Medicaid and CHIP Payment and Access Commission, January 2026 Public Meeting

January 29-30, 2026
[Meeting materials available on the MACPAC website here.[1]]
Meeting Summary

On January 29-30, 2026, the Medicaid and CHIP Payment and Access Commission (MACPAC, or "the Commission") held its January public meeting. HFMA presents the following summary of that meeting. Unless specifically attributed to MACPAC commissioners or staff, all forward-looking statements in this summary reflect a prognostication of the Commission's likely actions; such statements are not informed by any proprietary or inside information about MACPAC's future plans.

I. STATE AND FEDERAL TOOLS FOR ENSURING ACCOUNTABILITY OF MEDICAID MANAGED CARE ORGANIZATIONS: POLICY OPTIONS (Holly Saltrelli and Chris Park, staff)

ISSUE: Managed care is the predominant delivery system in Medicaid. As such, the effective oversight of Medicaid managed care programs is a priority for stakeholders. This session continued the Commission's examination of the use of managed care accountability tools. It reviewed key findings from stakeholder interviews and analysis of the Managed Care Program Annual Reports (MCPARs) available from the Centers for Medicare & Medicaid Services (CMS), identifying the opportunities and barriers to effective oversight that emerged from MACPAC's study. Staff then presented policy options to address the opportunities to improve Managed Care Organization (MCO) accountability, with a focus on equalizing the authorities across fee-for-service (FFS) Medicaid and managed care and on improving stakeholders' ability to leverage available managed care plan data.

PRESENTATION: Staff reiterated their findings from the December 2025 meeting before presenting three policy options built on those findings.

Among the key findings and background shared:

- 41 States and DC use contracts with comprehensive, risk-based MCOs
- 73 percent of beneficiaries are enrolled in managed care
- 56 percent of Medicaid benefit spending is on managed care
- "Federal requirements are minimal" on MCOs
    - For example, CMS must approve State-MCO contracts and MCO rate certifications
    - CMS has fewer oversight tools for MCOs relative to FFS
- For non-compliance with Federal requirements, CMS may deny Federal Medicaid matching funds for the entirety of a non-compliant plan's capitation payments, rather

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[1] Transcripts and presentation slides are generally available three to five days after the meeting on MACPAC's website.

than for just the portion that is out of compliance (e.g., home health), which would lead to a "disproportional" effect.
    - Thus, CMS rarely uses (and potentially has never used) this authority.
    - In FFS, CMS may withhold, defer, or disallow Federal Medicaid matching funds for the specific services/claims that are out of compliance.
- CMS requires States' contracts with MCOs to establish intermediate sanctions for specific instances.
    - Imposing sanctions is discretionary.
    - States may impose additional sanctions under State law.
    - MCPARs must include the results of any State sanctions, corrective action plans (CAPs), or other formal or informal intervention with an MCO, but "informal interventions" are not defined, leading to State variability.
- States vary in what they report on MCPARs and are likely not reporting all compliance actions.
    - States need better tools and guidance.
    - The data are not useful to beneficiaries or across States.

Staff presented three policy options:

(1) Congress should amend Federal Medicaid law so CMS can withhold, defer, or disallow Federal Medicaid matching for all or <u>part</u> of managed care capitation payments.
(2) CMS should provide clarification and guidance to support MCPAR data accessibility and completeness.
(3) CMS should issue guidance and/or toolkits on how to effectively use available data to assess plan performance.

If commissioners are interested, staff offered to come to the next meeting with recommendation language for any of these options.

DISCUSSION: In short, commissioners supported options 2 and 3 but many expressed concern about option 1—that is, allowing CMS to withhold Federal Medicaid matching for only a portion of the plan's capitation payment (i.e., the portion that is out of compliance), rather than the entirety (which rarely/never happens). Commissioners' concern was that option 1 would invite more frequent CMS intervention with a financial penalty on States, when the management of MCOs has been left to the States.

Commissioner Giardino began the discussion by stating his support for options 2 and 3 but expressing serious concerns about the first option. He said that Medicaid is a joint Federal-State program and that opening the door to more actions would lead to "additional micromanagement" by CMS "that would weaken the ability of State leaders to manage their population." Regarding the MCPAR guidance, notwithstanding this support for the option, he noted that many States deal with MCO issues informally and having to report every time feedback occurs would be onerous and create problems in the relationships. He suggested that States should be able to address issues with MCOs informally without having to report it.

Commissioner Hill supported not only options 2 and 3, but also the first. While acknowledging Commissioner Giardino's point, option 1 would introduce a level of precision and flexibility that doesn't currently exist. Even though it is a partnership between CMS and the States, there could be situations where CMS believes plans are out of compliance and there is disagreement with the State about what action, if any, would be appropriate. It would be helpful to give CMS the flexibility not to defer the entire amount but to target the issue (e.g., home health, transitions for children). Option 1 would not create more Federal requirements but gives CMS flexibility to target compliance issues. Commissioner Hill noted that FFS does not require deferring a provider's entire amount but only the claims at issue.

Commissioner Snyder also expressed support of options 2 and 3, but requested more information on (1) what would trigger CMS intervention in terms of withholding Federal matching funds, related to the severity, and (2) would CMS get involved when a State is not pursuing action that is needed, or is it on top of State actions? In response, staff gave an example from the 2024 "Access" rules (one of which was for FFS and the other for managed care[2]), which had many reporting requirements; for FFS, staff indicated that CMS said they would withhold Federal matching only for the reporting for that service, but for managed care, it would have to withhold Federal Medicaid matching funds on the entire capitation payment.[3]

Commissioner Bjork also supported options 2 and 3 but not 1, citing differences between FFS and managed care. States have contracts with MCOs (not so in FFS) and CMS has MCO tools, such as reviewing contracts.

Citing his prior experience at CMS, Commissioner Nardone said having the ability to do partial deferrals would have been helpful. Even so, without clear guardrails when this authority could be used, he would have some concerns about supporting. He also disagreed with comparisons between FFS and managed care, calling it a "false equivalency." Regarding option 2 (clarity around MCPAR data), he agreed with Commissioner Giardino that, while supportive of more clarity, informal interventions are required to be reported in MCPAR and that "bar should be set relatively high" because States do a good job of managing. He said when he was a State Medicaid director, he met quarterly with every plan; reporting all of those interactions would not be manageable and might not provide an accurate picture. But he could ultimately support options 2 and 3.

Commissioners Allen, Ingram, Killingsworth, and Heaphy mentioned their support for options 2 and 3 but not 1. Commissioners Killingsworth and Heaphy called option 1 a Federal overreach. Commissioner Brown could support option 1 if it had some guardrails, as described by Commissioner Nardone.

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[2] Both of these were published May 10, 2024 (FFS Access at 89 FR 40542 and MCO Access at 89 FR 41002).

