance uses, as Dr. Blau mentioned, or even severe
11 anxiety and depression may require these intensive
12 structured care that cannot be provided in a family setting
13 or a least restrictive setting.
14 Additionally, there are lack of available foster
15 homes. So, across the nation, we are seeing a capacity
16 crisis where there aren't enough beds in least-restrictive
17 settings to be able to place these children in. A lot of
18 our foster homes aren't equipped to care for children with
19 higher needs, such as depression or substance abuses.
20 There are additionally safety concerns. Some
21 youth may present behaviors that pose a risk to themselves
22 or others, which require that secure and highly supervised

1 environment to ensure their safety and other safety and
2 well-being. These youth also need stability, and they have
3 structural needs. So youth who have experienced multiple
4 placement disruptions may be placed in RTC settings to
5 provide a more stable and predictable environment.
6 And then, also, they may need specialized
7 therapeutic interventions. So some of these RTCs are
8 offering specialized therapeutic services, which are
9 tailored to issues individually like trauma, behavioral
10 disorders, or even developmental disabilities that come
11 from some of their trauma.
12 Some of the concerns that I personally have seen
13 or have with these placements is there is an over-reliance
14 on institutionalized care. Residential treatments may be
15 used as a default option rather than a last resort. So
16 this is leading to an institutionalized approach instead of
17 prioritizing family-based or community-based care.
18 There is a lack of individualized assessments.
19 So some youth may be placed in RTCs without a thorough
20 individualized assessment of their actual needs and
21 potentially resulting in inappropriate placements.
22 There's also a long-term institutionalized risk.

1 So extended care, they're being placed in these placements
2 for way too long. It can delay their permanency goals. It
3 can hinder their development into independent living
4 skills, and it can contribute to feelings of isolation,
5 disconnection from family or their community. And it also
6 brings in trauma reinforcement. So these institutionalized
7 environments can sometimes exasperate the trauma responses,
8 making it difficult for youth to build trusting
9 relationships and heal effectively.
10 MS. SCHOBER: Thank you so much.
11 Dr. Girelli, you lead an organization that
12 provides treatment to youth, and you sit on the board of
13 the National Association for Children's Behavioral Health.
14 Could you describe some of the challenges you and your
15 provider members face in providing the level of access to
16 youth, Medicaid-enrolled youth with behavioral health
17 needs?
18 * DR. GIRELLI: Yes, happy to. And I'd like to
19 thank you for inviting me to participate.
20 One of the things I was just noticing is the
21 convergence of some of the observations that Dr. Blau and
22 Ms. Washington have made with mine, despite that we hadn't

1 conferred on this at all. But I think that for all of us
2 in the provider world, residential treatment has been a
3 challenging service all along, owing in large part to the
4 acuity of the children and adolescents that we serve, but
5 that acuity has been on the rise.
6 One of the reasons for that is the aftermath of
7 the pandemic. Another contributor is related to the
8 reduction in the availability of other services. For
9 example, there are fewer available inpatient psychiatric
10 beds. So more children and youth are referred directly to
11 residential treatment rather than having gone through
12 hospital-based services first.
13 There has also, in many places, been reductions
14 in intermediate care and in foster homes. The loss of
15 intermediate care availability has resulted in children and
16 youth not getting services earlier in the trajectory of
17 their mental health needs, and so the acuity rises to the
18 point where residential treatment is needed, where it
19 otherwise might not have been.
20 And we're also seeing, partly related to some of
21 these other factors, higher levels of behavioral dis-
22 control, as Dr. Blau was referencing. For us, that's often

1 secondary to severe trauma or co-occurring conditions,
2 oftentimes substance abuse or intellectual disabilities.
3 So maintaining a safe therapeutic environment in
4 the face of that severe client dis-control is a very
5 significant challenge.
6 The inadequacy of both intermediate levels of
7 care and foster care -- treatment foster care -- means that
8 children and youth remain in residential treatment long
9 after the need for that level of care has been successfully
10 addressed, leading to some of the issues that Ms.
11 Washington addressed, and I also think clinical regression.
12 And the biggest challenge for us and for most
13 residential providers is staffing. The workforce crisis
14 exacerbated by the pandemic has been tremendous. The
15 funding that we get doesn't allow us to offer competitive
16 compensation. At a very basic level, there aren't enough
17 staff to maintain safety and fundamental treatment, but
18 beyond that, the workforce crisis is causing huge turnover
19 levels, which are disruptive in any work setting, but in a
20 treatment setting that is addressing trauma, it's all about
21 the relationships. And nothing undermines the treatment
22 more than relational disruptions that result from constant

1 staff turnover.

2 MS. SCHOBER: Thank you.

3 Director Corcoran, I wanted to first ask you to

4 reflect on some of the challenges that Dr. Girelli

5 mentioned and ask if Ohio is facing similar issues, and

6 then also to ask you about Ohio's decision to add

7 psychiatric residential treatment facilities as a Medicaid

8 state plan benefit, including any insights on the tools and

9 policies your states adopted to ensure appropriate access

10 to these treatment settings.

11 [Pause.]

12 * MS. CORCORAN: My apologies.

13 So, first, absolutely, Ohio is experiencing

14 everything that you've heard.

15 I would say that for those of us who have had

16 involvement -- and I mean, those of you as well,

17 Commissioners, who have had involvement with child welfare,

18 you know that the challenges of placement and finding an

19 appropriate match is not a new thing at all. You know, I

20 personally have made more than 100 calls to try to get a

21 placement for a child welfare kid.

22 Now, I will say, though, to the heart of your

1 question, I do believe that COVID has been a game changer
2 in -- not only in what we know now about the effect that it
3 has had on kids' mental health, but I also think that it's
4 contributed to kind of making more visible -- adding to the
5 level of pressure and the crisis, but making more visible
6 these issues, and they're much more widely discussed in my
7 -- from my perspective as a Medicaid director, not limited
8 to kind of the child welfare arena.
9 To the second part of your question, I want to
10 start, I guess, where Ms. Washington was, and that is,
11 particularly as the Commissioners are wrestling with this
12 question of available residential services, you know, I
13 want to very affirmatively kind of put out in front of you
14 that, particularly to Ms. Washington's point, about the
15 danger of inappropriate utilization of a bed, any kind of
16 bed, and the effects it has on a child.
17 So before I address the question of PRTFs
18 directly, I want to put it in the context of the reform
19 that Melissa mentioned. We instituted OhioRISE back in
20 July of 2022, and it stands for Resilience through
21 Integrated Systems and Excellence, and it is a specialty
22 behavioral health benefit for multi-system children, and in

1 particular, those at risk of custody relinquishment. They
2 maintain a managed care plan for their medical benefit, but
3 they then have specialty services that are administered or
4 managed by our partner Aetna Better Health of Ohio.
5 The fundamental premise of it is to build a
6 system of care using the SAMHSA principles and the research
7 and congressional-reported evaluation results of a system
8 of care, and in our case, the timing of it led us to also
9 take a look at the Family First Prevention Services Act.
10 So I want to just kind of put that together. That we chose
11 for the Family First implementation here in Ohio, we chose
12 collectively our first three services with our OhioRISE in
13 mind and said, okay, our first services are going to be
14 some that we know are on the clearinghouse, and then that
15 has been a principle.
16 We had some challenges in putting our design
17 together with the technical issues with CMS. We were able
18 to overcome them, of course, and there was certainly help
19 with that. But the fundamental commitment we made was to
20 have child welfare kids and kids who are in danger of
21 custody relinquishment be the priority, and it did take a
22 little bit of crafting with a (b)/(c) waiver. It took a

1 little bit of crafting with that in order to be explicit
2 about the child welfare, the custody relinquishment
3 component of it.
4 Then moving really into kind of what's the PRTF
5 connection here. So there was a broader, really holistic
6 reform going on, creation of this system of care model.
7 Our vendor has responsibility for the beds, whether it's a
8 PRTF or a hospital placement. At the time, we made a
9 commitment to bring PRTFs online as part of our benefit.
10 So, before I get to that, just a little bit more
11 included care coordination of a couple different levels,
12 intensive home-based treatment, behavioral health respite,
13 flexible funds. We have a 1915(c) waiver and mobile
14 response and stabilization service that's being implemented
15 statewide.
16 So we only began in July of '22. So I still feel
17 like we're in the very beginning stages, but at the time,
18 we made a commitment to include PRTF, and that's really the
19 heart of Melissa's question is -- and we actually did not
20 bring that up first. It came on really some months after
21 we started, deliberately, so that the focus would be on the
22 community services, the care coordination, the wraparound.

1 In doing so, I recall a conversation with my
2 cabinet colleagues, and I was very pointed in saying to
3 them, if we were not doing this OhioRISE and PRTF in the
4 context of managed care, I would never support the
5 development of a PRTF benefit in Ohio, and I really was
6 that clear or clearer. And my reason for that is really
7 what Ms. Washington said, and it is coupled with an
8 understanding that with the variety of types of beds,
9 services that are currently spread across child welfare,
10 mental health, Medicaid, there is a danger in that service,
11 that PRTF service, being kind of watered down. And we were
12 adamant that both because of a concern about, you know,
13 overuse of beds, but also because of wanting to maintain
14 that level of intensity of the service. So we utilized an
15 RFP type of process.
16 And now let me just tell you kind of where we
17 are, because it will illustrate some of the tension and the
18 challenges that I know you're confronting in your
19 conversations.
20 So, as I say, we started the PRTFs in 2022,
21 November of '22. We have been very constrained and very
22 deliberate about the growth. We have three providers

1 today. We have six new or expanded programs coming on in
2 the next, about 12 to 18 months, and we're just about now
3 to begin with Aetna, an expansion grant program to begin to
4 work on getting some other providers kind of lined up or in
5 the queue for development over the next couple of years.
6 And what is unique about it or why the managed
7 care component was important to us is where we provide much
8 more hands-on state involvement around the quality of care.
9 We provide oversight and technical assistance.
10 One of our first providers was a very skilled
11 provider who had been in business for many years, and it
12 was very foreign to them to have the state team in there
13 really working with them, not to be punitive, but to say,
14 you know, we've got this higher standard that we want to
15 achieve because that is what these kids need.
16 We currently have about 100 kids that are out of
17 state. We have about 100 on our PRTF waiting list. We
18 know that part of the reason for the waiting list is that
19 we're seeing more difficulty with out-of-state placements.
20 We'd rather have the more capacity here that we're
21 developing, but I think it also kind of illustrates the
22 tension that many Medicaid programs feel with having to

1 send kids out of state, wanting to develop the capacity
2 here at home. And so I'm just being, you know, completely
3 open with you about what our numbers look like and kind of
4 the yin and yang of this effort.
5 Finally, we just heard from our researchers about
6 initial results. First five quarters of study, we have
7 seen a notable decrease in the inpatient behavioral --
8 inpatient admissions for behavioral health utilization that
9 come in through an ED for OhioRISE kids. Similarly, we've
10 seen a decrease in emergency room utilization for BH crises
11 that did not result in an admission, and similarly, we've
12 seen nearly -- a 50 percent cut in ED utilization for
13 suicide ideation and, again, nearly a 50 percent reduction
14 in emergency room use for self-harm. All of those numbers
15 early, you know, just directional. Don't take them as
16 final.
17 MS. SCHOBER: Thank you.
18 MS. CORCORAN: So, Melissa, with that.
19 MS. SCHOBER: Thank you, Director Cochran, for
20 that extremely detailed overview of Ohio's efforts in
21 Medicaid. With the about six minutes we have remaining in
22 the moderated portion, I wanted to ask Drs. Girelli and

1 Blau to just share some of the factors in why a residential
2 treatment facility might decide to accept or deny admission
3 to a young person, that could lead to their out-of-state
4 placement. Director Corcoran alluded to a number of young
5 people still out of state. So if you could both opine
6 about some of the factors for that out-of-state admission
7 and referral process.
8 DR. GIRELLI: Do you want to take the lead on
9 that, Dr. Blau?
10 DR. BLAU: I'll get it started and you could pick
11 up, because Steve was doing this work and making those
12 decisions within that treatment center. And I think a lot
13 of times every center that I've ever been working with,
14 it's really been a matter of fit and whether or not that
15 they believe that their services and their treatment
16 approaches will actually help this particular child.
17 For example, if you are a really skilled facility
18 in addressing some autism spectrum disorders, you use an
19 applied behavioral analysis kind of thing, I mean, it might
20 not make sense to take juvenile justice kids that have
21 conduct disorders. That is somewhat of a simplistic way to
22 look at it.

1 The reality, though, is that in my experience
2 almost all residential facilities and their community
3 counterparts, they want to do right by the children and
4 their families, and so they are trying very hard to make
5 sure that when a young person comes into the facility, they
6 will be successful.
7 Now, obviously, that can't always be the case,
8 and so sometimes kids do bounce out and bounce around, and
9 that would be sort of considered a treatment failure, if
10 you will. So that's the main reason, from my perspective.
11 Steve?
12 DR. GIRELLI: Yeah. I would say, in my
13 experience, the biggest factor, by far, is the fit. What
14 are the needs of the child being referred and how do they
15 align with our areas of expertise and our resources?
16 Within that, though, I think there are some
17 things that cause a significant amount of agita. One is
18 staffing levels. Especially with the rise in behavioral
19 discontrol that we are seeing in recent years, we get very,
20 very nervous about maintaining a safe and therapeutic
21 milieu if we don't have, one enough, but as importantly,
22 staff who are well-trained and have good experience, and

1 really know how to provide treatment to kids with needs
2 that are that severe.
3 Our specialty is trauma-informed care, and so as
4 I referenced earlier, the relationships are critical. So
5 finding not only enough bodies, to be blunt, to fill the
6 positions, but those who can really use their relational
7 approach to help kids recover from trauma is a very big
8 challenge.
9 And the second major factor, really quickly, is
10 what's the discharge plan. Oftentimes we get referrals of
11 kids for residential treatment where there hasn't been
12 adequate thought given to where they will go after they are
13 done with us. With the decline in availability of
14 intermediate levels of care and therapeutic foster care
15 beds, oftentimes kids stay in residential treatment way
16 longer than they should, which is a disservice to them and,
17 frankly, a disservice to the residential treatment centers.
18 And with all the consideration about placement versus
19 treatment, we are very, very sensitized to that, as
20 providers.
21 MS. SCHOBER: Thank you. And I had one question
22 remaining, but I wanted to ask the Chair -- okay, thank

1 you.

2 So last question to you, Ms. Washington, which is
3 a nice segue. We know that residential treatment is a
4 necessity for some young people, but could you talk more
5 about the policies that you think need to be in place to
6 successfully transition those young people timely back to
7 community and into permanency and independent living?

8 MS. WASHINGTON: Yeah. So I'll make it very
9 quick. They already touched on a good portion of it. But
10 comprehensive transition planning is something that needs
11 to be implemented. So we need individualized transition
12 plans starting well before our young adults are leaving
13 care, addressing education, employment, housing, health
14 care, and support networks.

15 Housing support, of course, so needing more
16 resources to help transition for housing, education and
17 employment services, so we are looking at vocational
18 training skills, career counseling, assistance with post-
19 secondary education enrollment and funding. We are looking
20 at life skill training, so programs to teach financial
21 literacy, cooking, time management, other essential
22 independent living skills.

1 Health and mental health services, so continued
2 access to medical care, therapy, and substance abuse
3 programs, including extended Medicaid coverage. Permanent
4 connections and mentorships, so programs to establish
5 supportive adult relationships, including mentorships,
6 family reunification efforts, and peer support groups.
7 And then aftercare services, ongoing case
8 management, check-ins, post-transition to ensure stability
9 and address challenges that they are experiencing as they
10 transition out of institutionalized setting. And then,
11 lastly, culturally responsive services, so tailored support
12 to consider cultural backgrounds, their identity,
13 community-specific needs to ensure inclusivity and
14 effectiveness. Implementing all of these policies with a
15 young-centered and strength-based approach can greatly
16 enhance their chances at successful transition and a stable
17 transition as they are moving out of institutionalized
18 care.
19 Short, sweet, to the point.
20 MS. SCHOBER: Thank you so much. And with that,
21 Madam Chair, back to you.
22 CHAIR JOHNSON: Thank you so much. This is such

1 a great panel, and the conversation really brought the
2 issue to the forefront for us, most definitely.
3 I am going to look around at my Commissioners and
4 we are going to have an opportunity for them to ask
5 questions. Jami.
6 COMMISSIONER SNYDER: Thanks so much for joining
7 us today. A couple of you mentioned the specific challenge
8 related to serving individuals or youth with significant
9 behavioral health needs as well as intellectual and
10 developmental disabilities. I'm just curious to know from
11 our panelists, are there models in the country where you
12 think some have been particularly successful in serving
13 that population, individuals again with significant
14 behavioral health challenges as well as intellectual and
15 developmental disabilities?
16 DR. BLAU: So I'll start and say that this has
17 been an area of particular focus for the times that I have
18 been in government and trying to look at what are these
19 effective strategies. I will answer it by saying, number
20 one, yes, there are some very effective strategies that
21 folks are doing. Steve mentioned before the idea of
22 trauma-focused or trauma-informed care, very important

1 component to this. The evidence-based practices that have
2 been developed, that might be used within a residential
3 treatment center. Those are connected to this, as well.
4 I think that where we are struggling, and
5 continue to struggle, is in the area of a large facility
6 trying to serve lots and lots of kids. What we see, for
7 example, with intellectual disabilities is that we are best
8 off in smaller group settings, and trying not to create
9 such large facilities that it can be unwieldy, and again,
10 more difficult to try to get kids out of than the smaller
11 facilities, where the kids learn more about living in
12 family environments, or things of that nature.
13 So that's sort of the way I would start that
14 conversation.
15 DR. GIRELLI: To add to what Gary said, I agree
16 with all that. I think one of the challenges has been,
17 from a provider standpoint, by and large, those two
18 treatment populations have been served by completely
19 different organizations where there has been historically
20 very little overlap or connection. And I think that has
21 been a bit of a barrier.
22 I also think that those of us on the behavioral

1 health side really have relied on cognition among the
2 clients we serve, whether that's using cognitive behavioral
3 therapy or more insight-oriented therapy. And when we come
4 up against intellectual disabilities that hinder our use of
5 that, I have to admit, I think sometimes we throw up our
6 hands. And I think those historical factors have had a big
7 role.

8 And I also agree with Gary about what sort of
9 constellation of clients is best for different populations,
10 and that that doesn't always align.

11 COMMISSIONER SNYDER: Just one quick follow-up
12 question. I really appreciate you bringing up the fact
13 that these populations have historically been served by
14 wholly different groups of providers.

15 I'm curious to kind of know, just from even a
16 clinical perspective, whether you feel like it's more
17 effective to bring behavioral health services into a
18 setting, where individuals with intellectual and
19 developmental disabilities may have been served, into that
20 residential setting, or it's better to do the opposite, I
21 guess, in bringing kind of IDD services into a BH setting.
22 Or have you seen more success one way or another?

1 DR. BLAU: So I think historically we have seen
2 more success by having behavioral health services brought
3 into small group home settings that serve young people with
4 intellectual disabilities, or even physical health
5 disabilities. So I think in a general sense that would be
6 my response.
7 DR. GIRELLI: I was struggling with which I think
8 is better, but I have to agree with Gary, partly because as
9 important as the behavioral health interventions, the
10 therapies, are, I really think the living context is a huge
11 factor in how successful treatment is. So I think we're
12 better of keeping that treatment context intact and
13 importing into it behavioral health expertise that may not
14 be there already. So I would agree with Gary in terms of
15 which direction.
16 DR. BLAU: And I have to add one more little
17 thing here, for the Commissioners, particularly around
18 Medicaid issues, that the real goal to all of this is to
19 keep kinds from having to go in the first place, because
20 kids are better served by living in families and in
21 communities, and reduce the lengths of stay and the amount
22 of time, perhaps, that they are away from home.

1 And so one of the things that SAMHSA and CMS had
2 done, and we're pushing 10 years ago now, was an
3 informational bulletin, specifically related to coverage
4 for behavioral health services for children, youth, and
5 young adults with significant mental health conditions.
6 And there was a list, and Director Corcoran made a comment
7 before, that we need to put together these outpatient,
8 community-based services, peer support, in-home family
9 services, care coordination, respite care, a flex funding
10 approach that SAMHSA and CMS worked on together, that is
11 allowed within certain parameters of a state plan
12 amendment.
13 But I think that those are the things that we
14 really want to focus on to keep kids from going in the
15 first place and then helping young people transition and
16 discharge in the second place.
17 DR. GIRELLI: I agree with all that. I really
18 want to amplify the value of respite care, especially when
19 we are relying so much on therapeutic foster care, which
20 places tremendous challenges on foster parents. And the
21 availability of brief windows of respite, I think, is
22 invaluable.

