NCSL STANDING COMMITTEE on HEALTH

POLICY DIRECTIVES AND RESOLUTIONS

LEGISLATIVE SUMMIT
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CONTENTS

COMMITTEE: **HEALTH**

POLICY: **AGING SERVICES (OLDER AMERICANS ACT)**

TYPE: **DIRECTIVE**

The National Conference of State Legislatures (NCSL) strongly supports the Older Americans Act programs and the services funded through this act. NCSL urges Congress to:

- ~~i~~increase the funding authorization limit and appropriate sufficient funding to meet the growing demands for the OAA programs~~.~~, especially the National Family Caregiver Support Program, Nutrition Services and Adult Protective Services;~~;~~
- provide states flexibility to establish standards and decide how program funds will be distributed;
- ensure that OAA programs reach low-income, minority and rural older adult ~~elderly~~ households;
- increase effort~~s~~ to inform those eligible about services available to them under the OAA and other state and federal programs;
- strengthen the authority of state government through designated State Units on Aging to ensure that service funds under the Act are used to support independence in older populations and those in greatest social and economic need~~the most vulnerable members of the population, the very old, the frail, the isolated, and limited English-speaking individuals, with particular attention to low-income minority persons~~; and
- ~~provide~~ protect state~~s~~ ~~the~~ authority to distribute funds based on their own criteria.

NCSL urges Congress to provide states flexibility in the administration of the OAA and the authority to:

- transfer funds between the nutrition program and the social services program according to a state's needs;

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- ~~to transfer funds between~~ combine congregate and home delivered meals; and
- determine the type and circumstances under which Area Agencies on Aging (AAA)'s can directly provide services;~~.~~
- Allow states to hold back 1% of Title III funds to support piloting new innovations in home and community based supportive services;
- Support more OAA funding flexibility.

NCSL supports additional resources for the ombudsman program.

NCSL encourages federal policies and resources that support state programss using participant contributions, including voluntary contributions, cost sharing and private pay. NCSL believes that participants with incomes below 125 percent of the federally established level of poverty, should not be subject to cost sharing. Fees collected through fee for service ~~this~~ mechanisms should provide for expanded services and increased availability of services to older adults ~~those elderly~~ with the greatest economic and social need. This will also enhance the coordination and equity between OAA, the Social Services Block Grant, and state-financed programs that are often funded on a sliding fee scale.

Senior Community Service Employment Program

NCSL supports the Senior Community Service Employment Program and federal policies that strengthen coordination with states and national grantees and provide sufficient flexibility to align the SCSEP with state aging and workforce systems.

NCSL is also in support of moving the SCSEP from the Department of Labor to the Administration for Community Living to better integrate its services with aging programs.

~~calls for increased cooperation between the states and the national contractors. NCSL supports congressional proposals to provide states and national contractors more flexibility on administrative costs while keeping these costs to a minimum.~~

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Federal Policies on Aging

NCSL urges Congress to:

1. strengthen funding for Adult Protective Services and guardianship programs to help states protect older adults from abuse, neglect and exploitation;
~~1.~~2. preserve the financial integrity of the Social Security system;
~~2.~~3. eliminate all forms of age discrimination against older workers;
~~3.~~4. provide funds for direct services for older adults~~the elderly~~;
~~4.~~5. fund the development of integrated, coordinated, community-based continued care systems to help prevent the unnecessary institutionalization of older adults~~the elderly~~; and
~~5.~~6. provide additional support for gerontological research, education and training.

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COMMITTEE: **HEALTH**

POLICY: **FEDERAL REGULATION OF INTERSTATE AND INTERNET TOBACCO SALES**

TYPE: **DIRECTIVE**

Regulation of Interstate and Internet Sales of Tobacco Products

Illegal interstate, tribal and internet sale of tobacco products and other nicotine delivery systems affects the health and safety of the nation's citizens and has a particularly negative effect on state revenues. ~~Tobacco~~ Ssellers that evade state tobacco and other nicotine delivery product taxes: (1) use the profits of these sales to finance other illicit activities; (2) undermine state efforts to reduce youth access to ~~tobacco~~ these products by making lower cost products available to them through the mail; and (3) reduce state revenue. In addition, many of these sellers fail to comply with the provisions of the Master Tobacco Settlement Agreement, endangering state compliance with the Agreement and reducing state payments under the agreement by illegally gaining market share in cigarette sales by offering lower prices made possible by their failure to pay the appropriate state taxes.