[3] Although this was not a direct answer to the commissioner's question, it is worth noting that withholding Federal Medicaid matching is, at the first level, a punishment on the State, not MCOs or providers. States do not want Federal funds withheld from them. For CMS to punish the State by withholding Federal funds when the State is already taking action ("on top of State actions") does not seem advisable. Thus, the answer to the commissioner's question is likely that CMS would withhold Federal funds when the State is not pursuing action CMS deems necessary.

II. APPROPRIATE ACCESS TO RESIDENTIAL SERVICES FOR CHILDREN AND YOUTH WITH BEHAVIORAL HEALTH NEEDS: DRAFT POLICY OPTIONS

(Joanne Jee and Sheila Shaheed, staff)

ISSUE: The Commission continued its examination of appropriate access to residential treatment services for youth with behavioral health needs. MACPAC staff reviewed Federal requirements for Medicaid coverage of residential treatment services, summarized key findings and challenges with access, and presented draft policy options that addressed key challenges. These draft policy options highlighted the absence of easily accessible, public information on facility and bed availability; the availability of data on use of residential care, in particular in out-of-State facilities; and the need to strengthen discharge planning requirements, including for youth in out-of-State residential treatment.

PRESENTATION: Staff began the presentation with background and findings, mostly from the June 2025 chapter "Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid." Key points:

- For youth with disabilities, residential treatment is supposed to be the last resort (e.g., for those who pose a safety risk to themselves or their families and cannot be served in the community).
- Provider types include psychiatric residential treatment facilities (PRTFs), qualified residential treatment programs (QRTPs) for children in foster care, and other settings that do not meet the requirements of a PRTF or QRTP.[4]
- Difficulty finding real-time information on facility and bed availability and specialized care can hinder access to residential services. No single Federal data source related to this information exists.
- Out-of-State placements occur if in-State facilities are unable to meet a child's needs or denies admission, but there is no national data source on these placements.
    - Interviewees indicated that facilities prefer to admit out-of-State youth due to higher payments.
    - Out-of-State placements can make it difficult to maintain connections with family and transition back to the community.
    - Federal rules for discharge planning are brief and do not address out-of-State considerations.

Staff presented three policy options:

(1) Recommend Congress to require the Department of Health and Human Services (HHS) to develop and maintain a directory of youth residential treatment facilities.
(2) Recommend CMS to report on the use of residential treatment services, including non-

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[4] The broad Federal statutory exclusion of Federal financing to institutions of mental diseases (IMDs) does not apply to the "psych under 21" optional Medicaid benefit, thus allowing States to cover services delivered in PRTFs, a psychiatric hospital, or a psychiatric unit of a general hospital. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement mandates that States provide beneficiaries age 21 and younger access to medically necessary Medicaid services; if PRTF services for an individual are necessary per EPSDT, then it effectively becomes a mandatory benefit for the State, which may have to be provided in an out-of-State location (MACPAC June 2025 report, p. 39).

PRTFs and out-of-State residential treatment providers.
(3) Recommend CMS to revise Federal regulations to establish minimum requirements for discharge planning processes.

If commissioners are interested, staff offered to come to the next meeting with recommendation language for any of these options.

DISCUSSION: Multiple commissioners supported the idea in option 1 (require development of a directory of youth residential treatment facilities) but expressed concerns on implementation and feasibility in terms of accuracy and resources required (Commissioners Gerstorff, Killingsworth, McCarthy, McFadden, Nardone).

Commissioner McCarthy expressed support for the other two options, although was unsure if the last one (i.e., to update Federal regulations to further address discharge planning for these services) would add much value. Commissioner Nardone was strongly supportive of the second option (i.e., requiring CMS to report on the use of residential treatment services). Notwithstanding their Medicaid-focused purview, multiple commissioners suggested that the directory and reports would be more useful if they contained information pertaining to all payers (including self-pay), not just Medicaid. While acknowledging feasibility challenges, Commissioner Allen said such a directory seems critical.

Commissioner Gerstorff asked whether the non-PRTF reporting would include, for example, children boarded in an emergency department (ED) or inpatient beds. Staff responded that the option does not specify all data elements but CMS could engage stakeholders on what would be most helpful. Commissioner Killingsworth said ED utilization and extended stays (ED boarding) could be the most useful data as indicators of access issues.

Regarding option #3, Commissioner Killingsworth said that current Federal discharge planning requirements is a non-specific policy that is almost useless. She said greater specificity would be helpful. For example, if discharge planning policies do not require engagement of family members and identify community providers, they are useless.

Commissioner Allen said it is unacceptable and cruel that States keep individuals in out-of-State facilities because “we can’t figure out a way to bring them home”; there should be consequences for not bringing children home in a timely way.

Commissioner Hartman “had an 8-year-old who was suicidal” but facilities would only take those aged 12 and older. Thus, any information on facilities needs to include their age range.

III. CONSIDERATIONS FOR IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS: PRINCIPLES AND POLICY OPTION (Melinda Becker Roach and Janice Llanos-Velazquez, staff)

ISSUE: For the first time, States will soon be required to make Medicaid eligibility for certain applicants and existing beneficiaries contingent on their participation in qualifying community engagement activities in accordance with Public Law 119-21 (2025 Budget Reconciliation Act). This session introduced four principles for implementing community engagement (CE) requirements, which reflect findings from MACPAC's stakeholder interviews and commissioner discussions to date. The session also presented a policy option for monitoring and evaluating community engagement requirements, based on stakeholder and commissioner interest. Commissioners discussed including the principles and policy option, in the form of a recommendation, in MACPAC's June 2026 report to Congress.

PRESENTATION: Staff began by noting the related presentations from the September and December 2025 meetings, along with prior panel and commissioner discussions (The December meeting is presented in an HFMA Summary).[5]

Overview of CE requirements:

- The requirements apply to non-pregnant, non-dually eligible individuals age 19-64 who are eligible for the adult expansion group or a Section 1115 waiver providing minimum essential coverage (MEC), with exceptions.
- Such individuals must work or volunteer for at least 80 hours in a given month, or go to school at least half-time, to enroll in Medicaid and maintain eligibility.
- States must establish the requirements by January 2027 unless they receive a good faith effort exemption.
- CMS must issue an interim final rule (IFR) by June 1, 2026.

Staff provided four "draft principles that emerged from our research":

(1) CMS should provide timely Federal guidance and technical assistance to States.
(2) CMS and States should ensure that eligible individuals can gain and maintain coverage.
(3) CMS and States should prioritize efficiency when procuring, updating, and operating State information technology (IT) systems.
(4) CMS and States should use timely monitoring and evaluation data to inform policy and operations.