1 CHAIR JOHNSON: Thank you. That is very helpful.
2 And you actually brought up a question for me in terms of
3 how have you seen, or how do you think it would make sense
4 to better integrate youth voices into the design evaluation
5 of residential and other behavioral health services, as
6 well?
7 MS. CORCORAN: Just to start out, for OhioRISE
8 and for other of our youth-serving programs that we are
9 working on with the Department of Mental Health, we have
10 requirements for a youth advisory group, and that is some
11 of the best not only wisdom but feedback and encouragement.
12 So that's a built-in requirement component of it. We do
13 that at the state level. We also expect that of not only
14 our partner, Aetna, but also then the PRTFs who are
15 operating the PRTF service.
16 MS. WASHINGTON: I agree with Director Corcoran.
17 Having youth advisory boards is very fundamental to making
18 sure that people with lived experience and young adults who
19 have experienced this, their voices are being implemented,
20 but also actually utilizing them as opposed to just having
21 them in the room, making sure they're at the table and not
22 just in the room. And then just spaces such as this one,

1 as well, just making sure that someone with that specific
2 lived experience is there, and you are utilizing their
3 voices.
4 DR. GIRELLI: I agree with all that. I think
5 there are national organizations of youth who have been in
6 care that put out material that is invaluable. I also
7 think, at the very local level, involving not only people
8 with lived experience but wherever possible, people
9 actually living the experience, and having youth who are in
10 care and in foster families participate in planning and
11 providing feedback I think is really important.
12 As a provider, I have to acknowledge, it's hard
13 to do, and if you don't really commit to it, even the
14 logistical challenges can throw you off course. But I
15 really do think it is tremendously valuable.
16 CHAIR JOHNSON: Thank you. Angelo.
17 COMMISSIONER GIARDINO: First, I would really
18 like to thank the panelists for sharing a lot of really
19 valuable information in terms of the need for this element
20 to the continuum of care. It really makes a lot of sense.
21 I have a question that's probably more for Dr.
22 Blau and Dr. Girelli. What about the expectations in the

1 industry when a company sets up residential treatment in a
2 different state and accepts out-of-state clients. What is
3 the expectation for the industry, for dealing with one
4 level up? And by that, I mean when a child is accepted in
5 residential treatment for an out-of-state placement and
6 then there's a behavioral crisis, what's the expectation
7 for coordination with providers in that new state?
8 And the reason why I'm asking that is in my
9 experience it seems that one level up is dropping the kid
10 off at an emergency room, and then providers in that state
11 are left with dealing with a different state's Medicaid to
12 pay for crisis treatment, and then presumably inpatient
13 care, that that state was not involved in, because they
14 only approved the residential treatment.
15 So what's the expectation when a company sets up
16 residential treatment to accept out-of-state residents for
17 dealing with treatment, well, escalation of care needs?
18 DR. GIRELLI: Gary, I can't speak to the Medicaid
19 side of that, so maybe you can. There are other aspects of
20 it that I'd like to return to.
21 DR. BLAU: Well, the first response is that the
22 reality here is that residential treatment centers are

1 basically licensed state by state, so there are no
2 essential federal guidelines, other than those perhaps that
3 come from becoming a PRTF and what that actually means from
4 a Medicaid standpoint with staffing patterns and that
5 funding arrangement.
6 What really has happened in my experience,
7 particularly when I was Director of Mental Health for the
8 State of Connecticut, was that we had -- Director Corcoran
9 you will probably be, this was many years ago -- we had 450
10 kids out of state. And we addressed that issue through our
11 contractual relationship between the state and the out-of-
12 state provider, what was going to be the requirement if
13 there was a crisis, how to access it, what our demands were
14 essentially for being notified for these kinds of things.
15 But it has to be written into these contracts in order to
16 make it real, because there is no real national standards
17 that we can address.
18 DR. GIRELLI: Another consideration is that
19 sometimes it's not that an exceeding high acuity level is
20 why an out-of-state placement takes place. It could be
21 that there are very, very specialized needs that no in-
22 state provider can adequately address, whereas over the

1 border, in Massachusetts -- I'm in Connecticut -- over the
2 border in Massachusetts there is a facility that really
3 does very well with this population.
4 Regardless of what the reason for the out-of-
5 state referral is, I think one of the huge challenges is
6 how to keep that client connected to his or her family.
7 That's challenging enough when you're within state, but
8 when you're talking about across state lines, often with
9 families who are struggling with myriad other challenges,
10 to expect them to be able to come for family therapy
11 sessions and things like that is just unrealistic. And I
12 think the risk of longer placements and less successful
13 reintegration is higher with out-of-state placements. I
14 think virtual therapy models help with that somewhat, but I
15 still think it's less than ideal.
16 CHAIR JOHNSON: All right. Thank you. Heidi?
17 COMMISSIONER ALLEN: Thank you so much to all of
18 our panelists. This has been very illuminating. I started
19 my career working in residential treatment. That's
20 actually why I became a social worker. And I loved working
21 with the kids. And also have a teenager with a mental
22 health disorder, and I have to navigate the acute mental

1 health system.

2 And one of the things that I noticed coming back
3 into the mental health system with my teenager is a shift
4 in outpatient providers not wanting to work with people
5 with acute suicidality. And I felt like everywhere we
6 turned we had providers who were like, "Nope. That's too
7 much acuity for us," even when I was like, as a person who
8 had done many of these mental health assessments myself on
9 other people, I'm like, "He doesn't meet criteria for
10 inpatient hospitalization. Why can't he be served in your
11 very well-resourced outpatient mental health clinic?" But
12 nobody really wanted the liability.

13 And as a family member, that put me in a really
14 weird spot, because I couldn't tap into higher than just
15 regular outpatient, and I wasn't ready to send my kid away
16 to live away from home, in a residential treatment center.

17 So I'm wondering if that is just a New York City
18 experience or if some of you were experiencing that in your
19 local places, as well.

20 MS. CORCORAN: Absolutely. And I think just
21 picking up on Dr. Blau's and then feeding back into your
22 comment, Commissioner, I think what I hear from

1 particularly our child welfare colleagues and as well as
2 from parents across kind of the spectrum of disabilities is
3 because the pressures, the workforce challenges have gotten
4 to be so much, there's a feeling that the providers really
5 dictate the terms, call the shots. And you can understand
6 it if they don't have the staff.
7 So I think, at least now, we're very much aware
8 of that dynamic where you just have a scarcity of providers
9 who can meet these kind of -- I don't want to call it a
10 niche. Suicidality is hardly a niche, but where it takes
11 that elevated level of staffing.
12 And just going back to my example of us doing
13 some grants and such, I mean, our purpose with the further
14 development of our PRTF service is to try to target some
15 subsets or populations or subgroups who can be particularly
16 difficult to serve.
17 I know we had one kid, a younger boy who was a
18 diabetic and using his diabetes as a way of kind of the
19 whole behavioral involvement. And he was tough. I mean,
20 he could drop his blood sugar in no time at all. So we
21 ended up having to send him several states away, strictly
22 for that reason.

1 So I do think we have to focus on some of the
2 specialty needs or where the -- it's just that greater
3 challenge.
4 DR. BLAU: And I'm going to -- so it really sort
5 of -- I was jotting a note, because this is why all of our
6 communities really need systems of care, because a shared
7 responsibility across a whole host of providers, be it in
8 the physical health providers, your behavioral health
9 providers, your police, your hospital, your local mobile
10 crisis teams, everybody working together in that systems of
11 care makes a difference because some of these young people
12 are going to create those challenges, folks who were
13 talking about intellectual disabilities, autism spectrum
14 disorders, medically fragile youth, young people that are
15 sexually acting out. And the only real way to address
16 those liability issues is if folks are doing this together
17 and backing each other up and supporting each other.
18 MS. CORCORAN: That's right.
19 COMMISSIONER ALLEN: I had two other questions.
20 I didn't want to pile them all at once. Is that okay?
21 My second question is, what do we know about the
22 educational trajectories of kids who are in residential

1 treatment centers? Are they graduating from high school?
2 Are they going to college? One of the things I remember
3 from working in the residential treatment center is that it
4 was very hard to meet those kids' educational needs because
5 you would have kids of different grades all in one room.
6 They didn't have differentiated classes. They weren't
7 getting anything like what, you know, a kid in the
8 community would be getting for education. And that seems
9 to me like such a substantial barrier for reentry and
10 especially transitioning into a successful adult life. So
11 is this something that any of you are looking at?
12 And then I have one question after that, and I
13 promise I'll be done.
14 MS. CORCORAN: Well, I want to start with the
15 legal barriers first. In our state, we have, you know,
16 specificity about which school district will pay for what,
17 particularly for kids who have IEPs. And I am -- you know,
18 I am so thrilled to be able to say to you, we have actually
19 as part of our budget, a piece of language that our
20 Department of Education and Welfare has proposed to treat
21 these multi-system kids as if they were in the custody of
22 child welfare. In other words, that that placement or that

1 whatever their service needs are not then treated as a
2 parental voluntary decision and therefore financially are
3 entirely on the parent.
4 So I don't know how all other states work, but
5 that's even more of kind of an underscoring of Dr. Blau's
6 point about how you've got to be really trying to pull
7 these partners to the table because, you know, FERPA and
8 504 and IEPs and all of that and how that marries with
9 EPSDT is enormously complicated and can be really
10 individualized or complicated by individual states'
11 approaches to these kinds of kids and their educational
12 needs.
13 DR. GIRELLI: In my experience, most of the kids
14 in residential treatment have special education needs that
15 have usually been identified and for whom IEPs have been
16 written. I think in systems where the special ed services
17 and the behavioral health services are closely integrated
18 and there's high level of communication across the two, I
19 think the outcome is about what you would expect based on
20 the special ed needs. I don't think it's undermined by the
21 placement, but I do think -- and in some states,
22 residential treatment centers have their own schools.

1 In Connecticut, if you're an RTC, you have a
2 special ed school approved by the state. And I think
3 whether it's that model or others where there's a high
4 level of integration and collaboration between the two, the
5 likelihood of success of the student is much, much greater.
6 But I do have to say, I mean, one of the things
7 we always struggle with in our -- we have a private special
8 ed school that I think is excellent, but it's not public
9 school. I mean, it doesn't have all of the offerings that
10 a public school has because of its size and its resources,
11 and as good as I think we are, I think if our kids could
12 successfully be in public school with good special
13 education services, that's a better placement for them,
14 frankly.
15 DR. BLAU: And I think that you're bringing up a
16 very important overall component, which is the educational
17 piece and what graduation rates are really a function of
18 the outcome measures that we're focusing on. And remember,
19 what gets measured is going to get addressed, and
20 unfortunately, we do not have standardized measurement,
21 outcome measures approaches for residential treatment
22 centers. And so I think that what we need to start to do

1 is literally create these kinds of national requirements,
2 that we were not able to do that. And there's a lot of
3 reasons.
4 I just believe that whether it's amounts of
5 seclusion restraints or the number of -- you know, where do
6 kids get discharged to? Are they graduating? Are they
7 ending up back in recidivism for a juvenile justice
8 facility or another residential? These are all outcomes we
9 should be tracking, and that will help us to determine
10 whether or not a particular place is successful.
11 COMMISSIONER ALLEN: You brought up the last
12 thing that I was going to mention, which is one of the
13 things I remember most about my time in residential was
14 just how traumatic it was to have to do seclusion and
15 restraint and how common it was. And I'm hoping that with
16 new trauma-informed practices in many of these settings
17 that the seclusion and restraints have gone down
18 considerably, but I don't know if that's true.
19 And I also really noted the relationship between
20 staffing levels and seclusion and restraint, because when
21 you don't have enough staff to spend two hours talking with
22 one kid and you have to deal with something right away,

1 it's more likely to be let's get this kid taken care of,
2 and that way we can be back on the floor with everybody
3 else.
4 And so I was curious how you're navigating trying
5 to keep seclusion and restraint slow.
6 DR. GIRELLI: Your observation about trauma-
7 informed care and seclusion and restraint is spot on.
8 I think one of the challenges is what's defined
9 as trauma-informed care is sometimes in the eye of the
10 beholder, but I think when trauma-informed care really is
11 the prevailing approach, there are data, at least in small
12 samples, of significant reductions in restraint and
13 seclusion.
14 We teach a model of trauma-informed care called
15 risk and connection, and one of the metrics that some of
16 our clients use is restraint and seclusion, and in most
17 cases, the data indicate that there's a reduction.
18 CHAIR JOHNSON: Thank you so much.
19 We are almost out of time. I think we have you
20 for about four more minutes, and we actually have two
21 Commissioners who've had their hands up for a while. So if
22 they could be quick, I think that'd be really helpful. So

1 I'll start with Mike, and then we'll go to Adrienne as
2 well.
3 COMMISSIONER NARDONE: So, hello, everybody.
4 Thanks for the panel. Very informative.
5 I was wondering, Maureen, you mentioned during
6 your conversation about some of the issues or technical
7 issues that you ran into with CMS when you were trying to
8 develop the RISE model, and I was wondering, in terms of
9 flexibilities, are there things that CMS should be looking
10 at or exploring to kind of support folks in new models of
11 care or to bring kids back from out-of-state placements?
12 You know, in terms of Dr. Girelli mentioned the
13 intermediate levels of care, I would imagine that those
14 levels below the PRTF are a little harder to fund with
15 Medicaid because of the housing component.
16 I'm wondering, are there other policies that we
17 should be thinking about as MACPAC to recommend the CMS?
18 MS. CORCORAN: So a couple thoughts quickly.
19 You're absolutely dead on about the housing component being
20 a big challenge in working with the waivers.
21 Second, the primary reason why we used the
22 waiver, a waiver, is to get the special income level so

1 that we could pick up kids who were going to be
2 relinquished for custody, but they weren't yet. And so, if
3 we could pick them up with a waiver, they wouldn't be.
4 That was where we had some challenges. But we worked it
5 out with Ralph's help and -- but that was eye-opening, and
6 it meant we ended up with a (b)/(c) combination waiver,
7 which is too complicated, really, for what we want to be
8 able to do.
9 And the last thing I would just say quickly is,
10 you know, we made a commitment that we were going to fund
11 these services adequately, and again, the only way we could
12 do it was in a managed care environment. So we really have
13 tried to stay up on the rates and the staffing and the
14 technical assistance and all the rest of it, just
15 understanding they're very expensive services. If you want
16 evidence-based programs to fidelity, you have to be willing
17 to pay for it, and so that was kind of an underlying
18 premise of this managed care approach was to do that. We
19 had to have the scale and the catchment areas and the
20 ability to pay the kind of rates that necessary.
21 DR. BLAU: And I'm going to echo that as well.
22 The rate issue was huge and funding those community-based

1 alternatives. And I'm going to go back to that. And in
2 the chat box, I've tried to put in several links to
3 different things for, perhaps, if folks are interested.
4 And one of them is the 2013 informational bulletin that
5 SAMHSA and CMS issued together with all those services.
6 And what we're talking about there is funding
7 them at a level that will actually garner the kind of
8 workforce and, you know, the people that in order to do
9 that job. So from a Medicaid policy standpoint, I think
10 making sure that states know that those are services that
11 are allowable and that then folks can actually fund them to
12 a level that's necessary.
13 MS. CORCORAN: One other one, if I could, Dr.
14 Nardone. We just got approval for a braided funding model
15 for crisis which will -- the funding, the rate setting,
16 will provide a single payment to the identified crisis
17 providers for Medicaid children and non-Medicaid children.
18 So I do think on some of these more expensive services,
19 finding ways from a rate-setting point of view with
20 Medicaid where you can braid the funding more easily is
21 essential, because we just didn't think we were going to be
22 able -- and still is kind of clunky. But you don't want

1 some of these different types of services to have to be
2 saying, oh, well, you know, I can bill Medicaid for this
3 half hour for you and not for you. I mean, it just doesn't
4 work.
5 CHAIR JOHNSON: Thank you.
6 And then, Adrienne.
7 COMMISSIONER McFADDEN: I think I'm going to
8 choose to defer because I think Mike asked a question very
9 similar to what I was going to ask.
10 CHAIR JOHNSON: Okay. All right. So, with that,
11 we want to say thank you so much to the panelists. Your
12 background, your experiences have been very helpful to us
13 as we think about this topic even more, as we think about
14 some of the things we may want to dig a little bit deeper
15 into as well as potentially some recommendations moving
16 forward.
17 So it's so good to meet many of you and to see
18 Maureen. It's great to see you, as always. So enjoy your
19 day.
20 And then the Commission, we will now engage in
21 another conversation around this as well. So thank you.
22 MS. CORCORAN: Thank you.

1 CHAIR JOHNSON: All right. So that was a very
2 engaging conversation, right? And I apologize we couldn't
3 get to all the Commissioners, but there was a lot of great
4 questions. And as you can see, they're really able to
5 provide us with a wealth of information.
6 So I will open the floor then to see if there are
7 additional thoughts or considerations.
8 I know Carolyn wasn't able to get to you.
9 Anything you'd like to bring up?
10 COMMISSIONER INGRAM: Thanks. I was just going
11 to ask about the different platforms, and Mike kind of
12 asked that, addressed a little bit. But in our research,
13 it'd be helpful to just think about what you're seeing in
14 different platforms from states, state plan amendments
15 versus waivers. You know, what are the mechanisms that are
16 being used? It's just interesting to see and the reasons
17 why.
18 Thank you.
19 CHAIR JOHNSON: Thank you.
20 Sonja?
21 COMMISSIONER BJORK: Doesn't it seem like every
22 topic we try to tackle; workforce comes up? And yet I

1 don't know how to get at it as a research topic, et cetera.
2 We just had a whole discussion earlier this morning about
3 provider payments and workforce things. So do people have
4 ideas about how to frame that for this particular topic?
5 CHAIR JOHNSON: Any thoughts? So something
6 probably for us to think about, it sounds like. Thank you,
7 Sonja.
8 COMMISSIONER NARDONE: It comes back to the
9 rates, right?
10 CHAIR JOHNSON: Yeah.
11 COMMISSIONER NARDONE: Rate development
12 structure. I mean, that was what one of the folks said on
13 the --
14 COMMISSIONER BJORK: Some states like California
15 have changed the minimum wage for people involved in any
16 kind of health care services. I wonder, does that help in
17 this realm, or are there special programs to support the
18 pipeline of recruiting and training folks to work in this
19 field? It's a long game. You know, does that -- when does
20 that have an impact? And are those important policy things
21 for us to look at and recommend?
22 COMMISSIONER KILLINGSWORTH: If I could just

1 comment, Sonja, on your question specifically, my own
2 experience in Tennessee, we were trying to create better
3 models of care, especially for kids with intellectual
4 developmental disabilities and co-occurring behavioral
5 health needs, that even when we provided the funding for
6 higher-level staff, there wasn't sufficient volume, if you
7 will, of that level of staff who we could recruit to do the
8 work.
9 You know, you really want people who have a
10 higher level of training and experience, and they just
11 weren't there, even if we were willing to pay more for
12 them.
13 CHAIR JOHNSON: Thank you.
14 John?
15 COMMISSIONER NARDONE: Mike had asked this
16 question, and Maureen answered it, and she answered it
17 correctly. But I think one of the things to bring up on
18 this one is Ohio is not a Katie Beckett state. So that is
19 why they had to do the waivers to help get those kids in
20 around custody. I don't -- I tried to make Ohio a Katie
21 Beckett state when I was there, but it was going to cost a
22 lot of money. They were able to do it this way. So that's

1 one of those things of I don't know if that's a difference
2 as we're, like, looking across states around this issue
3 around relinquishment.
4 The second piece, and it's back to what Sonja was
5 saying, I mean, there's just literally not enough people to
6 do these services, and it's really hard work. And even if
7 you raise the rates, you're always running these questions
8 about who gets the rate, right? Does it just go to profit
9 margin? Do you hire more people? And, you know, some of
10 those other pieces in there. So it is a very, very complex
11 subject to address, and it's not just for Medicaid. I
12 mean, it's for all medical services.
13 CHAIR JOHNSON: Thank you.
14 Adrienne?
15 COMMISSIONER McFADDEN: Yeah. So, thematically,
16 what I was going to ask the panel is this just seems like a
17 really large topic for us to take on. All of the topics we
18 take on are large, but this one feels a little bit more
19 like we need to take one bite of the elephant at a time.
20 And so really wanted to kind of understand from their
21 standpoint, was it really sort of the discoordination
22 issues that they sort of talked about that were the largest

1 barrier? Was it the capacity issues of the community
2 outpatient services that were the larger issue? Was it
3 something else? And so just trying to give us some
4 direction as to which bite to start with.
5 CHAIR JOHNSON: Yeah, good. Very good point.
6 Very good point.
7 Melissa will help us get there, for sure.
8 Yes?
9 COMMISSIONER NARDONE: So the thing that I've
10 tried to focus in on my question and trying to understand a
11 little bit better, Melissa, you probably have all the
12 information around this to help me, is there is a
13 difference between PRTF and residential treatment
14 facilities. PRTFs are a Medicaid benefit, and Medicaid
15 will pay for that, and they pay for housing. The
16 residential treatment facilities that are not PRTFs, they
17 can be funded by Medicaid, but you can't pay for room and
18 board. You can pay for services.
19 So one of the things that I've encountered when
20 I've done some work for some of these entities -- and I
21 think it was Dr. Girelli who raised this -- was that the
22 intermediate levels, which would be below PRTFs, are a lot

1 more challenging to fund than when Jami was talking about a
2 model for IDD, and maybe bringing behavioral health
3 services in. It's a little less clear how Medicaid would
4 be able to support that.
5 And I just want to test that understanding that I
6 have=, to make sure that I, first of all, am understanding
7 the landscape, because I don't know how many kids are at
8 PRTFs versus the lower level of care. That's one thing
9 that I'm just trying to understand a little bit better.
10 But I think that's the landscape. You can correct me if
11 I'm wrong.
12 MS. SCHOBER: No, that's a correct understanding.
13 The Psych Under 21 benefit permits states to pay for
14 Medicaid services, including room and board, in psychiatric
15 residential treatment facilities, and those facilities are
16 subject to CFR regulations around, as Dr. Blau mentioned,
17 particular staffing assessment practices, seclusion and
18 restraint.
19 Then there are other residential treatment
20 settings. And going back to the September and October
21 presentations, those include qualified residential
22 treatment programs, which are directed at children in child

1 welfare, and then a category that I think is probably
2 unhelpfully, so apologies, called "other," which would be
3 other residential treatment settings. And Medicaid can pay
4 for services within those settings if they are below 17
5 beds, because they are subject to the IMD exclusion.
6 So it's possible to have some limited payment,
7 limited time period payment, in QRTPs, though, to the best
8 of my knowledge, only one state has exercised that option
9 through an 1115. That's Oklahoma.
10 And I don't want to get ahead of myself and sort
11 of over my skis, but when I come back with findings from
12 the work, well, two things. One, some states expressed a
13 reluctance to adopt that option because of the time
14 limitations placed on treatment, both maximum length and
15 then average duration, given that these are young people
16 with, as you heard from the experts, a lot of complex need,
17 and they may require lengthier treatment. And two, that
18 economies of scale were difficult for them in smaller
19 treatment settings, to pay for services and then the room
20 and board costs associated with the young person.
21 COMMISSIONER NARDONE: But for the QRTF, again --
22 MS. SCHOBER: The QRTP?

1 COMMISSIONER NARDONE: -- the QRTP, and correct
2 me if I'm wrong, child welfare can pay for room and board.
3 MS. SCHOBER: Yes. Yes.
4 COMMISSIONER NARDONE: So for me, some of the new
5 models of care, I think we talked about this maybe at the
6 last meeting, some of the models that try to braid some
7 level of intermediate housing with services is a little
8 more complex to fund through Medicaid, which I think the
9 speakers were kind of leading us to, that's where we should
10 be going.
11 So I guess having a good handle on that landscape
12 I think is important when we are talking about this topic,
13 and kind of what the limitations are. Maybe everybody
14 around here understands that, but I think it is important
15 to, and note, that that's the landscape.
16 MS. SCHOBER: Yeah, and just to your last point,
17 very quickly. Again, we don't know how many young people
18 are in PRTF versus other residential treatment settings
19 because there is not national survey data. We can get
20 limited information through AFCARS and other child welfare
21 data about where young people are placed, and then some
22 state bed registries. But again, there is not a national

1 survey of where those young people are, so it's difficult
2 to know in which states, which young people are in which
3 settings, for what duration.
4 COMMISSIONER NARDONE: Mm-hmm. So I guess where
5 I'm going with this is it would be very interesting to know
6 where you have innovative models that look at both the
7 residential piece as well as the services piece, that are
8 below PRTFs, are there models, and are the states, what are
9 the authorities that they are using to make that happen.
10 And are there any recommendations around that, that maybe
11 we should be thinking about to facilitate those types of
12 innovations.
13 CHAIR JOHNSON: Thank you, Mike. Thank you,
14 Melissa. Heidi.
15 COMMISSIONER ALLEN: So that was very in the
16 weeds. I'm going to go back up a little bit. No, I am
17 interested to know how that all falls out, too.
18 One of the things that was just so notable to me
19 is that this is a treatment of last resort, and that there
20 is both this big group of people who are waiting, which
21 you're wondering what's happening with them, like waiting
22 weeks, waiting months, waiting years. If you have that

1 level of acuity, how is it being managed in the community,
2 if you are meeting the criteria for a higher level of care.
3 And then you have this whole group of people, of young
4 people, who are languishing in these facilities and unable
5 to get out, and that seems to me like two sides of the same
6 coin. And I thought that they spoke to some really
7 important things that I hope that our work continues to
8 call out.