~~The~~ NCSL supports the Prevent All Cigarette Trafficking (PACT) Act (amended in 2021 to include electronic delivery systems (ENDS) which are defined broadly to include products delivering nicotine from any source, including synthetic nicotine. ~~became effective in June 2010.~~ NCSL also supports the PACT Act and the continuing partnership between the states and the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) to implement this important law that:

- ~~. The law: (1)~~ Imposes improved recordkeeping to support enforcement of state and federal requirements ~~to implement these recommendations~~;~~:~~;
- ~~(2)~~ Prohibits the commercial importation of tobacco products, including electronic nicotine delivery systems and other nicotine delivery

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systemssmokeless tobacco products, into any state in violation of state or federal law;

- (3) Increases the penalties for noncompliance with the federal laws regulating interstate and internet sale of tobacco products, electronic and other nicotine delivery systems;
- (4) Authorizes states to enforce tobacco, electronic and other nicotine delivery systems tax collections through the Jenkins Act;
- (5) Permits states to collect triple damages in any suit against entities selling tobacco and electronic and other nicotine delivery systems in states in violation of the laws of the state and make debts incurred in the purchase of these products uncollectible through actions in courts;
- (6) Prohibits interstate tobacco and electronic and other nicotine delivery systems sellers from doing business in a state that is party to the Master Settlement Agreement if the seller is not in full compliance with the Model Statute or the Qualifying Statute enacted by the state; and
- (7) Preserves existing agreements between states and tribal governments regarding cigarette and electronic and other nicotine delivery systems taxes; and
- Affirms and strengthens state authority to regulate and enforce electronic and other nicotine delivery systems delivery sales, including age-verification, directory-listing requirements and shipping and delivery restrictions.

FDA Regulation of Tobacco and Tobacco Products

NCSL supports the role of The Family Smoking Prevention and Tobacco Control Act of 2009 establishes the Food and Drug Administration (FDA) as the agency responsible for the regulation of the manufacturing, marketing and sale of tobacco, electronic and other nicotine delivery systems products to protect public health while preserving state authority to regulate the sale, distribution and youth access to these products.

Specifically, NCSL supports:

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~~n summary, the law: (1)~~

- Restrictions on the sale and marketing of tobacco and electronic and other nicotine delivery systems products to young people;
- ~~(2)~~ Requirements that ~~Authorizes the FDA to restrict tobacco marketing;(3) Requires~~ tobacco, electronic and other nicotine delivery systems manufacturers ~~to~~ disclose information about the ingredients of their products and any changes they make to the ingredients;
- ~~(4)~~Federal authority ~~Authorizes FDA~~ to require changes to tobacco, electronic and other nicotine delivery systems products to protect the public health;
- ~~(5)~~ Federal regulation of ~~Authorizes the FDA to regulate~~ "reduced harm" claims;
- ~~(6) Requires more~~ Pprominent health warnings;
- ~~and (7) Funds FDA~~ Rregulation of tobacco products and electronic and other nicotine delivery systems through a user fee imposed on tobacco, electronic and other nicotine delivery systems manufacturers;
- Evidence-informed federal efforts to reduce the addictiveness of tobacco, electronic and other nicotine delivery systems products;
- Preservation of state authority to regulate the sale,distribution, possession or exposure to tobacco and electronic and other nicotine delivery systems products including restrictions on the time, place and manner of tobacco product advertising; and
- Preservation of state-based civil claims and enforcement authority.

NCSL opposes unnecessary federal preemption that limits state authority to protect public health and enforce tobacco and electronic and other nicotine delivery systems taxes and youth-access laws. ~~The law does not permit states to regulate the content of tobacco products, tobacco labeling or advertisements. The law does preserve some important state and local government regulatory authority. Specifically, states may adopt laws or regulations related to the sale, distribution, possession or exposure to tobacco products and may restrict the time, place and manner of tobacco product~~

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~~advertising. The law also does not preempt most state-based civil claims. The preservation of state authority permits states to actively support and enhance FDA initiatives.~~

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COMMITTEE: **HEALTH**

POLICY: **SUPPORT FOR SENIORS AND PEOPLE WITH DISABILITIES**

TYPE: **DIRECTIVE**

NCSL supports ~~The development of~~ a comprehensive approach to deliver long-term ~~support~~ services and supports for older adults, ~~elderly persons and~~ people with disabilities and other individuals and families who re~~e~~ly on long-term care services.~~persons with disabilities is critical~~. A strong system can help states improve access to appropriate services, support independence and autonomy, strengthen caregiving and workforce capacity and better manage pressures on ~~Without such system, long-term care expenditures will continue to overwhelm~~ state and federal health care budgets.~~, limiting necessary expenditures for primary and preventive health care.~~