Based on those principles, staff presented a single policy option:

> "*The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to develop a transparent plan for monitoring and evaluating community engagement requirements in Medicaid that provides insight into how such policies affect eligibility and enrollment, health status,*

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[5] In the September 2025 meeting, the presentation said, "Staff will present interview findings this fall and publish a chapter in the March 2026 Report to Congress." However, in the January 2026 presentation, staff said, "We anticipate including the principles in the June report chapter on implementation considerations"

> *employment, and the attainment of other identified policy goals. CMS should identify new metrics for state reporting, as needed, and build upon existing data collection activities to minimize administrative burden. Additionally, CMS should ensure the timely publication of monitoring and evaluation results to inform policy and operational decision making.*"

Staff posted tables of "stakeholder-identified metrics for consideration" of (1) data that CMS already has, and (2) data that CMS does not have, specific to CE. The latter category included the following information:

- Number of Medicaid beneficiaries generally subject to community engagement requirements, including:
    - Number qualifying for an exception
    - Number qualifying for an exception based on an ex parte basis (i.e., based on information available to the State without needing beneficiary involvement)
- Number losing coverage due to noncompliance with CE requirements, distinguishing between the following:
    - Not meeting requirements
    - Not submitting evidence of compliance[6]
- Number satisfying the requirements, total and by each type of qualifying activity (i.e., work or work program, education, community service, or a combination), distinguishing between verified on an ex parte basis vs. manually.

DISCUSSION: Commissioner Hill said the principles were "spot on." However, considering that evaluations cost money and there hasn't been a commitment from CMS for an evaluation of the effects of the CE requirements, Commissioner Hill suggested that MACPAC consider recommending a statutory change, which is more likely to drive action. Commissioner Allen shared the same sentiment.

Commissioner Brown questioned the need for obtaining information on health status, which was not addressed.

While agreeing with the principles and option, regarding the first principle (timely Federal guidance and technical assistance), Commissioner Snyder was most concerned with States' readiness by end of this year.

Commissioner Allen said it would be helpful to measure time spent uninsured. She also mentioned "unintended disenrollment on unaffected enrollees"—that is, people not understanding the requirements do <u>not</u> apply to them and therefore do not [re-]enroll. Commissioner Karl agreed the CE metrics would be helpful. While the granularity raises

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[6] Within either of these two subcategories, it is not clear how individuals would be handled who believed they did not meet requirements and thus did not submit evidence of compliance. They would most likely be placed in the latter subcategory. This would be consistent with how many groups categorize individuals who do not reapply for regular Medicaid and are counted under "procedural disenrollment" or "terminated for procedural reasons" rather than "determined ineligible"; "[p]rocedural disenrollments occur when the State cannot verify an individual's ongoing eligibility at renewal." (KFF).

legitimate concerns about too much burden with reporting, this level of detail is important given the newness of the policies and the impact on beneficiaries.

Commissioner Ingram mentioned approaches for automation/ex parte (e.g., drawing from payroll stubs) but State systems do not have open APIs and some have problematic current practices. For example, one State requires a "wet signature" before processing eligibility. Another State calls the person's number to verify person is there and if the person isn't there, determinations are delayed. She also suggested self-attestation for volunteering as an example of offering flexibility for this population. She also described how, as individuals lose coverage, the remaining population is likely to be higher risk, higher need, and cost more, and suggested a recommendation to call for review of rates for providers and plans due to the effects of the CE requirements.

Commissioner McCarthy noted that once individuals leave Medicaid and become uninsured (or obtain different coverage), their insurance status is no longer available through Medicaid. It would be helpful to have that data—for example, how many move from Medicaid to Exchange coverage when their income increases. Commissioner Hartman agreed, stating that if individuals became ineligible for Medicaid because they became employed (i.e., increased income), it would be helpful to know that. Unfortunately, she said, many individuals who get a job or increased hours might no longer qualify for Medicaid but still don't qualify for job-based coverage.

PUBLIC COMMENT

Tricia Brooks (Center for Children and Families; former MACPAC commissioner) suggested that disenrollment surveys would be an effective way to capture what happens to individuals after losing Medicaid. Such surveys can be timely, getting information in the first weeks/months. Such data was captured and published in Arkansas, which had briefly implemented work requirements under a section 1115 demonstration. The number of people losing coverage was "frightening" and the work requirements stopped.

Thomas McDaniels (HIV/Hepatitis Policy Institute) asked MACPAC to recommend an explicit exemption from CE requirements for people with HIV/AIDS.

IV. CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS COVERAGE TRANSITIONS: POLICY OPTIONS (Linn Jennings and Ava Williams, staff)

ISSUE: Findings from MACPAC's work show that Medicaid-covered children and youth with special health care needs (CYSHCN) can have challenges with the transition from child to adult Medicaid and may experience a gap or loss in coverage during this period. This session provided a summary of the 2023 Transformed Medicaid Statistical Information System (T-MSIS) findings, key challenges, and current CMS requirements and guidance related to those challenges. MACPAC staff presented seven policy options for Commission consideration to address these findings.

PRESENTATION: Staff discussed the types of challenges this population faces in transitioning to adult coverage and focused on the following five issues, providing policy options for the first four.

1. Insufficient Time to Prepare and Respond to Medicaid Redetermination Notices

A. *Issues*.

(i) Redeterminations must first be done by States on an ex parte basis; beneficiaries are only contacted if more information is needed, which may not afford adequate time to provide the information.

(ii) Notices requiring additional documentation may lack clear, actionable steps in plain language.

(iii) There is no requirement for States to provide notice that a redetermination is being conducted, and many States don't begin the process until 60 to 90 days in advance of termination.

B. *Policy Options to Provide for Advance Notice for Anticipated Change in Circumstance*.

Option 1. **Recommendation**: CMS should require States to notify Medicaid beneficiaries at least 60 days before they age out of child Medicaid eligibility.

There is no federal requirement for States to notify beneficiaries. CYSHCN who are SSI eligible, receive a Social Security Administration (SSA) notice a year in advance of their age-18 SSI redetermination, and there is no analogous requirement for State Medicaid agencies in advance of CYSHCN aging out of child Medicaid.

Option 2. **Recommendation**: State Medicaid agencies should provide beneficiaries with a minimum of 30 calendar days to respond to requests for information to complete Medicaid redeterminations for CYSHCN aging out of child Medicaid eligibility groups.

Note: The 2025 Budget Reconciliation Act (P.L. 119-21) paused the CMS Eligibility and Enrollment (E&E) final rule through the end of fiscal year 2035. That final rule required States to provide beneficiaries with a minimum of 30 calendar days to respond to requests for information for changes in circumstances. Thus, CMS may not require this, but States could adopt the policy.

2. Lack of Clarity in Notices from the SSA

A. *Issues*.

(i) SSA notifies individuals of termination of their eligibility for SSI, and in those States that confer Medicaid eligibility based on SSI, the SSA notices include information about the effect of SSI termination on Medicaid eligibility. However, there are no federal requirements for SSA and State Medicaid agencies to coordinate on SSA notice language and the information related to Medicaid eligibility.

(ii) Beneficiaries have challenges understanding notice information about how losing SSI affects Medicaid eligibility. The SSA notices often do not include clear and actionable steps for retaining Medicaid coverage. Additionally, State Medicaid agencies do not have to tell a beneficiary of changes in their SSI eligibility unless it needs additional information to complete the redetermination.