9 One of the things that I kind of tried to ask
10 about but I don't know that it was a super clear question,
11 which is just what are paying outpatient providers to do
12 for acute patients? When I was navigating the system with
13 my kid, I kept getting directed to DBT, because DBT was the
14 only type of treatment where they had a payment code for
15 where you could reach out to somebody 24 hours a day. And
16 there were no other treatment modalities where the
17 providers got paid to have somebody on call or available 24
18 hours a day, and yet DBT was a model that wasn't working
19 for us.

20 And I was like, I can't believe that we're being
21 redirected to residential care just because this one random
22 treatment approach isn't working, because you don't have a

1 payment mechanism that we could have somebody on call if we
2 need to reach out.
3 And so I'd be interested in knowing a little bit
4 about what we do to serve kids with moderate acuity in the
5 mental health system, to provide them supports. And they
6 did mention a few things, but they seemed to be kind of
7 related to foster care, like respite and things like that.
8 But what are we doing to help kids stay home, outside of
9 the kind of outpatient mental health model, which is where
10 you see your therapist once a week, you see your
11 psychiatrist or medication provider once a month. What do
12 we have that's a step in between those two things?
13 And then I'm curious, like what happens when a
14 kid accomplishes their treatment plan and they're stuck in
15 one of these places? You know, it seems to me like a
16 terrible position for the facility, because they need to
17 bring in new people. And you tell this kid, like, "Keep
18 trying. Keep getting better. Keep doing the right thing
19 and you can go home," and they do, and they don't get to go
20 home, which is just awful. And yes, it's awful for the
21 state too, because the state is having to pay this higher
22 acuity when the kid is ready to go home.

1 So I'm wondering, who is on the hook for that?
2 Is there any kind of accountability? Is there any kind of
3 repercussions for systems not being willing to take kids
4 back into the community?
5 CHAIR JOHNSON: Thank you. Really good points.
6 Patti, and then Dennis.
7 COMMISSIONER KILLINGSWORTH: I'll be brief. I
8 just want to sort of call out a point that Mike raised, and
9 be sure that we bring it to the forefront, because it
10 really, again, points to the institutional bias in the
11 Medicaid law and regulation, that there is a preference
12 toward institutional care in terms of access. So when we
13 cover a benefit, when it's a covered benefit, and we cover
14 the room and board component of that benefit, we make it
15 accessible to anyone who needs it and qualifies for it.
16 Whereas if that same person, who needs that
17 institutional level of care, prefers the community-based
18 alternative, prefers an alternative that keeps them with
19 their family or near their family, all of the things that
20 we talk about in the home and community-based services
21 world, apply here too, then there has to be another source
22 of funding, private pay funding, to be able to cover the

1 cost of the room and board, and it makes the benefit
2 inaccessible to people.
3 So we talk about what is best, we talk about what
4 people prefer, and then we make the opposite actually
5 available to them. And it is a longstanding issue in
6 Medicaid law that is preventing people from accessing
7 community-based care.
8 CHAIR JOHNSON: Thanks, Patti. Dennis.
9 COMMISSIONER HEAPHY: Patti, thanks for saying
10 that. That's what I was thinking. And I think for me, I
11 was sitting here listening to folks, and we only had one
12 person with experience, and the quote/unquote "experts" who
13 are running institutions, running these places. And I want
14 to know what's happening upstream. What are the
15 alternatives? What are the HCBS alternatives for these
16 folks?
17 And I'd love to hear more about that, what Patti
18 is saying, and what Heidi was saying, as well. What else
19 is there? Where is the upstream preventative services that
20 could be put in place? I'd love to hear from folks with
21 lived experience, to say what alternatives are there that
22 you wish you had heard about when you were in crisis, or

1 are there alternatives out there? Melissa, have you come
2 across alternatives for these folks with kids?
3 MS. SCHOBER: I have, and included in the earlier
4 memos from this work was that 2013 bulletin that Dr. Blau
5 referenced, between SAMHSA and CMS. So Ohio is among the
6 states that have instituted some of those benefits,
7 including mobile crisis response. New Jersey is another
8 state that does that, and it provides, I've heard people
9 call it a firehouse model, but immediate, rapid response to
10 folks who are experiencing crisis, with some stabilization
11 services to that young person and their family for a period
12 of, say, up to six or eight weeks, to help them bridge to
13 get into community care.
14 Those are some of the services. There is also
15 intensive, in-home services that are sort of a mid-level
16 range. There's high-fidelity, wraparound intensive care
17 coordination services that a number of states offer. In
18 this work, and talking with states about access challenges,
19 they were very able and ready to connect those access
20 challenges with workforce issues and the pressure and
21 difficulty in finding workforce both for those moderate
22 complexity services and for residential treatment, and

1 expressed difficulty in finding, training, retaining, and
2 coaching those staff.
3 COMMISSIONER HEAPHY: And that's just endemic.
4 So if there were increased effort to invest in these
5 services, to help keep these folks, these kids, out of
6 these institutional settings -- I don't know. I just had
7 to raise the question. Thanks.
8 CHAIR JOHNSON: Thank you, Dennis. All right, so
9 thank you again, Melissa, for putting together a great
10 panel. A lot of great conversation, obvious that -- oh,
11 John. I'm sorry. I didn't do that on purpose, I just want
12 to go on record.
13 COMMISSIONER McCARTHY: Just one quick thing. I
14 want to go down what Dennis had just said, in that
15 direction a little bit. I think the thing about this --
16 and Heidi hit on some of these -- this is really complex,
17 just the care for these kids. They're human beings, and
18 everyone is different, so you do need to invest in all the
19 different ones, and you want to make sure that we're not
20 having institutional bias, and any people in institutions,
21 and providing services before that.
22 And I think that is one of the things -- Melissa,

1 I know you hit on it a little bit, but if we could look at
2 that to see how states are doing around those services, who
3 is covering some of those services, and are there other
4 barriers that we are not thinking of. And I don't know
5 what those are. I'm not a mental health expert. But back
6 to even with mobile crisis, that's a one-time thing, but
7 then, I don't know, do we need counselors in homes 24 hours
8 a day, or whatever it is?

9 But then the other issue that we used to deal
10 with a lot is then the child goes to school, and then all
11 that breaks down because the school is not equipped to
12 handle that kid, and Medicaid won't pay for that sometimes,
13 depending on what state you're in, because now you're in
14 school, and you're not at home, and what happens there.

15 So I think that would also behoove us to also
16 look at those issues of what other barriers there are
17 besides just home and community-based services, but what
18 about when kids are in school, are they able to get the
19 help that they need.

20 And again, I don't know, and I'm sure there are
21 some places that are doing a great job. But I am assuming
22 there are also some places that could improve.

1 CHAIR JOHNSON: No, I totally agree. I mean, one
2 of the questions I was going to have, what I felt like they
3 addressed a little bit of, is what are the roles that
4 partnerships like schools and families and community
5 leaders have in that. So that's a good point. I'm glad
6 you brought that back out.
7 Before I close us out, any other questions or
8 thoughts?
9 [No response.]
10 CHAIR JOHNSON: Okay. Well again, thank you,
11 Melissa. Great opportunity to hear from the panel. You
12 have everything you need from us, it sounds like? Okay,
13 perfect. Thank you so much.
14 Okay. So now we are going to open it up for our
15 second public comment period. At this time we invite the
16 public to raise their hand if you would like to offer a
17 comment. Again, I ask that you please introduce yourself
18 and the organization that you represent. And I also ask
19 that you keep your comments to three minutes or less,
20 please.
21 **### PUBLIC COMMENT**
22 * [No response.]

1 [Pause.]

2 CHAIR JOHNSON: Give it a few more seconds.
3 Okay, no comments currently, but I do want to remind you
4 that if you have comment later you can definitely go to our
5 website, the MACPAC website, and submit your comments
6 there, as well.

7 So with that we are going to take a break. We
8 will be back at 2:45 p.m. Eastern, and look forward to
9 talking with you all more then. Thank you.

10 * [Recess.]

11 CHAIR JOHNSON: All right. So today, I'm going
12 to turn it over to Allison and Chris, who will talk about
13 our analysis of the EQR process and present our
14 recommendations and potential recommendations and the draft
15 chapter. So I'll turn it over to both of you.

16 **### EXAMINING THE ROLE OF EXTERNAL QUALITY REVIEW IN**
17 **MANAGED CARE OVERSIGHT AND ACCOUNTABILITY**

18 * MS. REYNOLDS: Good afternoon, Commissioners.
19 Chris and I are back today to review the recommendations
20 and present the draft chapter for the March Report to
21 Congress on the role of external quality review in managed
22 care oversight and accountability.

1 We'll begin with a brief background on key
2 elements of the current EQR process. Next, we will quickly
3 review the challenges identified by our comprehensive
4 study. We'll spend the majority of our time this afternoon
5 presenting three recommendations and the rationale and
6 implications for each to you before turning it over to the
7 Commission for discussion. Our presentation will be fairly
8 brief, as you've seen this work previously.
9 Let's take a look at key elements of the current
10 EQR process relevant to our study findings and proposed
11 recommendations.
12 The Medicaid statute establishes a broad
13 oversight role for CMS in regards to Medicaid managed care
14 with few specific federal responsibilities. The statute
15 provides two direct oversight monitoring requirements.
16 One, a state must develop, implement, and update a managed
17 care quality assessment and improvement strategy that
18 includes access standards and procedures for monitoring and
19 evaluating the quality and appropriateness of care and
20 services, meets the standards set by CMS, and is subject to
21 monitoring by CMS. And two, a state must conduct an annual
22 external independent review of the quality of and access to

1 services under each managed care contract.

2 These federal, state, and managed care plan
3 activities are intended to function as an interrelated set
4 of compliance and quality requirements.

5 EQR elements relevant to our recommendations
6 today include external quality review organizations, known
7 as EQROs, which are qualified independent entities that
8 states must contract with to conduct periodic reviews of
9 the quality, timeliness, and access to care provided by
10 Medicaid MCOs; the mandatory quality review activities that
11 EQROs must conduct and report on as well as the optional
12 activities from which states can choose to have their
13 contracted EQRO also conduct; the protocols for conducting
14 and reporting on each EQR activity developed by CMS in
15 coordination with national quality experts and updated in
16 response to regulatory changes; and the annual technical
17 report, or ATR, which compares and evaluates the managed
18 care plans subject to EQR in a state and that states are
19 required to publish by April 30th for the previous year's
20 EQR activities.

21 Based on the comprehensive study we conducted and
22 have detailed for the Commission in several previous

1 meetings, we identified five challenges with the current
2 EQR process. One, the EQR process and state quality
3 strategies are not always aligned. Two, the EQR process
4 and the protocols used for EQR activities do not focus on
5 outcomes. Three, states vary in their enforcement of EQR
6 findings. Four, the annual technical reports recapping EQR
7 activities are not always accessible, and the findings
8 within them are hard for stakeholders to use. And five,
9 CMS oversight of the EQR process appears limited.
10 Based on our comprehensive study, analysis of the
11 2024 managed care final rule, and feedback from
12 Commissioners at our last three public meetings, we have
13 three proposed recommendations for your consideration. The
14 three proposed recommendations seek to shift the focus of
15 EQR activities from process and compliance to meaningful
16 outcomes and actionable data, and to improve the usability
17 of that data through reporting standardization and
18 summarization.
19 These proposed recommendations are intended to
20 build on MACPAC's prior and ongoing work examining
21 effective oversight of Medicaid managed care programs to
22 ensure beneficiaries have appropriate access to needed

1 services.

2 Our first proposed recommendation reads: "The

3 Secretary of the U.S. Department of Health and Human

4 Services should direct the Centers for Medicare & Medicaid

5 Services to amend 42 CFR 438.364(a)(2)(iii) to require the

6 external quality review annual technical report include

7 outcomes data and results from quantitative assessments

8 collected and reviewed as part of the compliance review

9 mandatory activity specified at 42 CFR 438.358(b)(1)(iii)."

10 Our first proposed recommendation is regarding

11 the triennial compliance review. This mandatory EQR

12 activity evaluates a state's managed care plans, policies,

13 and procedures against 14 federal standards detailed in 42

14 CFR 438, including standards related to access, coverage,

15 and authorization of services, and care coordination.

16 Stakeholders we interviewed describe this review as the

17 most comprehensive EQR activity conducted.

18 This recommendation reflects CMS's views

19 expressed in the preamble to the 2024 managed care final

20 rule and the Commission's views expressed in previous

21 public meetings that this data reporting requirement would

22 result in more meaningful ATRs, making them a more

1 effective tool for states to use in quality improvement and
2 managed care oversight with a greater emphasis on planned
3 performance outcomes.
4 This recommendation is also consistent with the
5 2024 managed care final rule requiring a state's EQRO
6 report outcomes data in the annual technical report from
7 the other three mandatory EQR activities.
8 Addressing Commissioner concerns about state
9 Medicaid agency administrative burden, the EQR protocol for
10 the triennial compliance review already suggests questions
11 and plan documents that could generate outcomes and
12 quantitative data. Including this data in the annual
13 technical report could demonstrate outcomes associated with
14 the processes evaluated.
15 Also, we want to note this recommendation is not
16 intended to create new measures nor mandate specific data
17 be collected and reported. It would simply require
18 reporting of outcomes and data already available to and
19 reviewed by the EQRO.
20 The Congressional Budget Office, or CBO, does not
21 estimate any changes in federal direct spending as a result
22 of this recommendation. The administrative burden could be

1 reduced by CMS updating the triennial compliance review
2 protocol simultaneously with the other three EQR activity
3 protocols as already required by the 2024 managed care
4 final rule.

5 Neither states nor managed care plans should see
6 a substantial increase in cost or administrative burden as
7 the standards are already being evaluated and the data
8 already being reviewed during the activity. Also,
9 including the outcomes data in the annual technical report
10 could generate additional insights for states and plans
11 that could improve the managed care program. Enrollees
12 will benefit from any improvements in the managed care
13 program's quality as well as having additional information
14 about plans. Finally, this recommendation would not
15 directly impact providers.

16 Our second proposed recommendation reads: "The
17 Secretary of the U.S. Department of Health and Human
18 Services should direct the Centers for Medicare & Medicaid
19 Services to update external quality review (EQR) protocols
20 to (1) reduce areas of duplication with other federal
21 quality and oversight reporting requirements; (2) create a
22 more standardized structure in the annual technical report

1 that summarizes EQR activities, results, and actions taken
2 by state Medicaid agencies; and (3) identify key takeaways
3 on plan performance."
4 Our second proposed recommendation addresses
5 feedback received from stakeholders that these reports are
6 currently too lengthy and too detailed for most readers to
7 comprehend.
8 Many stakeholders we interviewed valued the
9 flexibility CMS gives states to design the EQR process to
10 fit their states' needs but thought there could be a better
11 balance between this flexibility and reporting
12 standardization and consistency.
13 We want to emphasize this recommendation does not
14 create new measures nor mandate the collection of specific
15 data. It standardizes the structure of the annual
16 technical report and calls for summarizing key findings.
17 This more standardized structure for summarizing and
18 reporting EQR activities, results, and actions taken in
19 response by states would improve stakeholders' ability to
20 glean key takeaways on plan performance from the annual
21 technical report.
22 Finally, this second EQR recommendation supports

1 the Commission's view that CMS should identify areas where
2 external quality review reporting overlaps with other
3 federal reporting requirements and align EQR findings with
4 other oversight activities, bringing efficiency to the
5 process, reducing duplication of reporting and
6 administrative burden.

7 CBO does not estimate any changes in federal
8 direct spending as a result of this recommendation. The
9 federal administrative burden could be reduced if CMS
10 aligns EQR findings, data, and reporting with other federal
11 quality and oversight reporting requirements. States may
12 see an increase in their administrative burden initially to
13 respond to the modified ATR reporting structure but could
14 benefit from an overall reduction in administrative burden
15 if CMS reduces EQR reporting in areas where information is
16 duplicative of other federally mandated reports. Both
17 health plans and enrollees could benefit from increased
18 transparency and usability of ATRs resulting from reporting
19 consistency and summarized findings. Finally, the
20 recommendation would not have any direct effect on
21 providers.

22 Our third proposed recommendation reads: "the

1 Secretary of the U.S. Department of Health and Human
2 Services should direct the Centers for Medicare & Medicaid
3 Services (CMS) to require states to publish external
4 quality review (EQR) annual technical reports in a 508-
5 compliant format and for CMS to publicly post all state EQR
6 reports in a central repository on the CMS website."
7 While there are federal requirements for states
8 to post their ATRs publicly, our study found that most
9 recent reports can oftentimes be hard to find searching
10 each state's website. CMS could improve transparency by
11 developing a central repository for these ATRs on the
12 Medicaid.gov website, similar to the way CMS has recently
13 begun posting the managed care program annual reports, or
14 MCPARS.
15 The summary tables currently published by CMS do
16 not include findings from ATRs. Thus, stakeholders cannot
17 use these existing tables to assess plan performance.
18 Finally, CMS requires documents posted on its
19 website be in a 508-compliant format. Regulations already
20 require states to be able to produce the EQR reports in
21 alternative formats for persons with disabilities when
22 requested. So requiring states and their EQROs to submit a

1 508-compliant report to CMS would ensure that these reports
2 are available in a format accessible to those with
3 disabilities.
4 An alternative design suggestion is that CMS
5 could require a standardized executive summary in a 508-
6 compliant format in addition to the entire report.
7 CBO does not estimate any changes in federal
8 direct spending as a result of this third recommendation.
9 The administrative burden to develop a 508-compliant
10 template for the ATR would decrease over time in subsequent
11 years.
12 Similarly, states and health plans may incur an
13 initial increase in administrative burden to implement any
14 requirements on a 508-compliant format, but this burden
15 would also decrease over time.
16 Enrollees would benefit from increased
17 accessibility to ATRs in one location, and the
18 recommendation would have no direct impact on providers.
19 Looking ahead after today's discussion. Tomorrow
20 the Commission will vote on the three proposed
21 recommendations. We will finalize the chapter for the
22 March report to Congress. We will continue to examine

1 Medicaid managed care oversight and accountability,
2 including data from MCPARS available through CMS, and the
3 effect of requirements from the 2024 managed care rule as
4 they are implemented over the next four years.
5 Thank you for your time today, and we'll turn it
6 back over to the Chair.
7 CHAIR JOHNSON: Thank you so much for the work
8 there and the proposed recommendations.
9 Let me open it up to the floor then to see if
10 there are any comments or questions that will be helpful
11 before we vote tomorrow.
12 Tricia.
13 COMMISSIONER BROOKS: Thank you for this work.
14 As I've stated in the past, I think it's really important
15 having spent a lot of time going through EQR technical
16 reports. I concur with all of the evidence that you found,
17 you know, restating that.
18 And I'm in favor of these recommendations. The
19 one point I wanted to make is that one of the findings is
20 that you don't see alignment between the state quality
21 strategy and the EQR reporting, and I don't see anything in
22 these recommendations that address that. So I'm just

1 curious what more we might do in the future to take a look
2 at recommendations that would really strengthen that
3 connection.
4 The little graphic that you have that shows those
5 three legs of the quality strategy, I'm still thinking that
6 there's going to not be that connection between the state
7 quality strategy and the EQR reporting.
8 Thank you.
9 CHAIR JOHNSON: Thanks, Tricia.
10 Angelo?
11 COMMISSIONER GIARDINO: Yeah. I just wanted to
12 thank you for this. I think you really listened to what
13 our concerns were, and I think this is a good next step.
14 And I appreciate the idea that we would make these more
15 useful.
16 CHAIR JOHNSON: Thank you, Angelo.
17 Others? Mike.
18 COMMISSIONER NARDONE: Thank you.
19 I wanted to echo what Angelo just said. You
20 know, you obviously took the feedback from last meeting and
21 used it to craft the second recommendation around summaries
22 that I think is really helpful.

1 The one thing I just wanted to ask about, and I
2 think it's important, particularly as you're talking about
3 the EQRO work and some of the future MACPAC work around
4 managed care accountability, I just was wondering if in the
5 chapter, there could be some reference to that larger body
6 of work, because I think that this is really one of the
7 components of kind of how states try to achieve
8 accountability of their managed -- over their managed care
9 programs. And so I guess I would like to kind of have that
10 larger -- would like to see that larger context in the
11 chapter, and at least in my reading of the draft, I didn't
12 -- I don't recall seeing that in terms of some of the other
13 work that you're going to be looking at and how this fits
14 into that.
15 CHAIR JOHNSON: Thank you, Mike.
16 Okay. I do not see any more hands, live or on
17 the screen. So it sounds like you all did a great job of
18 really listening to our feedback, as it was already
19 articulated, and coming back with these draft
20 recommendations, and I think we look forward to the vote
21 tomorrow. Thank you.
22 [Pause.]