Core Principles

NCSL supports:

- federal resources and technical assistance to help states develop innovative programs to improve long-term services and supports;
- state flexibility and autonomy in setting eligibility criteria, consistent with federal requirements;
- policy approaches that improve federal-state coordination of services for individuals eligible for both Medicare and Medicaid;
- federal resources and policy approaches to help states expand the size ad capacity of the long-term care workforce;~~.~~
- ~~F~~federal support of state discretion to select validated or otherwise evidence-based standardized assessment tools for people who reoly on long-term care services that help states identify the services and setting most appropriate to meet long-term care needs.
- ~~States being provided new options for setting financial and functional criteria to qualify for these services.~~

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- ~~The development of expanded options for private long-term care insurance, flexible life insurance products, and home equity sharing programs, such as reverse annuity mortgages.~~
- ~~Initiatives to provide incentives for employers to offer and for individuals to establish health savings accounts and other innovative financing options to pay for a broad range of supportive services.~~
- ~~Efforts to assist family members who are caregivers, including tax incentives and programs that provide support services, such as respite care~~.

Increasing Options for Home and Community-Based Care

NCSL supports:

- ~~NCSL continues to support~~ the development of more home and community-based options under Medicaid;
- Federal policies that help states coordinate, streamline and integrate intellectual and developmental disability supports across systems of care, including medical, disability, behavioral health and aging services as people with intellectual and developmental disabilities grow older and their needs change.
- ~~to provide and integrate long term care services. NCSL supports the federal government encouraging states to develop innovative programs to improve the long-term care system. NCSL urges the Administration and Congress to work with states to develop assessment tools that will help states better identify what level of services individual clients need and the most appropriate settings for the client to receive care and these assessments should be made available to all elderly persons and persons with disabilities to help them plan for their long-term care needs.~~

Financing and ~~Long-Term Care~~ Insurance

NCSL supports strong federal action to protect consumers of long-term care insurance from predatory pricing or inadequate benefit plans. NCSL also supports efforts to develop long-term care insurance and other financing options as viable compliments to

Medicaid coverage of long-term care services, while maintaining Medicaid's core role in financing care. urges the Administration and Congress to speed the development of long-term care insurance as a viable alternative or complement to Medicaid support for long-term care services. ~~. At the same time, tax credits, partnership programs, and other incentives should not be seen as a tool for reduced funding for Medicaid.~~ While the states will continue to take primary responsibility for the regulation of long-term care insurance, NCSL supports the development and evaluation of programs and initiatives that would:

- ~~E~~expand options for private long-term care insurance, flexible life insurance products and home-equity sharing programs, such as reverse annuity mortgages;
- ~~P~~provide ~~i~~incentives for individuals to establish health savings accounts and other innovative financing options to pay for a broad range of supportive services;
- ~~(1)~~ provide preferential tax treatment for individuals who purchase qualified long-term care insurance;
- ~~(2)~~ provide tax incentives for private employers and a Medicaid bonus program for state and local government employers to encourage ~~the~~ them to offer long-term care insurance as an employee benefit;
- ~~and (3) encourage and~~ provide incentives to employers to offer long-term care insurance, as a condition of receiving federal benefits, such as business tax credits;

Alzheimer's Disease and Other Dementia Related Disorders

NCSL supports:

- ~~NCSL supports~~ continued federal efforts that ~~: (1)~~ lead to the development of new drug treatments;
- continued federal efforts to improve early detection and diagnosis of Alzheimer's disease and related dementias;

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- continued federal efforts to~~(2)~~ assist in disease management, including providing states with resources and options to deliver long-term services and supports in a manner that preserves the independence and autonomy of individuals with dementia-related disorders to the greatest extent possible~~; and (3) improve the early diagnosis of these conditions.~~.

Caregiver Supports

NCSL supports:

- efforts to assist formal and informal caregivers, including family members, through tax incentives and programs that provide support services such as respite care;~~.~~
- continued federal efforts to support unpaid caregivers of people with Alzheimer's disease and related dementias, with a particular focus on dementia-specific respite care and other targeted resources.