B. *Policy Option for Coordination between Medicaid and SSA on Notice Language*.

Option 3. **Recommendation**: Congress should require State Medicaid agencies to coordinate with SSA on notice language. Specifically, the agencies should review and update SSA's Program Operations Manual System template language for notices sent to individuals enrolled in SSI-related Medicaid who lose SSI when they are redetermined at age 18 to ensure clear and accurate information is provided about (i) Medicaid eligibility status during the Medicaid redetermination and (ii) what the beneficiary should expect during the Medicaid redetermination process. Staff concluded that CMS does not have the authority to require this.

3. Insufficient Support With Medicaid Redeterminations

A. *Issue*.

Beneficiaries do not get sufficient support, especially when navigating multiple transitions. CYSHCN and their families do not always have a dedicated case manager or care coordinator to support them with their Medicaid redetermination. However, States may provide case management to support transitions to adult Medicaid coverage using existing authorities, such as including section 1915(c) HCBS waivers and targeted case management.

B. *Policy Option for Guidance to States*.

Option 4. **Recommendation**: CMS should issue guidance to States on existing Medicaid authorities for supporting transitions to adult Medicaid coverage. Specifically, guidance should address (i) using existing authorities to provide dedicated case managers or care coordinators to facilitate the Medicaid redetermination process and the beneficiary's transition to adult Medicaid; and (ii) including transition planning procedures in those 1915(c) waivers that provide support to beneficiaries through the redetermination process.

4. Navigating Eligibility Transitions

A. *Issues*. States must provide 12 months' continuous eligibility for children under age 19. Many beneficiaries churn or disenroll when they age out of child Medicaid; they may need more time to complete the Medicaid redetermination at age 19. Beneficiaries and their families may feel overwhelmed in completing the redetermination, which is compounded when also navigating other benefit program transitions. States have existing flexibilities to make transitions easier, such as using SSI eligibility to determine Medicaid eligibility or extending child eligibility to age 21.

B. *Policy proposals to Extend Child Eligibility.*

Option 5. **Recommendation**: State Medicaid agencies should extend child eligibility up to age 21 for CYSHCN using existing State plan option authority. Four States have implemented this policy. CMS has clarified that States may extend coverage for individuals under age 21 who meet the criteria for nonmodified adjusted gross income (MAGI) eligibility groups.

Option 6. **Recommendation**: CMS should issue guidance to States on extending child Medicaid eligibility up to age 21 using the State option.

Option 7. **Recommendation**: Congress should extend the 12-month continuous eligibility period to through age 19 for CYSHCN. The 12-month continuous eligibility period ends at age 19, so a beneficiary's final 12-month period may be less than 12 months depending on how many months occur between their annual redetermination and their 19th birthday.

5. Optional Medicaid eligibility pathways for adults who are not eligible on the basis of disability

A. *Issues*. Many Medicaid-covered adults with disabilities are not SSI-eligible and must enroll in non-SSI related pathways to retain Medicaid coverage. A larger percentage of transition-age children who enrolled in disability pathways remained enrolled as adults in Medicaid expansion States than non-expansion States. States may cover optional adult Medicaid eligibility pathways, which can improve coverage transitions. Medicaid beneficiaries can also enroll in waiver programs, which may confer Medicaid eligibility through State optional pathways.

B. *Policy proposals*. No policy options presented.

DISCUSSION: Commissioners were generally supportive of the policy options, with one commissioner encouraging adoption of all the recommendations as they were while others raised concerns about the potential costs of expanding eligibility to age 21. For policy options 1 and 2, several commissioners suggested using 90 days, instead of a 60-day advance notice to beneficiaries and 30 days for beneficiaries to provide information. Another commissioner queried whether eligibility reinstated pursuant to a redetermination was retroactive to the day on which eligibility was terminated due to aging out, and if it is not, the commissioner felt the Commission should recommend that policy. Staff were also asked whether there was data on the percent of beneficiaries who lose eligibility for failure to complete paperwork; the data they reviewed did not provide information on why terminations occurred during the transition period.

On the policy options to expand eligibility through age 19 or 21, some commissioners were supportive but concerned about the costs of such a policy. Others argued that the costs were not likely that significant, with one believing the proposal might save money. To provide support for these recommendations, a couple commissioners believe more information was needed on the cost of churning in and out of the program. Another commissioner believes the costs would not be significant since the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21. Noting that commercial payors must cover kids on their parents' policies through age 25, one commissioner argued that through age 21 should be a program-wide policy—not just one that applies to this relatively small cohort.

Staff will return in March to present draft recommendations.

V. MEDICAID PAYMENT POLICIES TO SUPPORT THE HOME- AND COMMUNITY-BASED SERVICES (HCBS) WORKFORCE: DRAFT RECOMMENDATION (Katherine Rogers and Chris Park, staff)

ISSUE: Home- and community-based services (HCBS) workforce shortages reduce the Medicaid program's ability to serve people with long-term care needs in the home or community. As one way to address this, States have been exploring approaches to use Medicaid rate setting to attract and retain a sufficient HCBS workforce. In previous MACPAC public meetings, staff discussed their findings based on their review of HCBS authorities, Federal and State interviews, and a technical expert panel to explore ways to ensure that HCBS payment rates are adequate to achieve that purpose. During the September 2025 session staff outlined a draft recommendation to require States to report the hourly wages paid to HCBS workers for specified services. During this January 2026 session, staff presented a draft chapter for the March 2026 Report to Congress and a revised recommendation to promote the HCBS workforce, which incorporates feedback from the previous meetings, for a Commission vote.

PRESENTATION: Staff summarized their findings that HCBS payment rates influence HCBS workforce participation and that robust wage data are critical to rate development, but that there are significant limitations to existing data. Staff discussed that their findings led to three payment principles: (1) HCBS payment rates should promote an adequate workforce; (2) States should take a holistic approach to setting HCBS payment rates; and (3) HCBS payment rates should be reviewed for adequacy at regular intervals using available tools.

Staff further reviewed that the CMS 2024 Ensuring Access to Medicaid Service final rule (Access Rule) creates new requirements for States to report on payment rate adequacy but does not adequately address existing wage data gaps. For example, the Access Rule does not provide the granular data needed, does not require States to report average wage rates, and does not require the wage data to be publicly reported.

Staff then provided its revised draft recommendation. The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report, on a biannual basis, hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service, including mean, median, and range as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing, related data collection activities or tools, and publish data in a public repository on the CMS website.

Staff believe that this recommendation will allow States to gain access to more granular, robust wage data, which is needed for HCBS rate development, while allowing States to retain the flexibility to determine how to set rates and the specific amounts. The staff's revisions remove the previous biannual basis for the report (resulting in more flexibility for States) and provide discretion to the Secretary to specify the descriptive statistics to be reported rather than specifically require the mean, median, and range of hourly wages be reported. The revisions also specifically reference amending the Access Rule to address concerns raised in the September 2025 MACPAC meeting regarding the relationship between this recommendation and the existing reporting requirements under the Access Rule.