1 CHAIR JOHNSON: All right. So we have our last
2 session for today about simplifying administrative
3 requirements and identifying ways to reduce state burdens
4 while maintaining program quality for HCBS. So while we
5 wait for our analysts to come up and they can kick us off
6 once they're there.
7 [Pause.]
8 **### MEDICAID SECTION 1915 AUTHORITIES FOR HOME- AND**
9 **COMMUNITY-BASED SERVICES: ANALYZING FEDERAL**
10 **ADMINISTRATIVE REQUIREMENTS AND OPPORTUNITIES TO**
11 **STREAMLINE**
12 * MS. HUSON: Okay. Good afternoon, Commissioners.
13 So Kirstin and I are going to present the draft
14 chapter on Section 1915 HCBS authorities. This chapter
15 also continues our work to promote access to HCBS
16 specifically by looking at opportunities to streamline
17 federal administrative requirements for HCBS programs.
18 So I'm going to begin with some background on
19 Section 1915 authorities followed by considerations for
20 states when selecting authorities to operate their
21 programs. Then Kirstin will walk you through the five
22 buckets of administrative requirements and the findings

1 associated with each. We will end with the recommendation
2 and next steps.
3 So, as a reminder, we developed this framework
4 for HCBS in our June 2023 report to Congress. There are
5 four domains in this framework, and the draft chapter is
6 focused on the last domain of administrative complexity.
7 This domain examines state and federal burden in
8 administering multiple HCBS programs, often under different
9 authorities, constraints on state capacity and resources,
10 and the implications of system complexity for enrollees.
11 So there are four different Section 1915
12 authorities that states can use to deliver HCBS—Sections
13 1915(c), (i), (j), and (k). There are additional
14 authorities that states may use such as Section 1115
15 demonstrations, but this chapter focuses just on Section
16 1915. And so this slide gives you a brief description of
17 each of the four authorities, with Section 1915(c) being a
18 waiver authority and the other three being state plan
19 options.
20 So we contracted with Mathematica to better
21 understand the administrative requirements for each Section
22 1915 authority. Mathematica developed a report for us that

1 reviewed the requirements for each authority and grouped
2 the requirements into the five categories that are seen on
3 this slide. Mathematica then conducted 17 interviews with
4 state and federal officials as well as policy experts.
5 MACPAC staff also conducted additional interviews
6 with CMS and other policy experts to dive deeper into three
7 specific areas and to understand the implications of
8 potential policy changes. Those areas were technical
9 guides, renewal requirements, and cost neutrality.
10 States consider a number of factors when
11 selecting which HCBS authorities they will operate,
12 including the design flexibilities allowed under each
13 authority and the ability to waive various Medicaid
14 requirements found in Section 1902. This includes
15 statewideness, comparability of services, and community
16 income rules. And definitions for each are provided on the
17 slide.
18 States may also limit the number of HCBS
19 enrollees and cap individual resource budgets in order to
20 better predict and manage costs.
21 States also consider a number of other factors
22 when selecting federal authorities to design their HCBS

1 programs. This includes state capacity, including the
2 initial and ongoing financial investment, the
3 administrative complexity and burden on state resources,
4 and the need to balance direction from various
5 stakeholders, including state legislatures, beneficiaries,
6 and external stakeholders.
7 States also consider which populations they want
8 to serve and what services they would like to offer.
9 States also have to account for state policy goals, such as
10 direction received from the state legislature. And
11 finally, states sometimes make choices in response to
12 lawsuits.
13 MS. BLOM: Thank you, Tamara.
14 So now we'll move to our key findings grouped
15 under the five categories of administrative requirements
16 that we used for our policy scan and that were listed
17 earlier on slide 6.
18 For each of these categories, I'm going to review
19 state requirements and our findings, but in the interest of
20 time, I'll do kind of a high-level overview. But, of
21 course, the details for each of these categories can be
22 found in your materials.

1 So federal requirements related to reporting,
2 monitoring, and quality improvement vary across the 1915
3 authorities, of course, the four of them that we're talking
4 about today. All authorities, though, require that states
5 report annually to CMS on their programs.
6 States can rely on CMS technical guides for
7 reporting elements and guidance for programs that they're
8 operating under Sections 1915(c) and 1915(k). The Section
9 1915(c) technical guide is also generally applicable for
10 Section 1915(i).
11 In addition to annual reports for authorities
12 subject to renewal, which are 1915(c) and 1915(i), states
13 are required to conduct evidence-based reviews and report
14 the results to CMS two years prior to expiration of the
15 program. CMS reviews and completes a findings report, and
16 any items they identify have to be addressed by the state
17 before the renewal is approved.
18 Much of the feedback that we heard from states --
19 from interviewees -- sorry -- related to challenges using
20 CMS's reporting templates, submission portals, as well as
21 sort of the administrative burden of submitting those
22 reports.

1 So all 1915(c) -- 1915 -- sorry -- HCBS
2 authorities also have quality improvement requirements, but
3 how states demonstrate compliance with those varies. For
4 example, Section 1915(c) specifically requires states to
5 demonstrate that performance measures meet or exceed a
6 specific threshold of 90 percent in their 372 reports, but
7 for other authorities, those kinds of specific details are
8 not necessarily laid out.
9 States told us that they use the quality
10 monitoring data they collect for these federal requirements
11 for their own quality improvement purposes, but also
12 referenced administrative and technological challenges of
13 meeting those.
14 Specific federal requirements vary around
15 application, approval, and renewal processes, but states
16 must submit an application to CMS for all of the 1915
17 authorities. In some cases, it's web-based. In some
18 cases, it's a preprint. Section 1915(c) waivers, the most
19 common authority used for delivering HCBS, generally have
20 more complex and time-intensive requirements relative to
21 the other authorities, as you can kind of see here. For
22 example, the application itself is much longer than for the

1 others.

2 So this slide shows approval and renewal time
3 frames for Sections 1915(c) and 1915(i). Those are the
4 only HCBS authorities subject to renewal. Section 1915(c)
5 waivers are initially approved for three years or five if
6 the waiver is serving people who are dually eligible.
7 Section 1915(c) waivers are renewed every five years.

8 Section 1915(i) state plan amendments are
9 approved indefinitely unless the state chooses to restrict
10 eligibility to a specific population, in which case they
11 must be renewed every five years.

12 For both waivers and state plan options, states
13 can submit changes to CMS using the amendment process, such
14 as for changes to services offered or eligible populations.
15 And renewals allow the public to provide input on the
16 entire waiver and amendments with substantive changes
17 trigger an opportunity for public comment as well.

18 We heard from interviewees that renewals are
19 critical for oversight and overall program integrity as
20 they ensure that HCBS programs are complying with federal
21 law. Renewals also provide an opportunity for public
22 input. We heard that the renewal process is time

1 intensive, though, and can involve months of consultation
2 with CMS, with uncertainty around the timelines for
3 approval.
4 Some state officials we spoke with questioned the
5 need for a renewal process at all since CMS has the
6 opportunity to review any portion of the waiver whenever a
7 state requests an amendment, which is something that
8 happens with some frequency.
9 Interviewees told us that they value public input
10 and view it as critical to enhancing transparency among
11 states, community partners, and beneficiaries.
12 Requirements again for this kind of a common theme vary
13 across the authorities, but all authorities require this.
14 This slide is more focused on 1915(c) because
15 that's the authority most commonly used. It requires a
16 public comment process for waivers and amendments to
17 waivers. States must share the entire waiver with the
18 public and offer a comment period of 30 days. Sections
19 1915(i) and (k) also have specific public input
20 requirements.
21 States shared with us -- interviewees again
22 shared with us, there are challenges related to the delays

1 that sometimes the public comment periods can impose on
2 them. They lengthen the timeline for implementation and
3 for renewals and amendments.
4 Section 1915(c) waivers are the only HCBS
5 authority that has to comply with cost neutrality
6 requirements. Cost neutrality means that the average per-
7 person cost for waiver services should not be greater than
8 the average cost of the institutional services that would
9 have been provided if the waiver services were not
10 available.
11 Among HCBS authorities, this requirement is
12 unique to Section 1915(c), but similar provisions exist in
13 other Medicaid authorities, such as budget neutrality in
14 Section 1115. States use their annual CMS-372 reports to
15 demonstrate that they are in compliance with cost
16 neutrality. They must submit this report for each waiver
17 they administer, and interviewees we spoke with generally
18 agreed that states don't have trouble meeting the cost
19 neutrality requirements.
20 We heard mixed feedback from people we talked to
21 on eliminating the cost neutrality requirement.
22 Interviewees said that the data they used to demonstrate

1 cost neutrality can be useful in also demonstrating that
2 HCBS spending is lower than institutional care,
3 particularly in front of state leadership. Some federal
4 officials and policy experts indicated that eliminating it
5 could lead to an increase in HCBS spending to the extent
6 that states who were limiting their spending to stay under
7 the threshold relative to institutional care would increase
8 their spending in the absence of that threshold.
9 Several policy experts and state officials
10 expressed support for removing the requirement because of
11 the burden of demonstrating it through the annual CMS-372
12 report submissions and because the original reasons for
13 establishing this requirement back in the '80s when there
14 was uncertainty around how cost for providing care in the
15 community would compare to cost provided in an institution
16 are no longer relevant.
17 Federal requirements seek to safeguard conflicts
18 of interest in HCBS by separating the duties and
19 responsibilities of providers and defining clear roles.
20 For example, Section 1915(c) mandates that HCBS providers
21 cannot provide case management or develop person-centered
22 service plans, except in certain cases. Sections 1915(i)

1 and (k) limit who can conduct eligibility determinations,
2 level of care assessments, and develop PCSPs. Section
3 1915(j) requires that for providers who are involved in
4 developing PCSPs, the state has to ensure that the
5 provider's role is disclosed to the beneficiary.
6 States we talked to did not describe the
7 requirements around conflict of interest as burdensome.
8 Some said they can be tough to adhere to in rural areas or
9 Tribal communities where provider availability is limited
10 because the requirements can further limit provider options
11 for beneficiaries. Also, we heard that these requirements
12 can pose barriers to culturally competent care to the
13 extent that Tribal members, for example, prefer to see a
14 provider from their own community.
15 So, with that recap of the federal administrative
16 requirements in Section 1915 for HCBS, as well as our
17 findings around opportunities to streamline, let's move to
18 the recommendation.
19 So Recommendation 3.1 reads as follows: "To
20 reduce administrative burden for states and the federal
21 government, Congress should amend Section 1915(c)(3) and
22 Section 1915(i)(7)(C) of the Social Security Act to

1 increase the renewal period for home- and community-based
2 services programs operating under Section 1915(c) waivers
3 and Section 1915(i) state plan amendments from five years
4 to ten years."

5 Our rationale for this recommendation is that the
6 renewal process is resource-intensive for states and for
7 CMS, but at the same time, renewals are critical to
8 ensuring that states comply with federal policy and for
9 oversight of HCBS programs. This recommendation would
10 reduce the frequency of the renewals while maintaining the
11 critical elements they bring, such as oversight and public
12 comment.

13 The ten-year time frame aligns with federal
14 practice in that it has been used before for some Section
15 1115 demonstrations under the first Trump administration.
16 It is also the time frame used for the congressional budget
17 process where budget projections and cost estimates are
18 done over a ten-year budget window.

19 In terms of the implications of this
20 recommendation on federal spending, the Congressional
21 Budget Office indicated to us that this recommendation, if
22 enacted, is the type of policy change that could lead to

1 reductions in federal spending because of decreased state
2 administrative activities and the matching funds that
3 states would otherwise claim for those activities, but CBO
4 is not able to estimate changes in direct spending without
5 additional detail.

6 The recommendation, if enacted, would lead to
7 decreased administrative burden for states. It would have
8 no direct effect on enrollees but would extend the period
9 between opportunities for public comment that are
10 associated with renewals. The recommendation would have no
11 direct effect on health plans or on providers.

12 So, finally, in terms of next steps, we are happy
13 to take any Commissioner feedback or address any questions
14 that you have ahead of tomorrow's vote. This
15 recommendation, if approved by the Commission, will appear
16 in our March 2025 report to Congress.

17 So, with that, I'll turn it back to the Chair.

18 CHAIR JOHNSON: Thank you so much. We appreciate
19 the work that you all have done around this and looking
20 forward to talking about this issue and getting any
21 feedback that you all have.

22 So, with that, any comments from the

1 Commissioners? Questions?
2 Oh, Angelo.
3 COMMISSIONER GIARDINO: Again, great work, and I
4 appreciate the idea of moving something from five to ten
5 years, particularly with the work that you've done to show
6 that doing it more frequently isn't really helping. So I
7 think efficiency is a great thing.
8 Thank you.
9 CHAIR JOHNSON: Thank you, Angelo.
10 Mike?
11 COMMISSIONER NARDONE: Thanks for your work in
12 this area. I'm also supportive of this recommendation.
13 I did have a question just for clarification.
14 So, if we move this to ten years, do all the other
15 processes remain the same? So, in other words, evidentiary
16 process would be required two years before the ten-year?
17 And then also one of the things we talked about
18 earlier today was rates and the review of rates every five
19 years. I assume that would still be in place? I just
20 wanted some clarity around that.
21 MS. BLOM: Yeah. So anything tied to the renewal
22 would occur on this longer timeline, but anything not tied

1 to that, we weren't proposing any changes to rates or
2 anything like that.
3 COMMISSIONER NARDONE: I don't know how the
4 requirement reads in the statute or in the regulations, but
5 the requirement of five-year review of rates, that's
6 recommended? That would still be assumed would take place
7 even though we're moving to a ten-year time period?
8 MS. BLOM: Yeah, I think so. We hadn't
9 envisioned weighing in on that, that that would continue to
10 occur independent of the renewals.
11 COMMISSIONER NARDONE: Okay. Thank you.
12 The other thing I just would urge you to do in
13 future work -- I know a lot of the focus on this work was
14 around the cost neutrality requirement, but I would suggest
15 that we take a look at are there ways to streamline some of
16 the pieces of the 372 document. I think we talked -- when
17 this topic came up last time, I was reflecting back on some
18 of the back-and-forth on 372 quality indicators, both from
19 my time at the state as well as my time working at CMS, and
20 found that there's a lot of data that's produced that I'm
21 not sure moves -- it really helps with the quality
22 framework. And now that we're moving towards more

1 standardized quality metrics that HCBS programs are going
2 to have to report on, I would think that potentially opens
3 up opportunities for streamlining some of these other
4 quality metrics that states are reporting on now.
5 And I think that that is an opportunity for
6 additional flexibility, and I would just urge you -- that I
7 would hope that we would continue to look at that. I think
8 that really requires someone with a lot more expertise than
9 me to look at 372s, but I think that there is value in
10 looking at that as a way that we could -- particularly as
11 we're moving to more of a national standardized framework
12 around quality metrics, to further ease the burden on the -
13 - you know, the renewals of the waivers and the annual
14 reporting requirements.
15 Thank you.
16 CHAIR JOHNSON: Thank you, Mike.
17 Patti?
18 COMMISSIONER KILLINGSWORTH: A couple of things,
19 and I reiterate appreciation for the good work here and for
20 listening to the feedback that we've provided.
21 Kind of following up on Mike's comment first as
22 it relates to 372s, I've done them for decades. I can tell

1 you that the burden, some part of it, is not so much the
2 financial reporting, because those are typically reports
3 that are generated through the Medicaid Management
4 Information System. The system spits them out, if you
5 will, once those are developed. And so there is always
6 some work on invalidating, but the bulk of the work really,
7 as Mike pointed out, is around the quality reporting that
8 accompanies those 372 reports, which I agree needs to be
9 reconsidered in light of the new quality reporting
10 requirements that CMS has imposed. Instead of just keeping
11 on, we really need to think about whether we're going to
12 focus on outcomes or continue to focus on what are largely
13 compliance-based measures and the frequency with which that
14 needs to be done.
15 The second thing I would just say -- and I'm
16 sorry that I sound like a broken record, but I think it's
17 important to be on the record -- is that we are once again
18 looking at another example of institutional bias in the law
19 and regulation. Institutional services don't ever have to
20 be renewed. Once elected in the state plan, they are
21 covered indefinitely. There is no evidence package
22 gathering at intermittent points.

1 The things that apply to continue to offer a more
2 integrated and least costly benefit to people faces a much
3 higher barrier in terms of administrative requirements, and
4 that's something that we need to continue to raise and hope
5 that at some point Congress will finally listen.
6 CHAIR JOHNSON: Thank you, Patti.
7 Any other Commissioners?
8 [No response.]
9 CHAIR JOHNSON: Okay. Well, clearly again, job
10 well done. We appreciate it and look forward to the vote
11 tomorrow for sure. Thank you both.
12 MS. BLOM: Thank you.
13 CHAIR JOHNSON: All right. So now we will
14 actually open it up for our final public comment today.
15 Again, we invite people in the audience to raise your hand
16 if you'd like to offer comments. Please make sure you
17 introduce yourself and the organization that you represent,
18 and we do ask that you keep your comments to three minutes
19 or less.
20 And so, with that, do we have any comments?
21 **### PUBLIC COMMENTS**
22 * [No response.]

1 CHAIR JOHNSON: All right. Looks like we have no
2 comments, but I do want to remind you that at that later
3 time if you have a comment to please submit them on the
4 MACPAC website.
5 And with that, we will adjourn for the day and
6 see you all back here tomorrow at 10 a.m. Eastern. All
7 right. Thank you so much. Have a good evening.
8 * [Whereupon, at 3:24 p.m., the meeting was
9 recessed, to reconvene at 10:00 a.m., Friday, January 24,
10 2025.]
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PUBLIC SESSION

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

Friday, January 24, 2025
10:00 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
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
MICHAEL NARDONE, MPA
JAMI SNYDER, MA

KATHERINE MASSEY, MPA, Executive Director

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1 P R O C E E D I N G S

2 [10:00 a.m.]

3 CHAIR JOHNSON: Good morning, everyone, and thank
4 you for joining MACPAC for its second and final. We are
5 really looking forward to today's conversation, and we are
6 actually going to kick off our session with a vote on the
7 EQR and HCBS policy options we discussed on Thursday.

8 With that, as a voting meeting, MACPAC's
9 conflicts of interest rules are in effect. For your
10 awareness, our policies publicly posted on the MACPAC
11 website for reference. As required by our statutory
12 authority, MACPAC's Commissioners bring diverse
13 backgrounds, experiences, and expertise to the table, and
14 this diversity enhances our work, but also means we all
15 bring reportable interests to our discussions and decision-
16 making processes.

17 To ensure the integrity of our deliberations,
18 MACPAC's conflicts of interest policy is in place to
19 identify and disclose potential conflicts that might arise
20 during voting meetings.

1 Now here is a quick overview of elements of the
2 policy.
3 Commissioners are required to report certain
4 financial and other interests, both at the time of their
5 candidacy and annually thereafter. These reportable
6 interests, which are publicly available on the MACPAC
7 website, help us determine whether an interest could rise
8 to the level of potential conflict during a vote.
9 Under our policy, conflicts are assessed based on
10 four criteria: the interest must be particularly, directly,
11 predictably, and significantly affected by the outcome of
12 the vote.
13 To manage potential conflicts, the MACPAC Chair
14 appoints a Conflicts of Interest Committee composed of
15 Commissioners representing a range of perspectives. Before
16 voting begins, the committee reviews reportable interests
17 and any additional relevant information.
18 For today's meeting, the Conflicts of Interest
19 Committee met by conference call on January 9th, and
20 determined that based on that criteria no Commissioner has
21 a potential or an actual conflict of interest related to

1 the recommendations we are voting on today. Our Vice
2 Chair, Bob Duncan, chairs the committee, and the committee
3 members are Sonja Bjork, Jennifer Gerstorff, Angelo
4 Giardino, Tim Hill, and Jami Snyder. And I want to thank
5 the committee for your diligence and your service.
6 And with that I will turn it over to Kate to
7 facilitate the vote.

8 **### VOTE ON RECOMMENDATIONS FOR THE MARCH REPORT TO**
9 **CONGRESS**

10 * EXECUTIVE DIRECTOR MASSEY: Thanks, Verlon. So
11 we will start with a review of the EQR recommendations.
12 MS. REYNOLDS: Good morning. Our first
13 Recommendation 1.1:
14 The Secretary of the U.S. Department of Health
15 and Human Services should direct the Centers for Medicare &
16 Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to
17 require the external quality review annual technical report
18 include outcomes data and results from quantitative
19 assessments collected and reviewed as part of the
20 compliance review mandatory activity specified at 42 CFR
21 438.358(b)(1)(iii).

1 EXECUTIVE DIRECTOR MASSEY: So there are several
2 EQR recommendations, but we will vote on them individually.
3 So I will call roll.
4 Heidi Allen?
5 COMMISSIONER ALLEN: Yes.
6 EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?
7 COMMISSIONER BJORK: Yes.
8 EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?
9 COMMISSIONER BROOKS: Yes.
10 EXECUTIVE DIRECTOR MASSEY: Doug Brown?
11 COMMISSIONER BROWN: Yes.
12 EXECUTIVE DIRECTOR MASSEY: Bob Duncan?
13 VICE CHAIR DUNCAN: Yes.
14 EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?
15 COMMISSIONER GERSTORFF: Yes.
16 EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?
17 COMMISSIONER GIARDINO: Yes.
18 EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?
19 COMMISSIONER HEAPHY: Yes.
20 EXECUTIVE DIRECTOR MASSEY: Tim Hill?
21 COMMISSIONER HILL: Yes.

1 EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?
2 COMMISSIONER INGRAM: Yes.
3 EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?
4 COMMISSIONER KILLINGSWORTH: Yes.
5 EXECUTIVE DIRECTOR MASSEY: John McCarthy?
6 COMMISSIONER McCARTHY: Yes.
7 EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?
8 COMMISSIONER McFADDEN: Yes.
9 EXECUTIVE DIRECTOR MASSEY: Mike Nardone?
10 COMMISSIONER NARDONE: Yes.
11 EXECUTIVE DIRECTOR MASSEY: Jami Snyder?
12 COMMISSIONER SNYDER: Yes.
13 EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?
14 CHAIR JOHNSON: Yes.
15 EXECUTIVE DIRECTOR MASSEY: Okay, so that is 16
16 in favor, and just as a reminder, we have 1 vacancy on the
17 Commission.
18 Can we move to Recommendation 1.2?
19 MS. REYNOLDS: Recommendation 1.2 reads:
20 The Secretary of the U.S. Department of Health
21 and Human Services should direct the Centers for Medicare &

1 Medicaid Services to update external quality review (EQR)
2 protocols to (1) reduce areas of duplication with other
3 federal quality and oversight reporting requirements, (2)
4 create a more standardized structure in the annual
5 technical report that summarizes EQR activities, results,
6 and actions taken by state Medicaid agencies, and (3)
7 identify key takeaways on plan performance.
8 EXECUTIVE DIRECTOR MASSEY: Okay. Let's call
9 roll.
10 Heidi Allen?
11 COMMISSIONER ALLEN: Yes.
12 EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?
13 COMMISSIONER BJORK: Yes.
14 EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?
15 COMMISSIONER BROOKS: Yes.
16 EXECUTIVE DIRECTOR MASSEY: Doug Brown?
17 COMMISSIONER BROWN: Yes.
18 EXECUTIVE DIRECTOR MASSEY: Bob Duncan?
19 VICE CHAIR DUNCAN: Yes.
20 EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?
21 COMMISSIONER GERSTORFF: Yes.

