The Medicaid and CHIP Payment and Access Commission’s September 2024 meeting began with a summary of provisions in four final rules that the Centers for Medicare & Medicaid Services (CMS) recently issued on eligibility and enrollment, access to care, managed care, and nursing facility staffing and payment transparency. For each rule, staff provided an overview of key requirements, highlighted how CMS responded to MACPAC comments on the rules, and discussed how the new rules relate to ongoing and future work during this analytic cycle.

Next, the Commission heard a presentation on the ways that states expedite Medicaid eligibility determinations and enrollment for individuals in need of home- and community-based services (HCBS).

This session focused on the use of presumptive eligibility and expedited eligibility for individuals whose income is not determined using modified adjusted gross income (MAGI). MACPAC staff presented on the preliminary findings from interviews with state and federal officials, as well as other national experts. Interviews highlighted a large degree of state variation in how presumptive eligibility and expedited eligibility can be used for non-MAGI populations. In addition, MACPAC collected feedback demonstrating how these flexibilities can reduce the amount of time an applicant waits to receive HCBS.

Staff then presented possible policy options to help ease the administrative burden for states providing HCBS to Medicaid beneficiaries. Section 1915 authorities allow states to provide HCBS, but operationalizing these programs can be administratively burdensome. MACPAC has identified opportunities to alleviate some of that burden. In this session, Commissioners discussed two policy options: (1) increasing the renewal time period for Section 1915(c) waivers from 5 to 10 years, and (2) removing the requirement that states meet a cost neutrality test for Section 1915(c) waivers and directing the Secretary of the U.S. Department of Health & Human Services to release an annual report demonstrating the cost effectiveness of HCBS.

To end the day, the Commission heard a staff presentation and panel discussion on the Program of All-Inclusive Care for the Elderly (PACE), a provider-led model that provides fully integrated care to frail adults ages 55 and older with nursing facility level of care needs while allowing them to remain in the community. MACPAC staff presented an overview of the PACE model, including information on the regulatory framework, design elements, enrollment and spending data, and outcome evaluations. Next, a panel of experts on PACE discussed areas of interest regarding the model, challenges, and benefits. The Commission highlighted priority issues to address in subsequent interviews with state and federal officials, PACE providers, and consumer advocates.

Panelists included:

* **Kayla King**, PACE and Senior Care Options Program Manager at the MassHealth Office of Long-Term Services and Supports
* **Sabrena Lea**, Deputy Director for Long-Term Services and Supports in the North Carolina Department of Health and Human Services, Division of Health Benefits
* **Cindy Proper**, PACE Technical Director within the Division of Health Homes, PACE and COB/TPL in the Medicaid Benefits and Health Programs Group, Centers for Medicare & Medicaid Services

On Friday, the meeting began with an introduction to MACPAC’s work on residential services for youth with behavioral health needs. In response to the Commission’s continued interest in services for Medicaid-enrolled children and youth, MACPAC has initiated work to examine how Medicaid ensures that children and youth with serious behavioral health conditions appropriately access intensive services in residential settings following an assessment of their needs and the certification of medical necessity for this level of care. In this first phase of work, we are examining the challenges states face in providing appropriate and timely access to intensive residential treatment services for youth, including older age youth, those with prior admission to acute care settings, and youth with co-occurring conditions such as intellectual or developmental disabilities.

Next, the Commission examined the managed care external quality review (EQR) process as part of its work on strengthening managed care oversight and accountability. Staff reviewed prior work and presented an update on EQR requirements in light of the final Medicaid managed care rule released on May 10, 2024. The managed care rule requires that the annual technical report include any outcomes data and results from quantitative assessments of performance improvement plans, performance measures, and network adequacy. The Commission discussed the findings from the prior work and if there were areas to explore for potential policy options regarding how EQR could be structured to use outcomes data and improve the transparency and usability of EQR findings.

Staff then presented new work on the needs of justice-involved youth. Medicaid and the criminal justice system share responsibility for providing health care to Medicaid enrollees who are involved in the justice system. MACPAC has [examined the health needs of justice-involved adults](https://www.macpac.gov/publication/access-to-medicaid-coverage-and-care-for-adults-leaving-incarceration-2/) but the Commission has not yet explored the specific needs of justice-involved youth. Federal law generally prohibits states from receiving federal matching funds for services provided to individuals who are eligible for Medicaid or the State Children's Health Insurance Program (CHIP) while they are incarcerated. The session explores the health needs of and access to care for justice-involved youth and Medicaid’s evolving role in covering services for youth who are detained, incarcerated, or recently released from carceral settings.

To conclude the meeting, staff presented findings from a Technical Expert Panel (TEP) with representatives from federal and state government, hospitals, consultants, and researchers to update an earlier MACPAC state-level hospital payment index to compare fee-for-service (FFS) inpatient hospital payments across states and to Medicare payment rates. Key themes from the TEP included methods to calculate Medicaid payments using available data sources, meaningful benchmarks for Medicaid payment comparison, methods to account for supplemental payments and provider financing, and uses for the payment index.