Staff discussed the implications of the recommendation, including that CBO estimated no impact to Federal spending; States would be required to conduct additional data collection activities; no direct impact to enrollees or plans; and minimal direct impact to providers because of the possibility that they may report more data under the recommendation than under the

Access Rule alone.

DISCUSSION: The commissioners suggested a few ways to strengthen the chapter and expressed general support for the recommendation, including support for the changes that had been made in response to feedback provided during the previous meeting. A suggestion was raised for clarification on whether attendant care would be captured under personal care since several States offer both. A commissioner observed that States refer to services by different terms and raised the concern for being able to provide that access to information is ensured under the recommendation regardless of what term is used for the service. This commissioner also expressed the need to make sure all relevant categories of workers would be included under the recommendation (e.g., to make sure data are being collected on workers who are similarly situated to those specified in the recommendation language) and also suggested a catchall be added to the language to address other variables that could affect rates. In response, staff explained that current regulations do not provide full definitions of covered categories and the recommendation's language aligns with the regulatory language.

During a public comment period later in the session, concern was raised by a commenter that States are already struggling to get accurate data required under the Access Rule and that adding another layer of required information that must be collected will be overly burdensome on States.

During the vote on the recommendation for the March Report to Congress, which was held at the opening of the Friday January 30, 2026 MACPAC public meeting, the commissioners voted on including the recommendation on Medicaid payment policies to support the HCBS workforce. The vote was 15 in favor and 2 against.

VI. BEHAVIORAL HEALTH IN MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) (Janice Llanos-Velazquez and Anupama Warrier, staff)

ISSUE: Staff presented a draft chapter for the March 2026 Report to Congress with findings from the Commission's analytic work using calendar year 2023 Transformed Medicaid Statistical Information System (T-MSIS) data to measure utilization and spending for Medicaid and Medicaid expansion State Children's Health Insurance Program (M-CHIP) enrollees with behavioral health conditions and intellectual or developmental disabilities (I/DD). The draft chapter provides an overview of Medicaid enrollees with behavioral health conditions and behavioral health benefits in Medicaid, outlines the methodology and limitations for this analysis, and discusses key findings on utilization and spending for Medicaid and CHIP enrollees with behavioral health conditions.

PRESENTATION: Staff discussed the background and methodology they used for their analysis that formed their work for the draft chapter. Specifically, the study focused on 2023 data from T-MSIS for Medicaid and M-CHIP enrollees in the following two population groups: (1) children and youth and (2) the non-dually eligible non-elderly adult population. Enrollees from separate CHIP were excluded from analysis.

The term behavioral health includes mental health conditions and substance use disorders (SUD). Co-occurring disorders refer to both. Staff included enrollees with I/DD in the analysis.

There is no federal standardized definition for behavioral health services. Federal law requires certain Medicaid behavioral health services as mandatory services and provides for other behavioral health services as optional services that States may choose to cover.

For the analysis, staff: (i) defined behavioral health services as any claim or encounter with a primary or secondary behavioral health-related diagnosis code; (ii) classified services by care settings; and (iii) identified drugs used to treat behavioral health conditions.

The study found that in 2023 nearly 27 million (27.6 percent) of Medicaid and M-CHIP enrollees had a behavioral health condition and these enrollees accounted for 57.5 percent of total spending.

Staff walked through several detailed tables analyzing the total service-related spending for Medicaid and M-CHIP enrollees with behavioral health related conditions, classified by fee-for-service (FFS) and managed care encounter claims, and examined spending by demographics and geographic locations (e.g., rural versus urban). The tables shown in the staff presentation slides indicate that of the total 97.6 million Medicaid enrollees, 26.9 million had at least one behavioral health condition, 22.5 million had at least one mental health condition, 10.3 million had at least one SUD, 5.9 million had a mental health condition and SUD, 5.5 million had any I/DD, and 2.1 million had a mental health condition and I/DD. The new adult group represented the largest population in each of the following categories: (i) individuals with a behavioral health condition, (ii) individuals with a mental health condition, (iii) individuals with a SUD, and (iv) individuals with a mental health condition and SUD. However, non M-CHIP children represented the largest population with an I/DD and blind or disabled enrollees represented the largest population with a mental health condition and I/DD.

Looking at spending for enrollees with behavioral health conditions, the study compared spending by FFS and managed care. Spending percentage comparison between FFS and managed care on services for the categories of individuals with a behavioral health condition and for individuals with a mental health condition, as well as for services provided to all Medicaid enrollees, each represented around roughly 46 percent FFS and 54 percent managed care. For individuals with an SUD or with a mental health condition and SUD, spending increased to around 61 percent managed care and decreased to around 39 percent FFS. But for individuals with I/DD or with a mental health condition and I/DD the majority of spending was under FFS (with FFS representing roughly around 70 percent and managed care 30 percent).

Staff reviewed tables detailing total per enrollee service-related spending by selected health conditions and by total per enrollee service-related spending by selected co-occurring I/DD and mental health conditions, as well as tables and graphs of data showing total behavioral-related use and spending among enrollees with behavioral health conditions according to care settings and spending related to behavioral health drug use by drug group.

Staff shared data on children and youth enrolled in Medicaid and M-CHIP, reviewing spending and use of services by demographic category, geographic category, and age group. Of nearly 44 million enrolled children and youth, 17.4 percent had a behavioral health condition. A greater number of children and youth in rural areas had a behavioral health condition compared to those in urban areas.

Staff similarly shared data on non-dually eligible, non-elderly adult enrollees with behavioral health conditions, reviewing spending and use of services by eligibility group, demographic category, and geographic category. The blind or disabled eligibility group had the highest prevalence of behavioral health conditions. A greater percentage of enrollees in rural areas had behavioral health conditions as compared to those in urban areas. Around 69 percent of these adults with behavioral health conditions used at least 1 behavioral health service.

Key takeaways included:

- More than one-quarter of Medicaid and M-CHIP enrollees had a behavioral health condition and accounted for over half of total service-related Medicaid spending.
- Over 16 million non-dually eligible enrollees with behavioral health conditions used behavioral health services and 14.3 million used behavioral health drugs accounting for $79.8 billion and $15.5 billion in spending, respectively.
- About 17 percent of children and youth enrollees had a behavioral health condition; those under 13 years of age were more likely to use behavioral health services; spending per user was highest for those with co-occurring mental health and SUD conditions.
- About 15 million non-dually eligible, non-elderly adults had a behavioral health condition, with their behavioral health spending accounting for more than one-fourth of their total service-related Medicaid spending.

Data from this study will be included in a chapter in the March 2026 Report to Congress.

DISCUSSION: Commissioners were enthusiastic about future work in this area. Discussion reviewed further areas for future work related to behavioral health use and spending.