1 EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?
2 COMMISSIONER GIARDINO: Yes.
3 EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?
4 COMMISSIONER HEAPHY: Yes.
5 EXECUTIVE DIRECTOR MASSEY: Tim Hill?
6 COMMISSIONER HILL: Yes.
7 EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?
8 COMMISSIONER INGRAM: Yes.
9 EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?
10 COMMISSIONER KILLINGSWORTH: Yes.
11 EXECUTIVE DIRECTOR MASSEY: John McCarthy?
12 COMMISSIONER McCARTHY: No.
13 EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?
14 COMMISSIONER McFADDEN: Yes.
15 EXECUTIVE DIRECTOR MASSEY: Mike Nardone?
16 COMMISSIONER NARDONE: Yes.
17 EXECUTIVE DIRECTOR MASSEY: Jami Snyder?
18 COMMISSIONER SNYDER: Yes.
19 EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?
20 CHAIR JOHNSON: Yes.

1 EXECUTIVE DIRECTOR MASSEY: Okay. So that's 15
2 in support, 1 no, and 1 vacancy.
3 Okay, 1.3?
4 MS. REYNOLDS: Recommendation 1.3 reads:
5 The Secretary of the U.S. Department of Health
6 and Human Services should direct the Centers for Medicare &
7 Medicaid Services (CMS) to require states to publish
8 external quality review (EQR) annual technical reports in a
9 508-compliant format and for CMS to publicly post all state
10 EQR reports in a central repository on the CMS website.
11 EXECUTIVE DIRECTOR MASSEY: Okay. Heidi Allen?
12 COMMISSIONER ALLEN: Yes.
13 EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?
14 COMMISSIONER BJORK: Yes.
15 EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?
16 COMMISSIONER BROOKS: Yes.
17 EXECUTIVE DIRECTOR MASSEY: Doug Brown?
18 COMMISSIONER BROWN: Yes.
19 EXECUTIVE DIRECTOR MASSEY: Bob Duncan?
20 VICE CHAIR DUNCAN: Yes.
21 EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

1 COMMISSIONER GERSTORFF: Yes.

2 EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

3 COMMISSIONER GIARDINO: Yes.

4 EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

5 COMMISSIONER HEAPHY: Yes.

6 EXECUTIVE DIRECTOR MASSEY: Tim Hill?

7 COMMISSIONER HILL: Yes.

8 EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

9 COMMISSIONER INGRAM: Abstain.

10 EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

11 COMMISSIONER KILLINGSWORTH: Yes.

12 EXECUTIVE DIRECTOR MASSEY: John McCarthy?

13 COMMISSIONER McCARTHY: Yes.

14 EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

15 COMMISSIONER McFADDEN: Yes.

16 EXECUTIVE DIRECTOR MASSEY: Mike Nardone?

17 COMMISSIONER NARDONE: Yes.

18 EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

19 COMMISSIONER SNYDER: Yes.

20 EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

21 CHAIR JOHNSON: Yes.

1 EXECUTIVE DIRECTOR MASSEY: Okay. So that's 15
2 in support, 1 abstention, and just reminding everyone about
3 the 1 vacancy.
4 Okay. So just give us a minute while we switch
5 chairs, so that the analysts can read the HCBS
6 recommendations.
7 [Pause.]
8 MS. HUSON: Recommendation 2.1 reads:
9 The Secretary of the U.S. Department of Health
10 and Human Services should direct the Centers for Medicare &
11 Medicaid Services to issue guidance on how states can use
12 provisional plans of care, including policy and operational
13 considerations, under Section 1915(c), Section 1915(I),
14 Section 1915(k), and Section 1115 of the Social Security
15 Act.
16 EXECUTIVE DIRECTOR MASSEY: Thanks. Heidi Allen?
17 COMMISSIONER ALLEN: Yes.
18 EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?
19 COMMISSIONER BJORK: Yes.
20 EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?
21 COMMISSIONER BROOKS: Yes.

1 EXECUTIVE DIRECTOR MASSEY: Doug Brown?

2 COMMISSIONER BROWN: Yes.

3 EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

4 VICE CHAIR DUNCAN: Yes.

5 EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

6 COMMISSIONER GERSTORFF: Yes.

7 EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

8 COMMISSIONER GIARDINO: Yes.

9 EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

10 COMMISSIONER HEAPHY: Yes.

11 EXECUTIVE DIRECTOR MASSEY: Tim Hill?

12 COMMISSIONER HILL: Yes.

13 EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

14 COMMISSIONER INGRAM: Yes.

15 EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

16 COMMISSIONER KILLINGSWORTH: Yes.

17 EXECUTIVE DIRECTOR MASSEY: John McCarthy?

18 COMMISSIONER McCARTHY: Yes.

19 EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

20 COMMISSIONER McFADDEN: Yes.

21 EXECUTIVE DIRECTOR MASSEY: Mike Nardone?

1 COMMISSIONER NARDONE: Yes.

2 EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

3 COMMISSIONER SNYDER: Yes.

4 EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

5 CHAIR JOHNSON: Yes.

6 EXECUTIVE DIRECTOR MASSEY: Great. 16 in

7 support, 1 vacancy.

8 And then our last recommendation.

9 MS. BLOM: Recommendation 3.1 reads:

10 To reduce administrative burden for states and

11 the federal government, Congress should amend Section

12 1915(c)(3) and Section 1915(i)(7)(C) of the Social Security

13 Act to increase the renewal period for home- and community-

14 based services programs operating under Section 1915(c)

15 waivers and Section 1915(I) state plan amendments from 5

16 years to 10 years.

17 EXECUTIVE DIRECTOR MASSEY: Thanks. Heidi Allen?

18 COMMISSIONER ALLEN: Yes.

19 EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

20 COMMISSIONER BJORK: Yes.

21 EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

1 COMMISSIONER BROOKS: Yes.

2 EXECUTIVE DIRECTOR MASSEY: Doug Brown?

3 COMMISSIONER BROWN: Yes.

4 EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

5 VICE CHAIR DUNCAN: Yes.

6 EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

7 COMMISSIONER GERSTOFF: Yes.

8 EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

9 COMMISSIONER GIARDINO: Yes.

10 EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

11 COMMISSIONER HEAPHY: Yes.

12 EXECUTIVE DIRECTOR MASSEY: Tim Hill?

13 COMMISSIONER HILL: Yes.

14 EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

15 COMMISSIONER INGRAM: Yes.

16 EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

17 COMMISSIONER KILLINGSWORTH: Yes.

18 EXECUTIVE DIRECTOR MASSEY: John McCarthy?

19 COMMISSIONER McCARTHY: Yes.

20 EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

21 COMMISSIONER McFADDEN: Yes.

1 EXECUTIVE DIRECTOR MASSEY: Mike Nardone?
2 COMMISSIONER NARDONE: Yes.
3 EXECUTIVE DIRECTOR MASSEY: Jami Snyder?
4 COMMISSIONER SNYDER: Yes.
5 EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?
6 CHAIR JOHNSON: Yes.
7 EXECUTIVE DIRECTOR MASSEY: Okay. 16 in support,
8 and again, noting the 1 vacancy. Thanks, everyone.
9 VICE CHAIR DUNCAN: All right. I would like to
10 congratulate our Chair for her first official voting
11 process for tenure.
12 VICE CHAIR DUNCAN: Now we will transition into
13 Children and Youth with Special Health Care Needs:
14 Transitions from Pediatric to Adult Care Policy Options.
15 We've got Ava and Joanne joining us. We look
16 forward to hearing some of the results from the feedback of
17 our last meeting and where we move forward with this. So
18 thank you and look forward to hearing.
19 **### CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE**
20 **NEEDS: TRANSITIONS FROM PEDIATRIC TO ADULT CARE**
21 **POLICY OPTIONS**

1 * MS. AVA WILLIAMS: Thank you and good morning,
2 Commissioners.
3 Today Joanne and I will be presenting revised
4 policy options for our work on children and youth with
5 special health care needs, transitions of care. I will
6 start by highlighting some key background information
7 related to transitions of care in Medicaid as well as how
8 other federal and state agencies support children and youth
9 with special health care needs during their transitions. I
10 will then give a brief recap of findings from this work
11 before walking through the revisions to the policy options
12 based on Commissioner feedback. I will then end with next
13 steps and questions for Commissioners.
14 As a reminder, our objective for this project was
15 to examine how state Medicaid programs and MCOs
16 operationalize their transition of care policies for
17 children, youth, and special health care needs, how
18 beneficiaries and their families experience transitions,
19 and to identify whether barriers to transitions can be
20 addressed in federal policy.

1 During the course of this project, we have
2 completed a literature review, a federal and state policy
3 scan including all 50 state and D.C.'s interagency
4 agreements, also known as IAAs, as well as stakeholder
5 interviews and beneficiary and caregiver focus groups.
6 The bullets on this slide may seem familiar, but
7 I wanted to remind Commissioners of some key background
8 information. For example, when children, youth with
9 special health care needs reach adulthood, they need to
10 transition from a pediatric model of care to an adult one.
11 There's no standard transition process. However,
12 professional organizations have developed frameworks for
13 transitions with similar components, such as developing an
14 individualized transition plan.
15 Some state Medicaid agencies have transition of
16 care strategies still detailed in waivers and MCO
17 contracts, but there is variation in their components,
18 including if there's development of an individualized
19 transition of care plan.
20 Few beneficiaries and families share that they
21 were aware of their state's transition strategy, had a

1 service or care coordinator support them through the
2 transition, and received an individualized transition of
3 care plan.
4 In December, Commissioners requested more
5 information about the Health Resources and Services
6 Administration, also known as HRSA. HRSA is housed within
7 the Department of Health and Human Services, HHS, and has a
8 key programmatic focus of improving the livelihoods of
9 children, youth with special health care needs and their
10 transitions.
11 For example, HRSA has awarded grants to states to
12 increase the number of children, youth with special health
13 care needs who receive a patient and family-centered
14 medical home approach to comprehensive coordinated services
15 and supports, including their transitions of care.
16 Additionally, the Maternal and Child Health
17 Bureau within HRSA has developed the Blueprint for Change,
18 which includes resources for stakeholders, children, youth
19 with special health care needs, and their families to
20 improve the livelihood of this population with a focus on
21 their transitions.

1 The Maternal and Child Health Bureau also
2 administers Title V block grants to states, which can be
3 used to provide direct enabling and public health services
4 to improve the health and women, children, and families
5 through state Title V agencies.
6 Title V agencies are also required to use at
7 least 30 percent of their grant to improve primary and
8 preventative health care services for children, youth with
9 special health care needs, including case management and
10 care coordination services.
11 Additionally, state Medicaid agencies are
12 required to coordinate with state Title V agencies on
13 mutual objectives, roles, and responsibilities related to
14 their overlapping populations, such as children, youth with
15 special health care needs and IAAs. However, they are not
16 required to coordinate on transitions of care.
17 Next, I will go through a brief recap of the
18 findings.
19 Findings from family advocate interviews and
20 beneficiary and caregiver focus groups indicate that
21 beneficiaries and their families experience challenges with

1 locating information on their state's transition of care
2 strategy. Additionally, some service or care coordinators
3 assigned to beneficiaries and their families were unaware
4 of the state's transition strategy and unable to support
5 them during their transitions.
6 Findings from the literature review, stakeholder
7 interviews, and focus groups indicate that a structured
8 transition of care approach that includes an individualized
9 transition of care plan improves outcomes for children,
10 youth with special health care needs.
11 We also found that some states cover transition-
12 related services using a variety of existing authorities.
13 However, some states may be unaware of how these
14 authorities can be used.
15 Findings from our state policy scan and
16 stakeholder interviews indicate that states are not
17 required to and do not collect information related to
18 children, youth with special health care needs and their
19 transitions, creating a barrier to stakeholders'
20 understanding of this population and their needs.

1 Finally, findings from our state policy scan and
2 stakeholder interviews indicate that state Medicaid and
3 Title V agencies are not required to coordinate on
4 children, youth with special health care needs transitions
5 of care, and few currently coordinate on this population's
6 transitions.

7 Now I will go over the revisions to the policy
8 options based on Commissioner feedback.

9 This slide should also look familiar. It shows
10 challenges identified in our work and the policy objectives
11 and options for addressing these challenges.

12 Given the challenges beneficiaries and caregivers
13 had in locating information on their state's transition of
14 care strategy and receiving support during their
15 transitions, our first policy option specifies that
16 Congress should require states to develop a strategy for
17 transitions of care for children, youth with special health
18 care needs that includes an individualized transition of
19 care plan, the entity responsible for developing and
20 implementing the individualized transition of care plan,

1 time frames for the transition, and making the state's
2 strategy publicly available.
3 The revisions to this policy option clarify that
4 this is not a new mandatory benefit and is meant to require
5 states to document their transition strategies. Some
6 states may decide to describe their existing transition
7 strategies without changes, while others may decide to make
8 policy or programmatic changes, but states would retain
9 flexibility to determine the transition strategies that
10 work best for their children, youth with special health
11 care needs population, delivery system, and program design.
12 Additionally, policy options 1 and 2 now include all
13 children who have an institutional level of care need.
14 Given the findings related to the challenges
15 states may experience when trying to cover transition-
16 related services, our second policy option states that the
17 Secretary of HHS should direct CMS to issue guidance to
18 states on existing authorities to cover transition of care-
19 related services for children, youth with special health
20 care needs.

1 In December, Commissioners had a conversation
2 around this policy option, including, for example, what the
3 guidance should address. Since the policy option language
4 provides flexibility to the Secretary and CMS to decide
5 what could be included in the guidance, we left the option
6 as we presented it last month.
7 Given the findings that states are not required
8 to and do not collect data related to children, youth, and
9 -- children, youth with special health care needs and their
10 transitions, the third policy option specifies that the
11 Secretary of HHS should direct CMS to require states to
12 collect and report data related to, if beneficiaries
13 receive transition-related services, including the receipt
14 of an individualized transition of care plan.
15 Additionally, states should collect and report
16 data related to beneficiary and caregiver experience with
17 transitions.
18 The revisions to this policy option clarify that
19 this option does not require states to develop or collect
20 measures related to quality of care or outcomes for
21 children, youth with special health care needs transitions

1 of care, but instead states should collect and report data
2 related to the number of children, youth with special
3 health care needs receiving transition-related services,
4 what services they are receiving, as well as if
5 beneficiaries receive an individualized transition of care
6 plan.
7 Additionally, based on Commissioner feedback,
8 staff included that states should collect and report data
9 related to beneficiary and caregiver experience.
10 Lastly, given the finding that state Medicaid and
11 Title V agencies often do not coordinate on children, youth
12 with special health care needs transitions of care, the
13 fourth policy option indicates that the Secretary of HHS
14 should direct CMS to require that IAAs between state
15 Medicaid agencies and Title V agencies specify roles and
16 responsibilities for supporting children, youth with
17 special health care needs transitions from pediatric to
18 adult care.
19 This policy option is the same as it was last
20 month, but based on your conversation last month, we wanted
21 to clarify what is currently included in IAAs related to

1 children, youth with special health care needs transitions
2 of care.
3 We reviewed IAAs in each state and D.C. and found
4 that only four IAAs describe state Medicaid and Title V
5 agencies' coordination on this population's transitions but
6 with very little detail. For example, two IAAs state that
7 the agencies will develop messaging related to transitions
8 of care but did not describe what should be included in the
9 messaging.
10 Another IAA states that agencies will coordinate
11 on endeavors related to transitions of care but does not
12 describe what this should entail.
13 Today we would appreciate your feedback on the
14 revised policy options and which of these you would like to
15 advance for the June report to Congress. The four policy
16 options are viewed as complementary efforts to improve
17 children, youth with special health care needs transitions
18 of care but could also stand on their own.
19 Depending on feedback from the Commission, we
20 plan to draft the chapter for the June report to Congress.
21 If there is support for moving forward with these policy

1 options, staff would have returned with recommendation
2 language.
3 Thank you. I'll now turn it back to the Vice
4 Chair to begin Commissioner discussion.
5 VICE CHAIR DUNCAN: Thank you, Ava. Thank you,
6 Joanne, and thank you, Linn, who's not here for this great
7 work. It's greatly appreciated. It's nice to see the
8 feedback that was given at the last meeting incorporated.
9 So open it up now, Commissioners, for what you've
10 heard after our last meeting and where they've come back.
11 Any suggestions or feedback?
12 All right. Patti?
13 COMMISSIONER KILLINGSWORTH: First of all, I
14 agree with Bob and just appreciate the work that all three
15 of you have done here. I think this is really important
16 work, and I fully support the policy options.
17 I have just a couple of slight clarifications
18 that I would request that we make. In policy options 1 and
19 2, the language refers to children who require an
20 institutional level of care, which I think could be
21 misinterpreted to include only those children who are

1 actually institutionalized, which would not be our intent.
2 We want to be inclusive of children who would need an
3 institutional level of care but have opted for care in the
4 community.
5 So if we could change "who require" to something
6 like "who qualify for" or something along those lines who
7 meet an institutional level of care, I think language along
8 those lines might be more clear and less subject to
9 misinterpretation, and then if we can just make that clear
10 in the chapter.
11 And then in policy option 3, there's just a
12 slight misalignment between the actual policy option and
13 the next page of clarification. So the policy option says
14 that beneficiary and caregiver experience would be reported
15 to CMS. The clarifications say that it would be collected
16 but doesn't say reported to CMS. And so I think we should
17 make sure that both of those align and that we decide
18 whether or not the beneficiary caregiver experience data
19 should be reported to CMS, and if so, ideally, it could be
20 done so in a consistent way so that that data is useful for
21 comparison purposes across states.

1 Thank you again.

2 VICE CHAIR DUNCAN: Thank you, Patti.

3 Tim, then Dennis.

4 COMMISSIONER HILL: Thanks. This is important
5 work and -- I'm sorry. I'm used to being on a video call,
6 and I unmuted myself. And I should not have.

7 This has been rattling around in my head since
8 the last time we talked about this, and at the risk of
9 sounding uber bureaucratic, but I think it's important, I
10 get frustrated in these conversations where there is
11 supposedly coordination or not between HRSA and CMS on
12 populations that need some attention, right? And just
13 knowing from my experience inside the building, getting
14 them to talk, even when you have a recommendation that they
15 talk, is hard.

16 And so I wonder if there's an appetite for -- and
17 I don't have a good suggestion here -- a more aggressive
18 recommendation for HRSA and CMS to coordinate on the
19 agreements, because I just worry that they'll just be kind
20 of t's his problem, it's his problem, and not sort of

1 really directing it. And so I don't have a good
2 suggestion, and maybe we can follow up later.
3 But I thought about it last time, didn't want to
4 say it because it sounded wicked bureaucratic, but just
5 remembering what it was like in the building to get two
6 agencies to talk, it's really hard. And so maybe we should
7 be a little more aggressive.
8 COMMISSIONER INGRAM: Tim, just to clarify, are
9 you talking about option number 4?
10 COMMISSIONER HILL: Yeah.
11 COMMISSIONER INGRAM: Okay. And just to follow
12 up on this question -- and I know I'm out of order, but I
13 read that as state agency. But you're reading it as
14 federal agency?
15 COMMISSIONER HILL: Well, the agreement is at the
16 state level, but my worry is if we can't get HRSA and CMS
17 to agree on what should be in those agreements and kind of
18 direct the Medicaid agency and the Title V agency to do
19 things in the way that are going to be serving this
20 population, that's kind of where I'm going, if that makes
21 sense.

1 COMMISSIONER KILLINGSWORTH: Yes, that makes
2 sense. Thank you for clarifying.
3 MS. JEE: I think there's a little bit of
4 guidance on the IAAs at the federal level. So we could
5 take a look at what that guidance says to see if there's
6 anything that we can think about and bring back.
7 VICE CHAIR DUNCAN: Thank you, Tim, and I
8 appreciate you bringing your lived experiences in that,
9 because it doesn't do us any good to make recommendations
10 that can't be enacted. So thank you.
11 All right. Dennis.
12 COMMISSIONER HEAPHY: Thank you.
13 I think you did great work on everything you've
14 done here.
15 But I've got a recommendation for policy No. 1,
16 and these are based on recognition that care plans often
17 never get realized or implemented. And so where it says
18 the transition of -- it says -- I think it's number -- it's
19 one within policy recommendation 1, the only responsible
20 developing and implementing the individualized transition
21 of care plan. And then also, I put position -- transition

1 to care plan, that includes the names and positions of both
2 paid and non-paid coordination members or care plan
3 development members.
4 And that also to add, and No. 2, the name and
5 sign-off of adult primary care provider responsible for
6 implementing the plan, because too often, there's really --
7 there's not going -- there is no primary care provider to
8 hand off the person to who's going to be coordinating their
9 care. And so without having that name, there's someone
10 responsible there. The person's not going to get the
11 services they require, and so it's just to tell them that
12 the young adult is left in limbo as is their family.
13 And then in No. 4 -- well, before I go to No. 4,
14 do you have questions or thoughts, comments on that?
15 [No response.]
16 COMMISSIONER HEAPHY: Okay. And then policy
17 option No. 4, it's great that it says Title V agencies, but
18 these folks are often covered by multiple agencies in the
19 state that do not always communicate with each other. And
20 that would include the Department of Mental Health in the
21 state, Department of Developmental Services in the state.

1 And so I'd recommend putting Title V and other
2 agencies that work with the individual now and into the
3 future as an adult.
4 And where this is really important is because
5 folks move from all these inclusive services in school
6 until they're 21, and then they're handed off and they go
7 to an ACO. And the ACO, the person may get great services
8 as a kid, but as someone who's autistic -- and then they're
9 caught between DDS as an adult or the Department of Mental
10 Health as an adult. And so you want to make sure that
11 there's coordination between all the different agencies
12 that this person's going to be interacting with for the
13 rest of their life at the start and not having the families
14 have to deal with these, being trapped between the multiple
15 agencies as they're trying to get the person's health plan
16 and care together.
17 MS. JEE: Yeah, thanks for that comment, Dennis.
18 I think the idea of the multi-agency involvement
19 with these kids is something that we are hearing a lot
20 about in this project and in others. So we can definitely

1 go back and see what we can build into the chapter to make
2 that point.
3 I will just note that the regulatory citation
4 that you see in this recommendation is particular to the
5 IAAs between Medicaid and Title V. So I just wanted to
6 note that for you.
7 COMMISSIONER HEAPHY: Thank you.
8 MS. JEE: But we can definitely do some work in
9 the chapter language.
10 COMMISSIONER HEAPHY: Thank you.
11 And then what about providing an adult primary
12 care provider sign-off? Because there's got to be someone
13 that's going to take responsibility for these plans.
14 Otherwise, they're not implemented, and the folks are just
15 languishing without a primary care provider. And so a care
16 plan may be well written, but if there's no one that's
17 going to implement, it really has no value. This goes to,
18 I think, what Tim was saying as well. It's not going to
19 happen. Very frustrating.

1 MS. AVA WILLIAMS: Yeah. That's a very important
2 comment, and that's something that we heard throughout the
3 project.
4 The purpose of this policy option was to not be
5 prescriptive for states and allow flexibility. There's
6 several frameworks, such as Got Transition, Six Core
7 Elements, that detail that that's an important part of the
8 transition process. But we can definitely take that back
9 and see how can integrate that into the chapter language.
10 Thank you.
11 COMMISSIONER HEAPHY: Thank you.
12 VICE CHAIR DUNCAN: All right. Carolyn, then
13 John.
14 COMMISSIONER INGRAM: Thank you for putting this
15 together and making changes from our last conversation. I
16 wanted to go to Policy Option 3. And I know in the last
17 meeting we talked about our, I guess, concerns about
18 wanting more specificity, and maybe this is written vaguely
19 on purpose to give flexibility.
20 But I still struggle a little bit with what the
21 amount of burden and how and what data would be collected

1 in this area, and what costs would be then increased or
2 incurred by having to create platforms to collect and
3 report this out, because it is so broad and so vague.
4 So I'm wondering if there is any other
5 specificity that we need to provide or something we could
6 do to limit this looking like it's just going to boil the
7 ocean with gathering all this data.
8 MS. AVA WILLIAMS: I guess my first comment would
9 be we have sent these options over CBO and we haven't
10 received a score, so we can come back with that.
11 And my second comment would be yes to your first
12 thing that you said. It is written broadly on purpose.
13 And the team has been discussing what can and cannot be
14 used, what can and cannot be collected, and what would be
15 important.
16 I guess the one thing I would say about this
17 option is that it's meant to develop a baseline for this
18 information because there is just so little collected
19 already. During our project we had heard from researchers
20 and national experts on what could be collected. They had
21 several ideas, but they also noted the difficulty with

1 collecting information on this population, since it is so
2 small.
3 But yes, the team can definitely take it back and
4 try to think more about what could be collected and what is
5 boiling the ocean. Thank you.
6 COMMISSIONER INGRAM: And I think if we could
7 look at some of the contracts and what is required in terms
8 of collection around children transitioning, because there
9 are contract requirements in states that have managed care
10 that cover these populations. Did we already look at that,
11 about what's required to be reported, and maybe there's
12 something there. Because I know, at least in a lot of
13 states we operate, and Sonja may have more feedback on
14 this, as well, we are required to capture this information
15 and have the plans of care available for the state for
16 auditing.
17 And so I'm wondering if there is something in
18 some of those contracts that we could look at and use as a
19 way to talk about a baseline. So that you're thinking
20 about the number of individuals that are being served in a
21 transition, assuring they have a care plan with outcomes in

1 it, because we want it to be outcome-driven, without just
2 being so burdensome with the data. So in other words,
3 playing off of something that's already actually in
4 existence out there, just making the reporting of it more
5 public. I think that's what we're missing here.
6 MS. AVA WILLIAMS: Yes, I completely understand
7 that. During our work we did look at what states do
8 currently collect, and they don't collect information
9 specifically on children and youth with special health care
10 needs in their transitions, but in their normal collecting
11 reporting they do collect information related to
12 transitions, that could be related to transitions. I'm not
13 remembering off the top of my head how many we looked at,
14 but I can definitely go back and look and see what they're
15 already saying.
16 I guess I will say, any of the states that we've
17 talked to, like interview-wise, they didn't explicitly
18 state that they were collecting specifically on this
19 population in transitions, but noted what I just noted,
20 that some of their collection could be capturing this.
21 COMMISSIONER INGRAM: Thank you.

1 VICE CHAIR DUNCAN: Thank you, Carolyn. John,
2 then Mike, then Dennis.
3 COMMISSIONER McCARTHY: Can we go back to Policy
4 Option 4? When I first read this, I was like, oh yeah,
5 this is good. And then Dennis brought up an excellent
6 point about the other agencies. And then I got a little
7 concerned after you brought that up because -- and then
8 we've got the legal issue that, in statute, the Medicaid
9 agency is a single state agency. And so I'm assuming that
10 is kind of with this policy option, we are saying, in
11 essence, Medicaid is a single state agency. You are the
12 one that's -- you know, you've got to have an interagency
13 agreement with the Title V agency because that's, by law,
14 kind of how those things are done.
15 But I agree with Dennis because in so many states
16 the other agencies may be under a Secretary, so within the
17 same agency, but like in Ohio, the Department of
18 Developmental Disabilities is a completely separate agency.
19 Department of Mental Health and Addiction Services,
20 completely, like Cabinet-level agencies.

1 So he just brings up a really good point, that if
2 you don't say you have to somehow include them in that
3 interagency agreement, I'm afraid we're going to miss that.
4 And again, all states are different. You have a Medicaid
5 agency, maybe creating that agreement with a Title V
6 agency, and not taking into account the other agencies.
7 So I get why we said between Medicaid and Title
8 V, but I think if there is any way -- and I know you said,
9 Joanne, we could clarify it in the chapter. But I'm just a
10 little bit nervous that even if we clarify it in the
11 chapter, people are just going to just go look at the
12 recommendation, and if there's something -- and I'll think
13 about it, too. It's like I agree that the agreement has to
14 be between Medicaid and Title V agencies, but maybe we say
15 Medicaid agency and other Medicaid-providing agencies, or
16 something like that, just to make sure that we're having
17 them in there. Because I think Dennis, you know, probably
18 through the people he's helped, has seen this issue in the
19 state that he worked in. I haven't seen it in others.
20 So thanks.
21 VICE CHAIR DUNCAN: Thank you, John. Michael?

1 COMMISSIONER NARDONE: I was just going to say, I
2 was thinking that what I don't see in the recommendations,
3 and I might just be missing it or maybe we had covered it
4 in the chapter, but what I don't see is stakeholder
5 engagement in the development of the process.
6 So I wonder if maybe we want to look at Policy
7 Option 1 in addition to the process of making information
8 available, also for receiving feedback on the processes
9 that states have in place for transitions of care, so that
10 there is some recognition of the need for that type of
11 involvement in developing the processes.
12 And thinking back to Pennsylvania, I think there
13 are many ways that states could be receiving that
14 information, but I think to be explicit around what the
15 state views as how people can input into that process would
16 be helpful here.
17 MS. JEE: Yeah. Thanks for that comment. We
18 definitely heard a lot about the importance of the
19 stakeholder engagement, and Ava, you guys heard a lot about
20 just the level of their engagement right now already. Like
21 they're pretty important sort of piece of the puzzle

1 already, and really important for families. We heard that
2 a lot, that they were very important for families in terms
3 of like learning about the process of transition. So your
4 point is well taken, so thanks for that.
5 VICE CHAIR DUNCAN: Thank you, Michael. Dennis,
6 then Jami.
7 COMMISSIONER HEAPHY: Thank you. The other piece
8 that could strengthen the chapter is around the cultural
9 appropriateness of the process, to ensure that there is
10 cultural competency. I know we did some work in the state
11 with folks in the Medicaid office and a population of
12 folks. There were many, literally folks from all around
13 the world in this room, identifying different issues and
14 barriers to accessing services. And I am thinking
15 specifically like HCBS services in addition to medical
16 services. So ensuring that the HCBS services are provided
17 in a culturally appropriate manner.
18 Because these folks, I mean, you may have a child
19 transitioning to adulthood who is in school where they are
20 speaking English. At home there isn't anybody who speaks
21 English. So just ensuring that the care plan is developed

1 in a culturally appropriate way and meets the needs of the
2 family members, as well, as well as the individual.
3 Because in this population it is often not just the
4 individual. We have to look at the whole environment that
5 the person lives in. Thanks.
6 VICE CHAIR DUNCAN: Thank you, Dennis. Jami.
7 COMMISSIONER SNYDER: So I am stuck a little bit
8 on Policy Option 4, as well, given Dennis' commentary and
9 John's feedback, as well. I think the challenges, as both
10 Dennis and John mentioned, every state is organized a
11 little differently in terms of how agencies are set up. So
12 I wonder, with this policy option, if we could maintain it
13 as is and add language to advise the states, given that we
14 have the authority to do so, to form similar interagency
15 agreements with relevant state agencies responsible for
16 transitions of care for children with special health care
17 needs, something along those lines. That leaves it up to
18 the states to identify who those agencies are, what
19 agencies are responsible for that particular transition
20 work, and advises them to extend those IAAs to those
21 relevant agencies.

1 VICE CHAIR DUNCAN: Thank you, Jami. Any other
2 Commissioners?
3 [No response.]
4 VICE CHAIR DUNCAN: Seeing none, Ava, Joanne,
5 again, some great feedback from the Commissioners, more
6 around clarifications on things. But I think you did a
7 terrific job incorporating the feedback from our last
8 session into what was presented.
9 COMMISSIONER HEAPHY: This is Dennis. I couldn't
10 raise my hand. I think the issue really is coordination of
11 care, and the folks who receive the care coordination
12 through different agencies in their state. And so it's
13 ensuring that those entities that are responsible for
14 coordinating care for folks are all together in the care
15 plans and the care transition, and afterwards.
16 VICE CHAIR DUNCAN: Thank you, Dennis. No, thank
17 you for the clarification and suggestion.
18 So as I was saying, more feedback. Any questions
19 or anything else you need clarified from the Commissioners?
20 MS. AVA WILLIAMS: No. I think we have
21 everything. Thank you.

1 VICE CHAIR DUNCAN: Thank you, and again, thank
2 you for the work.
3 Madam Chair, back to you.
4 CHAIR JOHNSON: Thank you. Very great
5 discussion. I really appreciate all the work you have all
6 done around this.
7 All right. So next up we are excited to continue
8 our discussion on a Program of All-Inclusive Care for the
9 Elderly, or PACE, as we all know it is called. If you
10 recall, we began this conversation back in September. And
11 today we're going to hear from Brian and Drew, who will
12 share findings from their interviews with state and federal
13 officials, case providers, consumer advocates, and
14 researchers.
15 So I'll say to the Commission that as we explore
16 these findings, I really want you to think about how they
17 align with your perspectives and really share your thoughts
18 on the next steps for our work on PACE.
19 With that I'll turn it over to Brian and Drew.
20 Thank you, guys.

1 ### UNDERSTANDING THE PROGRAM OF ALL-INCLUSIVE CARE
2 FOR THE ELDERLY MODEL: INTERVIEWS WITH KEY
3 STAKEHOLDERS

4 * MR. O'GARA: Thank you. Good morning,
5 Commissioners. I am so excited we have a full hour now to
6 discuss PACE. I'm kidding. I'm kidding.

7 The presentation today, Drew and I will be just
8 giving you a very brief overview of our findings from
9 interviews with stakeholders. We'll start today with a
10 background to refresh your memory on the purpose of this
11 work and the methodology of our interviews. And then we'll
12 spend the bulk of today's presentation discussing key
13 findings across six areas: state program goals, provider
14 application process, beneficiary enrollment services and
15 disenrollment, federal and state oversight of the model,
16 and payment development on the Medicaid side. And we'll
17 end with next steps.

18 So just as a brief refresher, Drew and I were
19 last up here in September, and we presented you with an
20 overview of the PACE model's design and regulatory
21 structure as well as some outcome evaluations, and we also

1 had a moderated discussion with state and federal Medicaid
2 officials about the program.
3 PACE is a fully integrated Medicare-Medicaid
4 program. It is designed to serve adults ages 55 and older
5 who qualify for a nursing facility level of care but can
6 remain safely in the community.
7 Providers operating PACE receive a monthly blend
8 of capitated payments from Medicare Parts A, B, and D, and
9 state Medicaid agencies. And currently 84 percent of PACE
10 participants are dually enrolled in Medicare and Medicaid,
11 so that's a large majority of the population of this model.
12 The remaining 16 percent are Medicaid-only, and less than 1
13 percent are Medicare-only.
14 And as of December 2024, there were more than
15 80,000 people enrolled in the PACE model across 180
16 programs in 33 states and the District of Columbia.
17 And so since then, we are building on this
18 research we conducted, and we've been conducting interviews
19 to gain insights across four key questions: how does the
20 PACE model provide care for individuals in the community
21 with complex care needs; what challenges do states and

1 providers face in establishing and operating these PACE
2 programs; what are the experiences of individuals receiving
3 care through PACE; and what are the considerations for
4 oversight of the model at both the state and federal
5 levels.
6 To answer these four questions we conducted
7 interviews across six states. We spoke with state Medicaid
8 officials, PACE providers and organizations, and consumer
9 advocates. And we also interviews stakeholders at the
10 federal level from CMS, ASPE, and the National PACE
11 Association, which is the national industry association for
12 PACE providers. Between October and November, we conducted
13 22 interviews with these stakeholders.
14 And now on to what we learned from these
15 interviews.
16 The first kind of takeaway that we found was
17 around state program goals and how state Medicaid officials
18 viewed PACE as part of their state's LTSS offerings.
19 Stakeholders largely viewed PACE as a comprehensive
20 integrated car program option for dually eligible
21 individuals. State officials noted that since PACE is

1 designed to serve a somewhat niche population, PACE
2 actually complements other state programs to provide home
3 and community-based services, and that state officials and
4 consumer advocates described the level of care and care
5 integration offered by PAC as exceeding that of other
6 options, so most integrated options, especially compared to
7 FIDE SNPs and MMPs.
8 And because of this, state officials largely
9 expressed interest in growing the model where they were
10 able to. Four out of the six states that we interviewed
11 did have explicit goals to eventually offer the model
12 statewide, but state officials and providers noted
13 challenges in trying to expand the model into rural areas,
14 specifically around finding enough potential participants
15 to be financially viable as well as creating a network of
16 providers that would meet federal network adequacy
17 requirements. And states emphasized that their role,
18 largely, in overseeing the model is ensuring sustainable
19 growth and holding PACE providers to federal regulations.
20 Next, the provider application process.

1 Most states we spoke with did procure providers
2 through the request for proposal process. Some other
3 states did request that PACE organizations submit letters
4 of interest in operating a program. And one state we spoke
5 with actually just reached out to community partners,
6 health systems, and other organizations that they viewed
7 would be an appropriate PACE operator. Several states, in
8 addition to meeting the federal requirements, several
9 states required that organizations interested in offering
10 PACE apply and receive licensure from several additional
11 state licenses, such as licenses to operate adult day
12 centers and home health agencies.
13 And so with the PACE program, provider
14 organizations enter in a three-way contract, signed between
15 the provider, CMS, and the state administering agency.
16 These three-way contracts are used to hold the provider to
17 federal requirements around the model design and
18 administration.
19 And so providers highlighted that as currently
20 structured, CMS's applications for either starting a new
21 PACE organization or expanding a current PACE organization,

1 applications can only be submitted one day per quarter, and
2 they viewed this as a challenge to expanding the model.
3 And they also noted that as designed, the approval process
4 is lengthy and therefore costly.

5 Due to recent rulemaking, PACE providers now have
6 to receive state approval before receiving federal
7 approval, whereas before they were able to kind of pursue
8 state and federal approval simultaneously. So they noted
9 this as an additional challenge, since this further delays
10 the approval process.

11 Some states we spoke with did include additional
12 requirements in a separate two-way contract between the
13 provider and the state, but based on what we heard from
14 states, these contracts tend to be minimal and may just
15 hold providers to some additional state requirements or
16 regulations.

17 Next, we'll talk about the beneficiary enrollment
18 experience.

19 PACE organizations shared that they mostly do not
20 do formal marketing, and that most of their enrollees hear
21 about the program through word of mouth from other

1 participants. What we did hear widely from PACE providers
2 that we interviewed was that they felt PACE was not
3 included when beneficiaries are counseled on Medicaid HCBS
4 options in their states, as well as that potential
5 participants faced a lengthy enrollment process to get into
6 the program.
7 One state we spoke with, in addition to several
8 consumer advocates, raised concerns that PACE organizations
9 may selectively enroll participants. PACE providers do
10 have the responsibility and the duty of determining who is
11 eligible for the model, specifically who is able to live
12 safely in the community. So this state and these providers
13 felt that some PACE organizations may be using that
14 eligibility criteria of being able to live safely in the
15 community to exclude potential participants that they
16 viewed as high cost and high need individuals.
17 States are responsible for establishing the
18 process by which providers do determine eligibility for the
19 model, but state officials noted they do have to leave some
20 leeway for flexibility for the providers to use this
21 process, and therefore it could be open to interpretation.

1 Beneficiary services. So we heard, by and large,
2 across stakeholder groups, that PACE, as designed, offers a
3 wide array of comprehensive benefits, both medical and non-
4 medical, both at the adult day center and in the community.
5 But one thing that we did hear from consumer
6 advocates was they shared that some PACE programs may offer
7 fewer home-based services compared to other managed long-
8 term services and supports or home and community-based
9 services programs. This is due to the fact that while PACE
10 is required to offer all Medicaid services approved in a
11 state's Medicaid plan, there are no federal requirements
12 around the amount of services which must be provided in the
13 home or in a specific setting.
14 All the providers we spoke with used participant
15 and caregiver satisfaction surveys as well as participant
16 advisory committees to identify issues and make continuous
17 improvements to their organizations. And the states that
18 we spoke with used varying approaches to monitoring PACE
19 enrollee complaints, appeals, and grievances.
20 One thing we did hear around appeals and
21 grievances from consumer advocates was that PACE denial

1 notifications are often vague and lack clear explanations.
2 And this may be partly due to the comprehensive nature of
3 the benefits. And some consumer advocates also raised
4 concerns that PACE enrollees can find particular challenges
5 with appealing service denial decisions.

6 This may be due, in part, to the fact that PACE
7 organizations are both health care providers and health
8 care plans. So if, let's say, a beneficiary were to need a
9 second medical opinion to appeal a service denial, all of
10 their providers that are in network work for the same
11 organization, and they cannot see a provider that is
12 outside of the network. And that is a specific example
13 that we heard from one consumer advocate.

14 So disenrollment. All of the states that we
15 spoke with actively monitor their PACE programs for
16 voluntary and involuntary participant disenrollments, and
17 they use a variety of methods. One state we spoke with
18 requires PACE providers to use extensive coding and to
19 report every disenrollment. Another state we spoke with
20 uses financial incentives to keep the voluntary
21 disenrollment rate low among their PACE providers. And the

1 states that we spoke with stressed that disenrollments are
2 not common, due to the small size of the program and the
3 generally high satisfaction of participants.
4 Speaking with state and federal officials, we
5 heard that participant death and relocation out of a
6 program service area are the most common reasons for
7 disenrollment from PACE. These stakeholders did
8 acknowledge that voluntary disenrollments do occur more
9 often when an enrollee transitions to nursing facility
10 care. However, they were not concerned that this was due
11 to PACE organizations actively disenrolling participants.
12 Rather, they noted that oftentimes PACE organizations don't
13 have an extensive network of nursing facilities.
14 So for example, if a beneficiary who needs a
15 nursing facility wants to enter a specific institution, and
16 the PACE provider is not able to contract with that
17 institution, the beneficiary would have to disenroll from
18 PACE to move into that nursing facility.
19 And I'll pass it to Drew.
20 * MR. GERBER: Thank you, Brian. Through our study
21 we found that federal oversight of PACE occurs across

1 several CMS divisions, shared between the Center for
2 Medicare, the Center for Medicaid and CHIP Services, and
3 the Medicare-Medicaid Coordination Office. All together,
4 we found about nine groups throughout CMS play some role in
5 overseeing the operation of PACE at the federal level.
6 Oversight primarily consists of PACE site audits
7 and review of reported data. During a PACE organization's
8 initial three-year trial period, CMS conducts annual onsite
9 audits that check for compliance with federal regulations.
10 But following that trial period, CMS conducts its audits
11 virtually and at a frequency to be determined by risk
12 factors that CMS sets.
13 For reference, one PACE organization we spoke
14 with noted that their site had not been audited for over
15 five years, and that they were in the process of
16 documenting things in anticipation of an audit.
17 CMS described the audit process to us as resource
18 intensive for both them and the provider, but valuable for
19 program improvement purposes and for informing
20 policymaking.

1 As part of the audit and CMS's ongoing oversight
2 activities, the agency also reviews reported data, such as
3 financial reports, to assess the organization's soundness,
4 and examines utilization data for concerning patterns.
5 PACE organizations are required to submit the data on 23
6 medical and non-medical utilization elements on a quarterly
7 basis to the Health Plan Management System, similar to
8 other Medicare Advantage plans. These organizations also
9 submit Medicare encounters to CMS, but these are only for
10 activities that would generate a claim, such as a visit to
11 a contracted specialist, not for services provided in the
12 PACE center.
13 And I think as we have previously discussed,
14 identifying encounters in a PACE center can be challenging,
15 because unlike with traditional providers, a participant
16 may encounter various members of their care team while
17 visiting the center, potentially receiving a mix of what
18 could be considered Medicare- or Medicaid-covered services.
19 Federal officials and providers said that the
20 submission of Medicaid encounter data would be difficult
21 for most PACE organizations to accomplish, though we did

1 hear that there is a spectrum of sort of sophistication
2 among PACE organizations in their ability to do this.
3 Although, one federal official did also note to us that the
4 existing reporting requirements and the data that it
5 produced have fairly limited utility.

6 On the state side, states vary in the type and
7 level of oversight for PACE, but generally their efforts
8 check for provider compliance with federal regulation and
9 for service delivery. State officials and CMS both
10 emphasized that state oversight is not intended to
11 duplicate CMS audits. Several PACE program elements that
12 fall largely under state purview, such as reviewing and
13 approving involuntary disenrollments and monitoring
14 voluntary ones, as well as determining how PACE
15 organizations evaluate how participants can live safely in
16 the community, as Brian mentioned.

17 Like CMS, state oversight is mostly conducted via
18 audit. The frequency of the state audits vary, of course.
19 For example, one state told us that it audits new PACE
20 organizations annually, while more established legacy
21 organizations are audited every three years.

1 State officials did say that dialogue with PACE
2 organizations is ongoing outside of the audit process, as
3 well, and common audit activities included reviewing the
4 participant advisory committee minutes and reviewing
5 electronic medical records and other patient files along
6 with the service determination requests in order to
7 evaluate whether participants were receiving their approved
8 care services.
9 And while states have the option to require
10 additional data in the two-way agreements, as Brian
11 mentioned, state reporting requirements tended to be
12 minimal, and instead state officials tended to rely upon
13 satisfaction surveys administered to PACE participants. We
14 found that the federal government, CMS, does not request
15 that these satisfaction surveys be shared with them.
16 Instead, they are largely seen as tools for the program to
17 use in its own quality improvement. And CMS did note that
18 they likely anticipate that most of these satisfaction
19 surveys feed into the quality improvement plans that CMS
20 does discuss with the PACE organizations.
21 Moving on to quality measures.