One commissioner raised questions around the definition of behavioral health services, specifically pointing out the need for data to be able to link claims of individuals who might have a diagnosis on one type of behavioral health services claim but who may not have that diagnosis as a primary or secondary diagnosis on a different claim (in order for that second claim to be included in the data). Concern was raised about data analyzed missing certain people and claims that should be included, specifically with respect to those with I/DD and the potential that diagnosis of a behavioral health condition is missed in that population.

A suggestion was made for future analysis to consider the provider type who is furnishing the care, especially in the context of integrating certain care with primary care providers. There was also a suggestion for future analysis to better understand the breakdown of behavioral health services provided as inpatient, outpatient, or community-based services.

Another suggestion was made for further insight into therapy and behavioral treatments as compared to medications used for treatment. Specifically, the question was raised whether individuals can get access to needed therapy and therapists and a desire was expressed for transparency in Medicaid payment for these services.

In addition, a request was made for future work to analyze the reasons behind the use of behavioral health services in rural areas being higher than in urban areas.

VII. MEDICAID FOR JUSTICE-INVOLVED-YOUTH TRANSITIONS TO THE COMMUNITY (JoAnn Martinez-Shriver, staff)

ISSUE: With the exception of when an inmate is admitted for inpatient care for 24 hours or more, States generally may not use Medicaid funds for services furnished to inmates of public institutions, including youth in juvenile facilities. However, Medicaid is an important source of coverage for justice-involved youth (JIY) in the community. The SUPPORT Act clarified that States should suspend—not terminate—Medicaid eligibility for JIY during incarceration and also directed CMS to develop guidance on possible section 1115 demonstrations to improve care transitions after incarceration. That guidance indicates that federal financial participation is available for pre-release services for JIY for up to 90 days before release; those health care services must include case management, medication assisted treatment services, and a 30-day supply of medication. As of August 2025, 14 States include JIY in their section 1115 reentry demonstration populations.

Effective January 1, 2025, the Consolidated Appropriations Act (CAA), 2023, imposed requirements on States to provide (i) certain screenings and diagnostic services to eligible youth 30 days before release and (ii) targeted case management services 30 days before release and for at least 30 days after release. States were also given the option to provide Medicaid-covered services to eligible youth held in an institution before adjudication. The CAA, 2024, authorized four-year State planning grants for activities and expenses to comply with pre-release screening, diagnostic, and case management requirements. Those activities and expenses could include establishing automated claims processing systems, establishing prior authorization protocols, and acquiring IT to establish bi-directional information sharing for care coordination.

In the September 2025 public meeting, commissioners sought additional information on how States were implementing the requirements of, and authorities under, the SUPPORT Act, the CAA, 2023, and the CAA, 2024 because they believe implementation of those laws is complicated. Information was also requested on what States are doing to assess the readiness of correctional facilities to participate in re-entry activities, including the readiness to collaborate with Medicaid agencies and community-based providers.

PRESENTATION: Staff presented a draft chapter for the March 2026 Report to Congress describing findings from the Commission's work on selected State efforts to implement requirements that seek to improve care transitions for JIY who return to the community. The draft provides an overview of the demographics and health needs of JIY and reviews federal Medicaid policy for eligible incarcerated individuals. Staff presented findings from interviews with selected States on their efforts to implement these requirements and challenges in implementation.

Justice-involved youth are predominately male 15 years and older. In 2023, staff reports there were more than 29,000 youth in correctional facilities, and youth of color, low-income youth, and LGBTQ+ youth were overrepresented in the juvenile justice system. Approximately 70 percent of JIY have a mental health condition and 60 percent meet criteria for a substance use disorder. Common diagnoses include depression, attention-deficit/hyperactivity disorder, post-traumatic stress disorder, anxiety, and conduct disorders. The behavioral health needs of JIY are mostly unmet as is the need for care for both routine and chronic physical health conditions.

Generally, staff found that progress has been made implementing new policy requirements, but since State implementation is still in early stages, it is not known how these efforts address access and support transitions. One issue is the use of automated versus manual processes to suspend Medicaid eligibility, and manual suspension requires weekly file exchanges between the State juvenile justice agency or facilities and the State Medicaid agency. States are currently using a mix of automated and manual processes and are attempting to increase automation. However, challenges cited by stakeholders include numerous agencies involved, different authorizing environments for adult and juvenile corrections, unpredictable release dates (especially in jails where stays are shorter), and problems working with different systems, especially at the county or local level. States report using managed care plans to comply with service requirements; the plans facilitate continuity, use targeted case management, and include a “justice liaison” to help the youth and the care coordinator prepare for discharge.

Problems were also reported in enrolling correctional providers as Medicaid providers, which requires education on program requirements. Additionally, many juvenile justice facilities do not have the technology and infrastructure to bill for services though States are developing guidelines on billing and benefits for correctional providers. Stakeholders believe that coordination between Medicaid agencies and correctional agencies is critical. Some States report having these relationships, but for this effort to be successful, new connections will have to be made with entities that administer juvenile justice in the State. Some barriers include the technical complexity of consolidating data from multiple correctional facilities, especially with local institutions, the use of paper medical records in correctional facilities, and resources needed to update eligibility systems.

Other issues raised included: (i) problems recruiting and retaining staff to care for JIY with complex care needs while in the juvenile justice system, (ii) difficulty finding Medicaid-enrolled providers for JIY once they are released into the community, (iii) placement changes for JIY can delay access to care, and (iv) the inability for parents to provide support for access to care.

DISCUSSION: Overall, the commissioners were happy with the tone of the chapter and praised it as providing baseline data that was very informative and that explained the complexities of the challenges involved in JIY and access to care. Some commissioners felt the chapter would benefit from a sense of potential opportunities for improvement, which might lead to future recommendations. Alternatively, the staff could indicate that this is essentially a new policy that the Commission will assess in the future. Other commissioners were interested in the role managed care could play in improving continuity of care, believing there may be template language that could be added to agreements regarding data sharing, discharge planning, and care coordination. One commissioner asked whether there was anything else from the JIY perspective that could be added to inform the chapter; another asked about the percentage of JIY with disabilities.

VIII. AUTOMATION IN MEDICAID PRIOR AUTHORIZATION: INTERVIEW FINDINGS (Katherine Rogers and Patrick Jones, staff)

ISSUE: There has been a growth in the use of technology, including artificial intelligence (AI), to automate parts of the Medicaid prior authorization (PA) process, but there is not much information on how automation is used in such a process and its impact. Therefore, MACPAC conducted a literature review, a federal policy review, and stakeholder interviews on the role of automation in the Medicaid prior authorization process. During this session of the meeting, staff summarized their findings from this project, including regarding (i) how States and managed care organizations (MCOs) use automation in PA; (ii) the extent of Federal and State oversight, guidance, and regulation in this area; (iii) potential risks posed by automation in PA; and (iv) the impact of the existing regulatory environment on States' and MCOs' adoption of automation.