1 COMMISSIONER McCARTHY: Drew, can you hold on a
2 second? So the online version isn't changed in the slides.
3 Only what we see is changing.
4 EXECUTIVE DIRECTOR MASSEY: Thanks, John. Give
5 us a minute to see if we can fix it.
6 [Pause.]
7 CHAIR JOHNSON: We don't know exactly how long
8 it's going to take. Why don't you continue. And then of
9 course we note that the slides will be available after this
10 meeting, for sure.
11 MR. GERBER: Sure. So moving on to discuss
12 quality measures, during the course of our interviews,
13 stakeholders said that quality in PACE, like service
14 utilization, is difficult to measure. Federal officials
15 said that CMS does not directly collect data on quality
16 through its audit process, but they did note that the
17 agency's focus on access measures is intended to improve
18 the quality of services provided through PACE.
19 On the state level, most states we spoke with do
20 not require substantial quality reporting either, and some
21 officials said that they lack the staff capacity to review

1 such data, should it be reported. And as with the
2 encounter data, the ability to report these data varies
3 greatly among PACE organizations.
4 We heard that even where some measures exist,
5 stakeholders said that a lack of standardization in the
6 measures and how they are reported means that PACE
7 organizations can really only be measured against their own
8 past performance. With this in mind, nearly ever
9 interviewee discussed the creation of national quality
10 measures for PACE, which could be used to compare
11 performance across organizations in a state, or nationally,
12 and better understand the level of care that PACE
13 organizations provide.
14 Several groups are working on developing a PACE
15 measure set, but at least a few interviewees highlighted
16 the challenges of developing such measures, as they need to
17 be applicable to programs of various sizes and with
18 different patient mixes. And a few raised the question of
19 whether such measures would be useful, considering most
20 participants only have the choice of their local PACE
21 center.

1 Talking about payment development and the rate-
2 setting process, we touched a bit on this back in
3 September. Most states set Medicaid PACE rates as a
4 percentage of the amount that would have otherwise been
5 paid if participants were not enrolled in PACE.
6 While there's no federal requirement for these
7 rates to be actuarially sound, we did hear that most states
8 said that they rely on the actuaries that develop rates for
9 their Medicaid managed care programs to establish PACE
10 rates, which most states determined using data from fee-
11 for-service and managed care populations.
12 States we spoke with said they review and update
13 these rates annually. However, there were some cases where
14 rates had not been updated in many years.
15 Officials did say that rate updates are entirely
16 dependent upon the state budget, and since PACE is only a
17 small portion of the Medicaid funding allotted by the state
18 legislature, it can truly depend.
19 And one state official expressed frustration that
20 their agency lacks the necessary data about PACE costs and

1 performance to press the legislature for higher funding for
2 PACE rates.
3 We did hear CMS also reviews these rates and uses
4 an actuary to ensure the costs used for the AWOP are based
5 on comparable populations and allowable costs.
6 There were some differences in sort of the
7 methodology for rate development. State officials and PACE
8 organizations voiced differing opinions on how Medicaid
9 rates for PACE are set. Only one state in our study
10 develops PACE rates using utilization and experience data.
11 Despite basing rates on an organization's
12 reported costs, we did hear the most concerns about
13 Medicaid rates from providers in this state. In that state
14 and others, providers voiced concerns that state approaches
15 to rate setting do not capture the full cost of providing
16 Medicaid services in PACE, especially where rates are based
17 on models that cover different services and populations.
18 We did hear from one PACE provider that said
19 while they do not think Medicaid rates cover the center's
20 Medicaid costs, they acknowledge that shortfalls are
21 covered by subsequent savings on the Medicare side as

1 participants may avoid costly care such as a
2 hospitalization due to Medicaid services.
3 In general, state officials appeared to
4 understand both perspectives. One state explained that
5 PACE organizations, which tend to have low nursing facility
6 placements, benefit from a blended rate that includes both
7 institutional and community well populations, while another
8 state noted that PACE rates may always seem insufficient to
9 PACE providers considering they're designed to be a
10 percentage of the rates that those providers might receive
11 for participants that were in nursing facilities or served
12 through other HCBS.
13 Throughout the course of our study, we did hear
14 that states are increasingly aligning the administration of
15 their PACE programs with that of Medicaid managed care and
16 integrated D-SNPs, both in their oversight practices and
17 their approach to developing rates. Some stakeholders
18 raised concerns about this trend, saying that PACE does not
19 fit neatly into these existing systems.
20 Several officials mentioned using D-SNP
21 populations to help develop PACE rates, while others

1 described using MLTSS encounter reporting infrastructure to
2 try and capture PACE services.
3 One state official said that PACE organizations
4 want to be treated like other managed care plans in some
5 regards, but that many of these organizations are unwilling
6 to provide the financial information that managed care
7 plans must regularly report.
8 We found that federal regulations also
9 distinguish PACE from managed care in terms of payment.
10 Per regulation, states may only make payments to PACE
11 organizations through the capitated rate, preventing states
12 from making targeted non-capitated payments that can be
13 made to Medicaid managed care plans.
14 One state official described how this limitation
15 created frustrations as the state considered pursuing
16 efforts to support PACE organization startup costs,
17 disburse incentive payments related to meeting vaccination
18 goals, among other things.
19 As we move on to our next steps, we plan to
20 incorporate our interview findings, as well as the
21 discussion here today, into a draft report chapter that

1 describes the PACE model, the challenges that we heard from
2 stakeholders, and potential areas the Commission may choose
3 to explore in future work.

4 We'll be returning in April with this draft
5 chapter for your consideration, but for today, for our
6 discussion, we'd like to begin hearing whether there are
7 any areas from our presentation today or your briefing
8 materials in which the Commission would like further
9 clarification about PACE and its operations, additionally,
10 where the Commission would want us to potentially go in the
11 future with an eye looking at how the PACE model might be
12 updated.

13 And with that, I'll pass it back to the Chair.

14 CHAIR JOHNSON: Thank you, Brian. Thank you,
15 Drew. It was very helpful.

16 And you've heard what they've asked us to do
17 during our time here. Wanted to know your thoughts. Are
18 there clarifying questions that you may have around what
19 you've heard today or even back in September, and are there
20 areas that you want to explore more that you think would be
21 really helpful, particularly as we think about the Medicaid

1 program? Are there things that we would -- that may be
2 scalable that we want to explore a little bit more as well?
3 And there's some ideas.
4 So I'll open up the floor to all of you.
5 All right. So Patti.
6 COMMISSIONER KILLINGSWORTH: So I'll start with
7 just a few comments about PACE. Based on my own
8 experience, having led LTSS programs in a state, I concur
9 that PACE is really, in some ways, a best-in-class
10 integrated care model. It is an area in which funding
11 streams are at least combined, in which there is
12 interdisciplinary intensive care management, and really
13 importantly, a very flexible and comprehensive benefit
14 structure that gives PACE organizations, you know, a ton of
15 autonomy to really deliver the care that people need in
16 order to help them live safely in the community. So that's
17 kind of the good side.
18 Obviously, there are some limitations of the
19 model as it was traditionally designed around an adult day-
20 based sort of hub, if you will, and which doesn't really
21 allow people a lot of choice to receive services in their

1 homes. I know there are people who receive some home-based
2 care, but it tends to be fairly minimal, as sort of was
3 mentioned in the comments.
4 And then there's been this issue with sort of it
5 not being a replicable model, especially as it relates to
6 rural areas.
7 On sort of the other side, if you will, as we
8 think about managed care broadly and how we typically think
9 about managed care, there are just lots of challenges with
10 regard to the PACE program, and they're really sort of the
11 result of the way that the statute and the regulations have
12 been crafted for this particular model.
13 So, as was mentioned, there's just very little
14 oversight. There's very little monitoring. There's very
15 little quality reporting. There's very little transparency
16 around the services that PACE individuals actually receive.
17 There's very little accountability for how the dollars are
18 spent. There's no requirements around network adequacy or
19 network adequacy monitoring. Just so many of the things
20 that we expect managed care organizations to have to do,
21 PACE organizations are completely exempt from. There's no

1 encounter reporting. There's no reporting of all of the
2 services that they deliver in a way that you can reasonably
3 sort of understand what actually is happening in a PACE
4 site.
5 In addition to that, they're exempt from some
6 pretty important HCBS policy considerations. So when we
7 think about conflict of interest policies and how those
8 typically apply in home- and community-based services, this
9 is an area where the managed care entity gets to decide
10 what people get, they get to deliver what people get, and
11 they don't have to report what people get, which just sort
12 of flies in the face of everything that we think of from a
13 conflict of interest perspective.
14 They're also exempt from the HCBS settings rule,
15 except in states where states have decided to enforce those
16 requirements themselves. But there's just not the same
17 expectation that settings in which services are delivered
18 are not institutional-like. And all of that just gives me
19 an awful lot of pause.
20 Add to that sort of the fact that even though
21 they're not treated like a managed care organization in

1 some way, there's a fairly significant amount of
2 administrative burden that goes into creating a PACE
3 program, and so they're relatively small in terms of the
4 numbers they serve.
5 In Tennessee, we had one which served a few
6 hundred people, but added the burden sort of having like
7 another managed care entity. So from a staffing
8 perspective and all of that, they can be very challenging
9 to maintain while serving a relatively small number of
10 people.
11 And then I have some concerns about the rate-
12 setting process, because sort of the requirement around
13 actuarial soundness just makes sense to me, right? We want
14 to make sure that we are paying entities a fair and
15 appropriate rate but not overpaying based on the services
16 that are being delivered. And if you have no insight into
17 the services that are being delivered, you have no idea if
18 you're overpaying or not.
19 The typical sort of strategy, as you noted, is to
20 pay a capitation payment that's based on a blend of nursing
21 facility and community-based care costs, but as a practical

1 matter, most of the people in PACE don't receive nursing
2 facility services. And so we're probably in reality
3 overpaying when we're taking into account -- and in some
4 states, it's largely based on the cost of nursing facility
5 care. We're sort of overpaying for the services that we're
6 providing in a way that we would never do in a traditional
7 managed care program.
8 So I could go on, but I won't. I'll just say
9 this. As we think about direction, in order for me to have
10 interest in policy options that might expand the use of
11 PACE, I have to start with a program that feels like it is
12 accountable, transparent, appropriately reimbursed, and
13 high quality in a way that we can actually measure and see.
14 And so I would just recommend that we start there with how
15 do we sort of bring PACE up to a standard where we could
16 really think about it being a replicable -- wanting to
17 identify policy options that could allow for expansion.
18 CHAIR JOHNSON: Thank you, Patti.
19 We'll have Mike, then Dennis, then Carolyn, then
20 Sonja.

1 COMMISSIONER NARDONE: So I come at this a little
2 slightly differently. In Pennsylvania, we found PACE to be
3 a pretty effective model in terms of being a tool in a
4 toolbox.
5 And as you see states kind of increasing the use
6 of PACE programs across the country, you know, a lot of
7 that is in states that really don't have other models of
8 integrated care, and PACE is kind of the main effort to
9 really bring that type of integration at the ground level
10 that frequently doesn't come in like a larger managed care
11 plan.
12 So I think it's -- I don't -- you know, because
13 of the scalability issues, I don't think it's the answer to
14 integrated care, but I think it can certainly be part of
15 the toolbox of things that states can use in terms of
16 figuring out a strategy around integrated care for dual
17 eligibles.
18 Having said that, I do agree with many of the
19 points that Patti made. I think we should be looking at,
20 you know, ways that, you know, we can make sure we're --
21 you know, have a quality framework, and that there is, you

1 know, some national indicators that indicate that. Sounds
2 like some of those efforts are underway.
3 I'd like to learn a little bit more about the
4 national quality, like where they're at in terms of
5 developing that framework.
6 I think we also have some of the survey results.
7 I would anticipate that those rates of, you know, feedback
8 from the consumers are relatively positive, generally
9 speaking.
10 So I know they were in Pennsylvania. That might
11 not, you know, cover other states. But I think having some
12 sort of way of doing that, you know, kind of be available
13 and transparent to people, totally on board with that.
14 You know, I would also say that if -- just for
15 the AWOP conversation, which is Patti mentioned that the
16 rates are often not actually sound, that would require a
17 legislative change. The AWOP is written into the PACE
18 statute. So if we wanted to look at creating a requirement
19 that the rates were actually really sound, that would be a
20 congressional recommendation.

1 You know, states do have flexibility, and I'm not
2 -- in terms of how they set those rates. You know, when I
3 looked at rates across the country, maybe there were states
4 that overpaid for PACE, but there were also states that
5 didn't adjust their AWOP for several years. And some of
6 the activity that we engaged in at CMS was really to
7 encourage states to look at updating some of those rates
8 periodically.
9 So I think there's a lot more to unpack here. I
10 think I would be interested in kind of looking at the areas
11 that maybe are a barrier to expansion, particularly in
12 rural areas where those might be policy efforts.
13 You know, I had an opportunity to do some work a
14 couple years back around COVID and some of the changes that
15 PACE programs made to integrate more home- and community-
16 based services, more technology into the provision of care.
17 And I wonder if some of those findings maybe point in the
18 way of direction of ways to advance into other rural areas.
19 But, you know, I think that, you know, I would
20 like to be -- you know, whereas I want to see some of those
21 refinements to create some quality infrastructure around

1 PACE and some of the other things that Patti mentioned, I
2 think I also would like to look at, you know, what are some
3 of the barriers that maybe are unintentionally in the
4 statute that could maybe either have an exception process
5 or otherwise if a state wanted to further advance the
6 goals.
7 So I have a lot more I can say on this. I could
8 talk for a longer time, but I'm going to cede my time.
9 Thanks.
10 CHAIR JOHNSON: Thank you, Mike.
11 Dennis.
12 COMMISSIONER HEAPHY: Thank you.
13 I agree with everything Patti was saying,
14 everything Mike was saying. They're both on spot, I think.
15 Not necessarily contradictory at all.
16 I think for me what was missing somewhat from the
17 report is a unique history of PACE, you know, with the On
18 Lok community and the idea that PACE was really developed
19 as a culturally appropriate place for people in the
20 community to come together to not just address medical
21 needs but to address isolation and loneliness. So it's

1 built around that small Chinese community in San Francisco,
2 and it's one of those issues where when scale happens, all
3 of a sudden, it becomes generic and homogenous. And so how
4 much of what makes PACE unique is being lost as it becomes
5 homogenized and it just becomes a different model of care?
6 I don't know how you put that in the report, but just to
7 say like it was -- it was very unique. And the first PACE
8 program around the country all maintain that unique
9 community-driven, population-appropriate idea of bringing
10 people together through this isolation and loneliness,
11 which is why everything is so focused on that center, the
12 PACE center.

13 And the thing I wanted to raise actually was
14 about -- beyond limited networks and other things is the
15 HCBS issue, particularly for folks with disabilities and
16 whether or not PACE is actually appropriate for folks with
17 disabilities with different HCBS needs and elders.

18 I recommend this article by Lisa Iezzoni. She's
19 a pretty renowned expert in disability access issues in
20 health care and the concerns that she's raised around PACE.

1 And I'm saying all this -- I think the PACE
2 program is great, but it's just -- it's like, is it
3 appropriate what would need to be changed in a statute to
4 make it appropriate for this population? I've actually
5 worked with a few people trying to figure out how might we
6 make PACE work for folks with disabilities, but the way the
7 statute is written right now, it just does not work for
8 certain populations. And so I think Lisa speaks to that
9 well.
10 But those are my comments. Thanks.
11 CHAIR JOHNSON: Thank you, Dennis.
12 Carolyn?
13 COMMISSIONER INGRAM: Yeah. This is one of those
14 areas where I think it was Mark Twain who said something
15 like 20 years from now, you'll be more disappointed by the
16 things you didn't do than by the things you did. And this
17 is one area where I think is when I was Medicaid director,
18 I wish I would have done more.
19 It's sad or disappointing to see that we're this
20 far along in integrating care for duals, and we have a
21 program like this that isn't responsible in terms of

1 publishing or being transparent. And it's reporting its
2 quality in surveys, in oversight, and that there's so much
3 confusion around who does oversee them and the rate-setting
4 process.

5 So I think I just had some clarifying questions,
6 and I'll try not to repeat all of the areas that Patti
7 covered. But just starting with in the documents we had on
8 page 7, you talk a little bit about how the eligibility for
9 the program and people getting to come into the program is
10 really the choice of the PACE site, I believe, correct?
11 And then that some states have hired enrollment brokers on
12 top of that to make sure cherry-picking doesn't occur.

13 Is there any other oversight process of the
14 states that don't have an enrollment broker to make sure
15 that the PACE site is appropriately taking people who are
16 able to live in the community and not cherry-picking, or is
17 it just that one enrollment broker?

18 MR. O'GARA: Yeah, that's a great question. We
19 heard from one state that used an independent enrollment
20 broker, and that was the state that had concerns about
21 selective enrollment. I don't believe the other states we

1 spoke with mentioned specific kind of third parties that
2 were involved in the enrollment process or tasked with
3 identifying the appropriateness of the population that
4 ended up in the model.

5 COMMISSIONER INGRAM: No auditing or anything
6 like that, that didn't know? No auditing? No?

7 MR. GERBER: We didn't get into every state-
8 specific audit process, but we do know that they have the
9 ability to go to PACE organizations at any time to sort of
10 go through their enrollment. We did hear from one state
11 that they are able to place sort of individuals at the PACE
12 organizations to sort of streamline that process so that
13 they are sort of embedded in the eligibility process, but
14 it was not something we dug into deeper yet.

15 COMMISSIONER INGRAM: Yeah. So that's one area,
16 I think, in our final reporting we need to make sure to
17 call out. My experience of trying to help people get into
18 PACE programs is that they definitely do cherry-pick, and
19 that it's hard to actually get people in who want to be
20 able to live in the community to get those services. It's
21 not as easy as it is made to sound. Now, that may not be

1 every single PACE site, but that's at least the experience
2 I have in working with those that I've worked it.
3 The other piece that was confusing, I think, to
4 me, and maybe it was around page 12 in the report, talking
5 about the CMS oversight versus the state oversight. It
6 sounds like CMS would come in and do audits, but it sounds
7 like the state maybe doesn't do those audits. In the D-SNP
8 models and others we have agreements that clearly outline
9 what the contractor is held to. There is information on
10 your Medicare side about how you're audited, and on the
11 Medicaid side how you're audited. But that doesn't sound
12 like that's the case here. That's correct? I'm understand
13 that correctly?
14 MR. GERBER: Well, so CMS publishes its audit
15 protocol, and has conversations with organizations about
16 that process. I would say that there doesn't appear to be
17 coordination between CMS and states on their audit
18 processes. States can set some guidelines or
19 clarifications in two-way agreements about what their audit
20 process may include. I think we found out the state audit
21 process can really vary in terms of what's done. But

1 generally there is a sense of trying to avoid duplicating
2 efforts.
3 COMMISSIONER INGRAM: Mm-hmm. Okay. And it
4 sounds like from the interview you did there are pieces
5 where folks aren't finding helpful at all the reporting
6 that's coming out. Is that correct, some of the reporting?
7 MR. O'GARA: Yeah. We heard that from one
8 stakeholder specifically about the 23 data elements that
9 are reported into HPMS quarterly, and we heard that that
10 was not necessarily useful unless there was maybe a spike
11 in the report of one specific data element. But the
12 stakeholder also mentioned that there is wide variability
13 in how PACE programs report those various data elements, so
14 it's difficult to kind of look at that dataset alone and
15 make comparisons or takeaways about general trends.
16 MR. GERBER: I will note that CMS meets with the
17 PACE organizations and walks through their audit results,
18 and states are invited to join those calls. But we did
19 hear from officials in one state that they personally find
20 that the audit report is difficult to parse, and insights
21 are not really clear for program purposes.

1 COMMISSIONER INGRAM: And is there any
2 coordination between CMS and the states on the rate-setting
3 process? I mean, are the states gathering and getting the
4 Medicare information and data, so that if they are trying
5 to do rate-setting on the Medicaid side they are at least
6 looking at that Medicare payment?
7 MR. O'GARA: That is a good question.
8 COMMISSIONER INGRAM: Yeah, I don't think they
9 are, from the data you've given us.
10 MR. O'GARA: Yeah.
11 COMMISSIONER INGRAM: But that's fine to ask. Go
12 ahead.
13 COMMISSIONER NARDONE: So I think the Medicare
14 rates are set differently, and then the state rates. And
15 the Medicare rates for PACE, as I recall, are based on
16 Medicare Advantage rates, Medicare traditional fee-for-
17 service in the area that the PACE sites are located.
18 COMMISSIONER INGRAM: But is that data ever
19 shared back with the state, or are the states looking at it
20 when they are doing rate-setting?
21 COMMISSIONER NARDONE: I don't --

1 MR. O'GARA: I will just note that that didn't
2 naturally come up in our interviews since we were focused
3 on the Medicaid side of the rate-setting process. That is
4 a good question. I just don't think that came up in our
5 interviews.
6 MR. GERBER: Right. And I would add that, again,
7 most of the states we spoke with do use their actuary to
8 develop those, so whether the actuary is taking that into
9 account as part of that process is not something that we
10 investigated.
11 COMMISSIONER INGRAM: Maybe Jenny will know and
12 eventually we can go find that out. So I'm just going to
13 probably echo some of the same concerns that others have.
14 I'll quit asking you questions. But it just looks like
15 there's very little reporting. There's little transparency
16 in terms of the quality or outcomes that are held here. It
17 sounds like no coordination around the rate-setting piece.
18 It sounds like there's little done to try to make sure
19 people are served, if they can be, in different ways in the
20 community. It sounds like there's still cherry-picking
21 going on. And then you have to hire and spend even more

1 money on outside enrollment brokers to make sure that
2 cherry-picking doesn't happen.
3 It sounds like it's fraught with a lot of issues,
4 almost. You could take almost any area -- we didn't get
5 into lots of other areas here -- about notices that go to
6 members about their rights. You know, we didn't get into
7 how grievances and appeals are handled by the Medicaid
8 agency and the Medicare side of things.
9 So I think there's a lot that we could learn from
10 the MMP demonstration, that integrated care, even the
11 financial side, there is a lot we can learn from the
12 current D-SNP operations. It feels like we've advanced all
13 these models for integrating care, and this one has been
14 left kind of, I don't know, in the past.
15 So I'm really disappointed and somewhat shocked.
16 So I think there is a lot of work that could be done here
17 to give recommendations on how to bring this back up into
18 what could truly be a better integrated program. You know,
19 just the fact that we are this far along and people can't
20 report encounter data, that's just very shocking to me.
21 There's hardly any people in this program. How could you

1 not report encounters about what services they're getting
2 and what outcomes they have?
3 So I'll stop there. I think there's a lot of
4 work that we could do to make recommendations here. I'm
5 happy to help, and I appreciate you at least calling this
6 forward so we could start to take a look at it. Thank you.
7 MR. GERBER: Thank you. I did want to make one
8 clarification. The state that we spoke with uses the
9 Independent Enrollment Brokers for all Medicaid enrollment
10 in that state, so it was not hired just for the PACE.
11 COMMISSIONER INGRAM: Thank you.
12 MR. O'GARA: And I would like to just clarify,
13 it's in the memo, I know, but the consumer advocates we
14 spoke with did acknowledge that they personally did not
15 have a ton of interaction with PACE enrollees, just due to
16 the small size of the program. And that obviously should
17 not, you know, tamper any concerns that we might have about
18 the program. I'm just noting that, you know, it's one of
19 those models where it seems like we really have to dig for
20 information.

1 COMMISSIONER INGRAM: Yeah. I think that speaks
2 volumes when you say that, I mean, that there's no public
3 reporting, there's no transparency, there's nothing
4 published about their member satisfaction surveys. I think
5 that speaks volumes that it's so hard to find the
6 information, because it's probably not there. It's not
7 transparent. It's not publicly available.
8 And we hold other organizations, I think, to
9 standards. We've just brought those other programs ahead
10 in terms of what we expect for standards, for transparency,
11 encounter reporting, rate-setting, grievances and appeals,
12 member outreach enrollment, just all those things. So
13 we've got some work here to do, to make sure that these
14 programs come along in the same fashion. Thanks.
15 CHAIR JOHNSON: Thank you, Carolyn. I just
16 wanted to clarify, when she talks about the encounter data,
17 you said that it was anything that had a claim on it,
18 right, they could report the encounter data.
19 MR. GERBER: On the Medicare side.
20 CHAIR JOHNSON: Okay. Gotcha.

1 MR. GERBER: For states, some have been exploring
2 how to sort of adapt the encounter codes they use for their
3 Medicaid managed care for PACE, but as we mentioned, there
4 are some difficulties in just how services are provided in
5 the center.

6 MR. O'GARA: And to clarify, the Medicare
7 encounter data is for services that are provided outside of
8 the day center. So this is usually specialty services.

9 CHAIR JOHNSON: Okay. All right. Thank you.
10 Jenny.

11 COMMISSIONER GERSTORFF: So since we're all
12 invoking actuarial soundness, I figured I better speak up.
13 I am not particularly concerned about a requirement for
14 actuarial soundness for PACE. The actuarial soundness
15 requirements that we have for comprehensive managed care is
16 relatively recent in the scope of managed care programs.
17 We didn't really have that, and we didn't have all of the
18 current requirements for it until the last couple of
19 decades, the most recent being 2016, where we started
20 having to do this every year.

1 And that's because managed care is so big, and we
2 need accountability, and there are so many ways that it can
3 go wrong. And PACE is so small. And what we are spending
4 is a reasonable amount of money on people, with really good
5 outcomes, based on all of the research and interviews you
6 guys have done. So I'm not terribly concerned about that.
7 In the situation where states have their
8 actuaries set the rates because they're capitation rates,
9 actuaries would have to follow our controls and standards
10 of practice, and the rates would be actuarially sound. So
11 as it stands right now, states have the option to have
12 actuarially sound rates by engaging their actuaries.
13 So I just wanted to add that.
14 COMMISSIONER KILLINGSWORTH: If they had claims.
15 Sorry, Jenny. I'll just say that, right. It's hard to
16 develop an actuarially sound rate without claims. And so
17 with no encounter data, which states don't have, you really
18 can't.
19 COMMISSIONER GERSTORFF: I agree that having
20 encounter data makes setting actuarially sound capitation

1 rates much easier, Patti, but it's not a requirement for
2 setting actuarially sound capitation rates.
3 CHAIR JOHNSON: Thank you. Mike, and then Heidi.
4 COMMISSIONER NARDONE: Yeah. I mean, some of the
5 problem around encounters, right, are unique to this model
6 in the sense that -- well, are not unique to this model but
7 understanding the difference of this model, which is that
8 it's center-based, they might have many different
9 encounters with a medical professional. I guess we could
10 encounter that and try to come up with a rate structure.
11 But, I mean, I think when you're talking about having
12 encounter data for every contact, I think that's some of
13 the complexity there, just to understand it.
14 I would also point to PACE actually, in some of
15 the studies I've seen around health quality, there was a
16 recent ASPE study. I don't know if you looked into that.
17 I don't know if you can maybe expound on that. I don't
18 have it on the tip of my tongue, but some of the results
19 compared PACE to some of the other models of care, where
20 PACE was actually, in some aspects, rated more highly than
21 some of the Medicare Advantage plans. I just want to make

1 sure that that is kind of also incorporated into this
2 discussion.
3 I think one of the things that I would like to
4 learn a little bit more about is some of the things that
5 Carolyn mentioned and Patti. You know, I wonder, how much
6 flexibility the states have to oversee that in the
7 agreements that they have with PACE programs. And I know
8 there was at least one participant in the September meeting
9 that mentioned that they had an agreement with the PACE
10 program. It sounds like you found that those requirements
11 were maybe somewhat minimal, or not as robust as they could
12 be.
13 But I'm wondering, is that because -- why is
14 that? Is it because it's seen as the program that CMS
15 runs, Medicare runs, rather than that the state can add
16 requirements? Is there anything that would specifically
17 prohibit states from doing that?
18 And also, when states have flexibility in how
19 they set the AWOP, so they can basically, as MLTSS sees
20 reductions in the broader program, that shows costs going
21 down, that's what the PACE program also has to compare to

1 that, or they can develop how the -- the way I understand
2 it, and you have to correct me if I'm wrong. But that they
3 have flexibility in terms of how they actually set it, and
4 there's a fair amount of variability across the states
5 around how they do it.
6 So I think one of the things that's probably
7 helpful is also to just understand the context of that in
8 terms of what states do have the flexibility to do and what
9 they choose to do, and maybe why they don't do it.
10 The other thing I would just say is that it does
11 seem like, having been on the inside, there are a number of
12 different entities that are overseeing this. And I don't
13 know if you got a sense, if there was any administrative
14 streamlining that needed to happen to maybe make this a
15 little more easy to get through the administrative
16 processes, or at least streamline that process. I think it
17 sometimes is a program that maybe doesn't have a house,
18 like one home.
19 MR. GERBER: That's definitely a concern that we
20 heard from a few stakeholders. Speaking to the two-way
21 agreement piece, I would say we didn't hear that there was

1 any certain limitation on flexibility states have in
2 setting these agreements. CMS really saw it as an
3 agreement between the state and the provider.
4 I would say, based on prior work we've done,
5 looking at state Medicaid agency contracts, it seems that
6 this may just be an area where states are building internal
7 expertise and maybe developing capacity to explore these
8 contracts. For example, one state official we spoke with
9 compared the contracts for the two programs, noting that
10 their two-way agreement was about 12 pages long, and the
11 SMAC for their integrated D-SNP was well over 150 pages.
12 So that just sort of speaks to the differences in level of
13 requirements.
14 I would say two of the states we spoke with are
15 in the process of updating these agreements, and these are
16 both states that have sort of been, I would say, leaders in
17 trending towards using their MLTSS experience in the state
18 to sort of inform how they are approaching PACE. I don't
19 know if, Brian, you have anything.
20 MR. O'GARA: Yeah, just to add on to the
21 flexibility point. One of the states we did speak with

1 about their two-way contracts, updating their two-way
2 contracts, their problem with flexibility specifically was
3 around the day center requirement, and that's in federal
4 regulations.
5 So at least from what we've heard, some of the
6 tension around state flexibility isn't necessarily tied to
7 the use of two-way agreements, and may just be some of
8 those elements of the federal regulations that are kind of
9 more concrete.
10 And to your point about administrative
11 streamlining within CMS, we did hear that MMCO has been
12 named like a coordinating division for PACE, but, of
13 course, they don't have any regulatory authority over
14 programs that serve dually eligible individuals. So, you
15 know, it still seems to be pretty fragmented.
16 And then to your point about health outcomes,
17 yes, ASPE did a study that showed that PACE enrollees were
18 less likely to be hospitalized, use emergency department
19 visits, and use institutional care, and were no more likely
20 to die than enrollees in FIDE SNPs and non-integrated MA
21 plans.

1 CHAIR JOHNSON: Thank you. Heidi.

2 COMMISSIONER ALLEN: Yeah. I just feel like PACE
3 is a very innovative program. And while I agree that
4 understanding how money is being spent is important, it
5 does seem like trying to record encounter data in a care
6 center, where people are interacting with their providers
7 on a regular basis, and trying to interpret encounter data
8 outside of that system.

9 You know, like normally we would look at a
10 program, and if they had low utilization of specialty care
11 we might worry that there's access issues. But in this
12 situation, you might interpret low utilization of specialty
13 care as these multiple encounters that they're having with
14 their care team, and this day center might be preventing
15 the need for specialty care, and that that might actually
16 be a positive outcomes.

17 And it's interesting to me that we've heard from
18 beneficiaries, we've heard from state officials who say
19 that people love this program. And I think in Medicaid,
20 and even in Medicare, it's really wonderful when you see
21 people reporting that they are having such a high-quality

1 experience, and thinking about how little, like we're still
2 in the new access rules, trying to understand beneficiary
3 experience for managed care.
4 So it's kind of like what measures really matter.
5 And if we pursue recommendations that involve measures, I
6 would like to think about what measures really matter very,
7 very carefully, so that we don't disadvantage these
8 programs, seeking to make them more like programs that are
9 less successful, and have less weight on beneficiary
10 experience.
11 You know, I understand the need for
12 accountability, but from what I've heard so far, and
13 correct me if I'm wrong, there aren't like indicators of
14 concern. And I'd like to understand more, a little bit why
15 Patti thinks that they might be overpaid and whether or not
16 -- you know, you mentioned that they don't have access to
17 certain funding streams for building infrastructure and
18 things like that. And if we identify this overpayment,
19 this potential overpayment as they're using money in a more
20 flexible way, that we would then calibrate and end up

1 disadvantaging them and making them impossible to exist.
2 And I would really not want to do that.
3 CHAIR JOHNSON: Thank you. Carolyn.
4 COMMISSIONER INGRAM: Yeah, just back on some of
5 the other comments from previous folks, did we look, at
6 all, or ask the states if they have the capacity to oversee
7 these programs?
8 MR. O'GARA: We didn't ask them directly, but it
9 did come up in several interviews. I'll note that one
10 state with a fairly healthy PACE presence, for example,
11 noted that their team is four people, and that they drive
12 around the state trying to visit all of the PACE programs.
13 So staff capacity certainly did come up.
14 COMMISSIONER INGRAM: Okay. And then the only
15 other thing I would question is in terms of the outcomes of
16 the program. It's good that at least there's somebody
17 starting to study it. But if you have an organization
18 that's able to cherry-pick and choose who comes in, the
19 outcomes are going to be a little bit better than other
20 organizations who just have to take everybody.
21 I'll stop with that. Thank you.

1 CHAIR JOHNSON: All right. Any other questions
2 or thoughts? I want to thank you both for your continued
3 work on this. I personally have always appreciated the
4 PACE model as one of the ones that went on from the On Lok
5 program that was mentioned earlier, when I was at CMS. And
6 so really, I appreciate how it has grown over time.
7 But I also share a lot of the same concerns that
8 many of you all have raised, as well. I do believe there
9 is interest in exploring this further. You know, as we
10 think about it, I think you mentioned 84 percent of the
11 individuals here were in the duals program. That does
12 continue our duals work, for sure. But there are a lot of
13 issues that were articulated -- beneficiary enrollment, the
14 oversight piece of it, the quality piece, quality measures,
15 and all of that.
16 So do you all have what you need to kind of move
17 forward and come back to us with some other thoughts, as
18 well?
19 MR. O'GARA: Yes, I think we definitely do, so
20 thank you.

1 CHAIR JOHNSON: Okay. Thank you so much. We
2 appreciate it.
3 All right. So we are now going to open it up for
4 our final public comment period for this week. We do
5 invite people in the audience to raise their hand if they
6 would like to offer comments. Again, we do ask that you
7 identify yourself and the organization you represent, and
8 we also ask that you keep your comments to three minutes or
9 less.
10 So with that, let's go to the comments.
11 All right. First off, we have Camille Dobson.
12 **### PUBLIC COMMENT**
13 * MS. DOBSON: Good morning, Commissioners. Can
14 you hear me?
15 CHAIR JOHNSON: Yes, we can hear you.
16 MS. DOBSON: Okay. Perfect. Thanks so much.
17 Camille Dobson, Deputy Executive Secretary of Advancing
18 States. We represent the aging and disability agencies in
19 the states and territories that delivery home and
20 community-based services to older adults and people with
21 physical disabilities.

1 And I have worked for many years with MLTSS
2 states, and I think many of the concerns that Patti and
3 Carolyn raised about comparability and self-selection, lack
4 of applicability of the managed care rules to PACE sites,
5 have continue to roil. I think that the states have a hard
6 time understanding the experience of individuals in the
7 PACE sites because of the lack of transparency.
8 But I did want to focus mostly, quickly, on the
9 quality issue. As you all know, CMS issued an HCBS Quality
10 Measure Set voluntarily last year, and through the access
11 rule, requiring states to report on it. And one of the key
12 elements is a Consumer Experience Survey.
13 As the steward of the National Core Indicators
14 for Aging and Disability Survey, which is included in the
15 Quality Measure Set, we have long encouraged our states to
16 survey their enrollees in PACE. We had 18 states last
17 year, and of those 18, 4 surveyed their PACE sites, in a
18 representative sample where you can actually see the
19 experience of PACE enrollees next to MLTSS, fee-for-
20 service, Medicaid individuals in nursing facilities, on
21 things like access to the community, their relationships,

1 choice and control, service and care coordination, access
2 to health services.
3 And so I put out there for thought, for the
4 Commission, about whether CMS has the regulatory authority
5 to apply the HCBS measure set to PACE sites for at least
6 the Medicaid-like services that they are delivering around
7 personal care and the other types of supportive services
8 that allow people to live in their community. I think it
9 might be a way to get around sort of just the medical
10 Medicare measures and really get to the core of the home
11 and community-based services that they should be providing
12 to people to keep them at home.
13 Thank you.
14 CHAIR JOHNSON: Thank you, Camille. Next up we
15 have Patience White.
16 DR. WHITE: Great. Good morning, Commissioners.
17 Can you hear me? I assume you can.
18 CHAIR JOHNSON: We can.
19 DR. WHITE: Great. I am Co-Director of Got
20 Transition with Peggy McManus, and we have had the pleasure

1 of working with the Abt Group on this policy area. So I am
2 really addressing the pediatric health care transition.
3 We have sort of three comments we just wanted to
4 bring forward. One is on Slide 5, where it states no
5 standard transition process. Well, actually there is,
6 which was briefly mentioned, that there are recommended
7 professional association recommendations around the six
8 core elements, and so forth. So we would to be added to
9 the no standard transition process is available within
10 Medicaid and CHIP. I think that's the key addition there.
11 On Slide, I think it's number 12, on Policy
12 Number 1, we also wanted to suggest that perhaps there
13 should be more specificity here. One of the key issues
14 that comes up is having a concise medical summary and help
15 finding with an adult doctor, and going over changing in
16 care and coverage options. This comes up constantly. I
17 obviously give a lot of care to this population around
18 transitions. So we would like to add that specificity if
19 it is possible.
20 And then lastly, Slide 17, on Policy Number 4, we
21 thought it would be helpful to sort of amend it direct CMS

1 to develop a pilot process on pediatric to adult health
2 care, around sort of designate those kinds of projects with
3 value-based payment options that were aligned with the
4 professional organizations. I think thinking about that
5 and getting a jumpstart would be very helpful in this whole
6 process.
7 So those are our suggested recommendations.
8 Thank you for letting us comment.
9 CHAIR JOHNSON: Thank you, Patience. We
10 appreciate it. Next, we have Richard Antonelli.
11 DR. ANTONELLI: Yes. Good morning. Can you hear
12 me?
13 CHAIR JOHNSON: We can hear you.
14 DR. ANTONELLI: Yes. Thank you. I also would
15 like to speak to the transition. My name is Richard
16 Antonelli. I'm a general pediatrician and the Medical
17 Director of Integrated Care at Boston Children's Hospital.
18 I am also the co-principal investigator on the Center for
19 Improving Care for Children with Medical Complexity. So a
20 sincere thanks to MACPAC for taking on this issue of
21 transitioning from pediatric to adult care.

1 I will be parsimonious with my time, but I
2 wanted, first of all, to express how grateful I am and
3 impressed I am about the evolution of these recommendations
4 from last month's meeting to this one. A sincere thanks to
5 the Commissioners for the commentary, and to the staff for
6 making those recommendations.
7 A couple of things that I'd like to point out.
8 As somebody that has written pretty extensively and done
9 quite a bit of research about a care plan, having a care
10 plan is literally a structural measure. The value of the
11 care plan comes in what was the process by which it was co-
12 produced, by the person, patient, family caregiver with
13 other members of the care team.
14 So a multidisciplinary, multidomain care plan
15 that is made on the pediatric side is potentially only of
16 value if the necessary elements on the adult side of the
17 transition or transfer actually happen. And as somebody
18 that established a transition clinic here at Boston
19 Children's Hospital, I literally was referred patients that
20 were 30 and 40 years old. I could give them a spectacular
21 care plan, and then basically said, "Good luck finding an

1 adult gastroenterologist," "Good luck finding an adult
2 provider that understands autism."
3 So I really want to point out that while I
4 applaud an explicit expectation of the care plan, that, in
5 fact, elements of what care plan implementation would look
6 like, this would address a couple of things. One, the
7 integration and endorsement of folks on the adult side that
8 would actually be stepping into the roles of the care, and
9 two, one of the Commissioners pointed out the engagement of
10 the patients and families. This would be a robust
11 demonstration of engagement to get these patients,
12 generally with complex needs, into the adult side, hence
13 the term "integration."
14 I would also like to point out -- in fact, I
15 really appreciate the Commissioners pointing out about not
16 boiling the ocean with respect to measurement. So I do
17 want to make a couple of comments about the measurement
18 space before I end my comments.
19 One is that essentially all the data that we have
20 right now is on the pediatric side. I'm thrilled that HRSA
21 has launched the so-called longitudinal cohort, where we

1 can track these youth and young adults up to age 21. But
2 we really don't have data on the adult side. We do know,
3 anecdotally, it's really tough, hence the fact that you
4 have pediatricians doing consultations on 30- and 40-year-
5 old people.
6 But it would be very helpful to look and see
7 where these patients land on the adult side, and to do that
8 without saying we need new measures, and let's take 10
9 years to do it. We could simply look at mandated Medicaid
10 CMS, either Medicaid core set or HCBS measures, that could
11 then be stratified, for example, on the basis of disability
12 status, looking at the adult side, how many of the patients
13 that were receiving those services on the pediatric side
14 continue to receive the appropriate services on the adult
15 side.
16 So I do feel that we need more robust data for
17 the purposes of improvement -- I want to emphasize that --
18 on the adult side. So building the bridge from the
19 pediatrics to the adult side is essential. But we are kind
20 of flying blind except for lots and lots and lots of
21 anecdotal data on the adult side.

1 And with that I will close my comments my just
2 thank you for highlighting how incredibly important this
3 issue is.
4 CHAIR JOHNSON: Thank you very much. Liz Parry,
5 you are up next.
6 MS. PARRY: Hello. Good morning. Can you hear
7 me?
8 CHAIR JOHNSON: We can hear you.
9 MS. PARRY: Great. Thank you. Hi. My name is
10 Liz Parry, and I'm with the National PACE Association.
11 Thank you so much for your interest and focus on PACE.
12 PACE has played a significant role in supporting the goal
13 of state and federal policymakers to serve individuals who
14 need long-term services and supports in a capitated
15 integrated care model.
16 Through the community-based comprehensive and
17 highly coordinated PACE model of care, participants can
18 remain independent in their homes for as long as possible.
19 NPA really appreciate the thoughtful approach, questions,
20 and comments by MACPAC Commissioners and staff.

1 One thing important to note, most participants
2 are 65 years or older, about 91 percent of our population,
3 and they have chronic health conditions. The average PACE
4 participant has six or more chronic conditions, and nearly
5 half the PACE participants have dementia.
6 NPA supports increased access to PACE, and we are
7 pleased to see the number of new PACE organizations has
8 grown quite a bit over the last few years. In 2024, 25 new
9 PACE organizations opened, compared to 6 that opened in
10 2023. Today there are a total of 180 PACE organizations,
11 serving over 80,000 individuals.
12 However, despite this growth there are still 17
13 states with no access to PACE, and even in states that
14 offer PACE there are significant areas unserved by PACE.
15 Specifically, in PACE states, on average, over 50 percent
16 of estimated eligible individuals do not have access to
17 PACE, and many of these areas have no PACE coverage, and
18 have health care disparities and/or are rural communities
19 that could benefit from PACE services.

1 We are pleased that just last week HRSA, in
2 recognition of this challenge, did offer some new grant
3 opportunities for PACE to expand into rural areas.
4 While we are committed to the continued growth of
5 PACE, we are equally committed to assuring the quality of
6 the PACE care model, so we appreciate the dialogue today
7 from so many of you, raising some of these questions.
8 PACE has a long history of providing high quality
9 of care to participants that meet their unique health care
10 needs, and having a uniform set of performance measures
11 that are both important and actionable for the PACE
12 population without overburdening PACE organizations will
13 help sustain the quality of care for participants.
14 Therefore, NPA supports CMS working with states
15 to develop thoughtful and targeted national PACE standards
16 for service delivery and performance data sources and
17 metrics.
18 It is also important to note that CMS just
19 recently issued updated Medicaid rate-setting guidance,
20 which we are hopeful will help provide additional clarity
21 and transparency with the Medicaid rate-setting process, to

1 make it fair and equitable for both states and PACE
2 organizations.
3 As MACPAC continues to focus on PACE, NPA hopes
4 the Commissioners will think about how to continue to grow
5 the model, ensure easier access for participants, while
6 also balancing the needs to assure the high quality of
7 care.
8 Please feel free to reach out to NPA any time if
9 you have any questions or need any additional information.
10 Thank you so much for your time today.
11 CHAIR JOHNSON: Thank you so much for your
12 comments.
13 Any other comments out there?
14 [No response.]
15 CHAIR JOHNSON: Okay. So again, thank you for
16 the comments we received. I also want to remind all the
17 audience that you may also submit your comments on the
18 MACPAC website, if you have additional ones to share.
19 So with that we will adjourn for the day, and we
20 will see you all next month, on February 27th and 28th.
21 Enjoy your weekend.

1 * [Whereupon, at 11:57 a.m., the meeting was
2 adjourned.]
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