PRESENTATION: Staff discussed the project's goal of understanding how automation is used in the Medicaid PA process in both fee-for-service (FFS) and managed care. The project defines automation as "the use of technological tools such as algorithms and AI that supplement or replace human action or decision making." The PA process is intended to reduce costs through promoting cost-effective and appropriate care, but concerns have been raised that PA may delay or deny needed care. The project focused on the uses of automation that replace or supplant human decision-making in the Medicaid PA process.

Staff provided an overview of the PA process under Medicaid. Medicaid programs have the authority to impose PA as a utilization management tool. PA requirements vary by State and between FFS and managed care plans. Staff also outlined how automation is used in PA by providers to pre-fill forms, check compliance, and identify and retrieve documentation; and by payers to format data, make real-time PA decisions, and identify services or providers for automatic approval.

Staff reviewed the benefits and risks of the use of automation. Benefits that were identified included reduced administrative burden for providers and improvement in payor processing times. Risks that were identified included limited transparency in how the automation tools make decisions and data bias.

Staff also provided an overview of current oversight of automation in Medicaid PA. To the extent there are any Federal policies, those policies do not explicitly prescribe or prohibit use of automation. Current regulations do, however, require that an individual with expertise review denials made by MCOs. Also, CMS has issued requirements related to automation in the Medicare Advantage PA process which allow AI to be used to assist with PA decisions, but decisions must be based on the individual.

Based on the interviews conducted, staff made several findings. States and MCOs use automation in the Medicaid PA process, including for extracting information from electronic health records, determining whether services require PA, and referring PA requests for clinical review. In particular, automation is used to synthesize and analyze large amounts of data. Almost all States and MCOs reported not using automation for final PA decision making. Interviews indicated that MCOs more than FFS programs use automation. Staff also found that the government has limited insight into the use of AI in the Medicaid PA process. There is very limited guidance and existing policies do not set minimum standards nor do they prescribe or limit uses.

Seven States have passed laws regulating the use of automation in PA. Key to note is the variation between these State laws, including variation in how automation is defined across State laws. Some of the State laws apply to AI and automation, while others apply only to AI. All but one of the State laws includes some form of a “human in the loop” requirement for PA denials.

Staff summarized concerns raised in their interviews, including some stakeholders warning that the use of automation may increase denials and negatively affect access to care and noted that MCOs particularly may dial approval rates through use of automation. Concern about the appropriateness of data used for automation models was also raised, including that AI models train on data that do not reflect Medicaid population attributes. In addition, some raised concerns about the potential for reduced transparency into the fairness and accuracy of PA decisions. Some MCOs and providers raised the concern that the need for resources may create a divide between those providers and payers who do and who do not have adequate resources to use AI in different ways. In addition, limited Federal guidance slows adoption of automation tools since States and MCOs are reluctant to adopt systems which may become irrelevant once policies are adopted. The variation in State approaches was also noted as making it difficult for MCOs and providers to navigate requirements and limitations that apply to them. Staff noted States generally expressed support for there being some Federal guidance, but some warned about the limitations of a one-size-fits all approach.

Key takeaways noted included that: (i) actors are integrating automation in the Medicaid PA process but how automation is being used in that process is not well documented; (ii) the use of automation could improve efficiency but there are significant concerns about barriers to care and lack of transparency; and (iii) it is difficult to assess the impact of automation in the Medicaid PA process given the limited amount of information and visibility available.

Staff expect to include a chapter on PA automation in the June 2026 Report to Congress.

DISCUSSION: The commissioners were overall in agreement about the importance of the topic and were engaged in providing feedback and suggestions to staff. Several commissioners suggested looking to Medicare and determining whether Medicaid guidelines should be aligned with Medicare. One commissioner specifically suggested looking at the WISeR CMMI model.

Support was expressed for identifying potential guiding principles to recommend for use of automation for Medicaid PA, rather than recommending specific limitations or rules in order to provide enough flexibility (e.g., not be too restrictive or prescriptive) to account for the rapidly changing area of technology. The overall themes were expressed of encouraging approvals for care faster while ensuring proper review in cases where care is being denied.

A suggestion was raised to ensure that the definitions being used for automation in any future recommendation takes into consideration that simple algorithms (such as a decision tree) should not be considered AI. Other suggestions included considering the possibility of (i) auditing third party denials to ensure AI is working properly and that bias is not part of the model, (ii) CMS certifying AI systems and requiring the use of such certified systems for AI is to be used in PA, and (iii) clearly articulating what satisfies a "human in the loop" requirement to ensure the requirement is meaningful (such as standards for expertise of that human). In addition, suggestions were made around the importance of: (i) ensuring that the data used by AI tools are reliable; (ii) transparency of the information provided to enrollees and providers about PA decisions that are made; and (iii) transparency into how decisions based on automation are being made. For example, commissioners raised that clear, informative notifications identifying the reason for any denial need to be provided to beneficiaries and providers so that it is actionable for the beneficiary to appeal the decision. There was also discussion about the burden involved in trying to appeal a denial and how that burden discourages denials being challenged and use of the appeals process. A suggestion was made for better data on the number of denials that are contested.

IX. EXPLORING THE ROLE OF THE STATE MEDICAID AGENCY IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY: PROGRAM AGREEMENT AND WAIVER FINDINGS (Brian O'Gara and Michelle Conway, staff)

ISSUE: PACE is a provider-based program that offers 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. Staff indicated that as of November 2025, 74,000 dually eligible older adults were enrolled in 198 PACE programs across 33 States and the District of Columbia, and roughly 80 percent of PACE enrollees are dual eligibles. The June 2025 Report to Congress included a chapter presenting findings on the statutory and regulatory framework governing the program, as well as key elements of the PACE model. During development of the chapter, commissioners and stakeholders had questions about the transparency of the PACE model, particularly how States and the federal government evaluate compliance and monitor quality.

PRESENTATION: Staff discussed their work exploring how State Medicaid agencies oversee PACE organizations and carry out their oversight responsibilities. Staff presented findings from a review of three oversight documents:

- Required three-way program agreements among CMS, States, and PACE organizations;
- Optional two-way agreements between States and PACE organizations; and
- BIPA 903 waivers.[7]

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[7] The authority for BIPA waivers is found in section 903 of the Medicare, Medicaid, and the SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554).

Oversight of PACE programs is spread across several divisions and offices within CMS. The Center for Medicare is primarily responsible for oversight of PACE, but it coordinates monitoring activities with other CMS components. CMS oversight activities include audits of PACE organizations and review of quality data submitted through the Health Plan Management System (HPMS) each quarter. There are relatively few domains where States have primary oversight responsibility.

Required Three-Way Program Agreements

These agreements consist of seven articles, covering topics including eligibility and enrollment/disenrollment, appeals and grievances, quality assessment and performance improvement, and data collection and reporting requirements. They use standardized language, but State-specific language may be added as appendices. In those appendices, States may, consistent with federal law and regulation, address requirements for qualification as PACE program eligible individuals and other terms and conditions.

CMS establishes the role a State plays under the three-way agreement; these duties include conducting readiness reviews, monitoring PACE programs during the trial period, ongoing program monitoring, monitoring of corrective action plans (CAPs), and monitoring of level of care redeterminations. Some monitoring is conducted in conjunction with CMS (e.g., trial period) and other areas are done solely by SAAs.

Optional Two-Way Program Agreements

Staff reported that sixteen States and the District of Columbia use two-way agreements, and three more States are considering it. These agreements are used to supplement federal oversight though the specific agreements vary among States. For example, the document review revealed that only three States address trial period monitoring requirements in two-way agreements. Staff also found that two-way agreement provisions for ongoing State oversight are broad, generally requiring availability of records and the facility for review or inspection. Nine States use these agreements to address CAPs, and six States use them for enrollee level of care redeterminations. Fourteen States require PACE organizations to submit data on top of federal requirements on issues such as grievance and appeals, enrollment and disenrollment, and incident reporting. Nine States require submission of additional financial data, eight require additional quality reporting, such as quality assurance plans and reviews, seven require submission of encounter data (though in most cases the scope is not specified), and twelve require additional reports on topics ranging from service utilization to fraud and abuse. Seven States provide for an expanded role of the SSA in administering PACE, such as marketing review and beneficiary education.

BIPA 903 Waivers

Staff indicated they reviewed 47 waivers and found two primary issues. Waivers were sought for the requirements for in-person assessments and reassessments and service determinations as well as for the requirement for social workers with a Master's degree. In response to the COVID-19 public health emergency (PHE), CMS allowed PACE organizations to use remote technology to conduct these assessments, and many organizations submitted waivers to permit them to continue remote assessments after the PHE ended. Most of these waiver requests also sought to waive the in-person assessment for service determinations. With respect to waivers to substitute other types of clinical professionals for Master's level social workers, PACE organizations cited a shortage of these professionals.

DISCUSSION: With barely disguised hostility toward PACE programs, several commissioners focused less on the role of these agreements and waiver requests on State oversight of and care quality under PACE programs and instead focused on the cost of PACE as an integrated care model. Commissioner McCarthy asked whether the cost of PACE was worth it. Commissioner Ingram called for a matrix of what is required under PACE contracts and what is required of D-SNPs; she also sought data on the cost difference per person between PACE and Medicare Advantage and other plans, mentioning specifically D-SNPs. Commissioner Heaphy asked for data to compare quality and outcomes between PACE and D-SNPs, noting surprise at reporting differences. Several commissioners, such as Commissioners Killingsworth, Snyder and Nardone, noted that the Commission could highlight that States have an opportunity to leverage agreements for purposes of quality reporting and performance improvement, and suggested the Commission could develop a comprehensive set of principles for best practices to measure quality of PACE programs. Commissioner Killingsworth also believes that the balance of oversight responsibilities between CMS and States is off. Commissioner Nardone was interested in knowing why some States do not use two-way agreements, wondering whether it was a State capacity issue.

Staff will return in March to share findings from stakeholder interviews.

X. FEDERAL POLICY FRAMEWORK FOR BENEFICIARY HEALTH AND WELFARE IN SELF-DIRECTED HCBS (Gabby Ballweg and Katherine Rogers, staff)

ISSUE: Self-directed HCBS is a beneficiary-controlled HCBS delivery model that allows individuals to choose their HCBS workers and have control over the amount, duration, and scope of services and supports in their person-centered service plan (PCSP). Self-direction models must include a person-centered planning process and PCSP, information and assistance (I&A) supports, financial management services (FMS), a quality assurance and continuous improvement system, and an individualized budget. CMS also requires that States provide satisfactory assurances of certain protections for HCBS beneficiaries, including those enrolled in self-directed HCBS programs. These protections include assurances related to the health and welfare of enrollees.

PRESENTATION: Staff reviewed federal law, regulation and guidance on health and welfare assurances under self-directed HCBS. The findings focused on incident management systems, conflict of interest standards, and safeguards specific to self-direction.

Incident Management

Incident management involves identifying, reporting, triaging, investigating, resolving, tracking and trending critical incidents and requires interagency and stakeholder collaboration. The 2024 Ensuring Access to Medicaid Services final rule imposed minimum regulatory standards for incident management across authorities, and it added a definition of critical incident to the regulations that includes elements relating to abuse, exploitation, restrictive interventions, certain medication errors and unexplained or unanticipated death.[8] Additional regulatory requirements that must be in place by July 2027 include data sharing across investigative agencies' investigation resolution reporting, including by HCBS providers; using claims data and data across State agencies to identify unreported critical incidents; and State minimum performance standards and documentation requirements. Electronic incident management systems must be implemented by July 2029. These requirements apply to HCBS authorities that offer self-direction and to HCBS delivered via managed care.

Staff report that many States have met some or all of these requirements.

Conflict of Interest Standards

In order to protect the State and stakeholders from misaligned financial incentives and safeguard beneficiary health and welfare, HCBS programs must abide by conflict of interest standards. Under these standards established under the various HCBS authorities, HCBS providers may be prohibited from developing person-centered service plans or from conducting functional needs assessments. One authority prohibits HCBS providers from also providing case management and another prohibits a beneficiary's representative from also acting as the HCBS provider. States may also implement optional conflict of interest standards.

Specialized Safeguards for Self-Direction

Authorized Representatives. Because beneficiaries may authorize a representative to assume responsibility for their care, each HCBS authority includes safeguards for the use of a representative. Under some HCBS authorities, the representative must undergo an evaluation of their ability to self-direct a beneficiary's services. Under others the State must develop policies for the authorization process for representatives, the extent of decision-making the representative may undertake, and the safeguards ensuring that the representative makes decisions on behalf of the beneficiary.

Section 1915(j) Assurances. The State plan option under section 1915(j) of the Social Security Act sets forth specific health and welfare assurances that are not found in other self-directed

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[8] See 42 CFR 441.302(a)(6)(i)(A).

programs. These include requirements for monitoring service delivery and budget utilization, continuity of care requirements for beneficiaries transitioning to another care model, and information and assistance supports. Regulatory requirements specify which entity is required to meet the requirements (e.g., financial management services or case managers).

DISCUSSION: Only a few commissioners made public comments. Generally, they noted that self-direction is designed to provide more control and authority to the individuals who use the services, and there is a balance between ensuring that control and the policies States implement to ensure health and safety. Commissioner Killingsworth, who was concerned about potentially overreacting and developing policies that might lead to unintended consequences, did not think more policy was required for this issue. Commissioner Heaphy echoed that concern; specifically, he worried about the impact of too many requirements on the ability of guardians to carry out their responsibilities. Commissioner Nardone expressed interest in environmental scans for State incident management practices to determine whether existing safeguards are sufficient. He also queried whether the basic framework is adequate or whether States must do more to increase incident management systems to address issues.

Staff will present findings from State environmental scans in a subsequent public meeting.