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COMMITTEE: **HEALTH**

POLICY: **ARTIFICIAL INTELLIGENCE IN HEALTH CARE**

TYPE: **RESOLUTION**

WHEREAS, the integration of Artificial Intelligence (AI) in health care presents significant opportunities to enhance patient care, improve health outcomes and increase operational efficiencies;

WHEREAS, states are at the forefront of developing and implementing AI policies tailored to their unique health care needs and challenges;

WHEREAS, robust data privacy and security measures must be enforced to protect patient information used in AI systems, in compliance with existing federal and state regulations;

WHEREAS, AI technologies must undergo validation appropriate to the level of risk they present, with healthcare applications-subject to rigorous, ongoing evaluation to assess and verify their performance, reliability, fairness and safety prior to deployment;

WHEREAS, in light of state legislative and regulatory activity in this area, federal preemption of state AI laws and regulations could interfere with state efforts to create solutions that meet the unique needs of their residents and businesses.

NOW, THEREFORE, BE IT RESOLVED, that the National Conference of State Legislatures urges the federal government to:

- Collaborate with states to develop guidelines for the reasonable, trustworthy, and human-centered use of AI, including transparency in AI decision-making processes, accountability mechanisms for AI developers, deployers and users, robust privacy protection of health information, and uses that enhance rather than replace the patient/provider relationship;

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- Incorporate insights and best practices from state-level initiatives in establishing any federal framework for the regulation of AI in health care;
- Work with states, standards development organization and federal partners to advance standardized protocols for data sharing and interoperability, ensuring that AI systems can securely and efficiently access and utilize health data across state lines;
- Support initiatives such as model cards and nutrition labels and/or other formats that convey source attribute information to ensure consistent and standard transparency of AI developers;
- Work with states to adopt plain language descriptions of the logic and rationale for AI applications (including attributes defining the intended use and inappropriate use of the model, the testing data sets used for developing the model, and the results of feasibility and real-world testing) used by AI/Machine Learning so the functionality, risk, potential bias, and signs of model drift are easily understood by end users.
- Provide regulatory support for initiatives that ensure developers have safe access to diverse data sets and initiatives that allow models to be trained and tested on robust data appropriate to the populations for whom the models will be used;
- Collaborate with states to support the development of a diverse and skilled AI workforce in health care;
- Partner with states on financial investments in education and training programs to equip health care professionals with the skills needed recognize the risks and limitations of AI;
- Work with states and standards development organizations to develop federal standards for AI performance monitoring and evaluation to keep AI system reliable, fair and safe over time. This should include, local, recurrent validation (process of ongoing technical checks and improvements after deployment) and post-market surveillance (monitoring real-world impact and user safety) of AI systems.

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- Consult with states as they debate and develop AI legislation and regulations, paying particular attention to how any federal law or regulation will impact state laws governing AI. Federal laws and regulations in the AI space should establish a strong national policy floor, set a consistent and aligned baseline of rights, safety and accountability while preserving states' ability to adopt additional protections in their own laws as needed; and
- Ensure that federal AI legislation and regulation does not usurp states' ability to legislate and regulate in areas that traditionally rest under the oversight of states and local governments; and

BE IT FINALLY RESOLVED that a copy of this resolution be sent to the President of the United States, all members of Congress, and all relevant federal and state officials.

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COMMITTEE: **HEALTH**

POLICY: **IMPORTANCE OF FEDERAL ACTION TO ENCOURAGE FAMILIAL AWARENESS OF TYPE 1 DIABETES AND APPROPRIATE AUTOANTIBODY SCREENING OPTIONS TO DETECT RISK FOR DEVELOPING THE DISEASE**

TYPE: **RESOLUTION**

WHEREAS, type 1 diabetes is an autoimmune chronic medical condition affecting millions of individuals worldwide.

WHEREAS, a type 1 diabetes diagnosis obligates a child or adult diagnosed with the condition to take insulin, utilize a variety of technologies, and see a team of doctors throughout a patient's lifetime at a measurable cost to manage the disease.

WHEREAS, type 1 diabetes is now recognized as developing over three stages (e.g., stage 1, stage 2, and stage 3) with a diagnosis of each stage potentially allowing for early interventions to alter the course of this autoimmune disease.

WHEREAS, the onset and diagnosis of type 1 diabetes are now somewhat predictable thanks to autoantibody screening tools, especially for those with a close relative living with type 1 diabetes, permitting patients to avoid or forestall a condition known as diabetic ketoacidosis or DKA.

WHEREAS, people at risk for type 1 diabetes are often unaware of the risk factors associated with developing the condition.

WHEREAS, the majority of those diagnosed with type 1 diabetes have no otherwise identifiable family history with the autoimmune disease with certain common viruses amplifying a person's risk.

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WHEREAS, in youth, regardless of any socio-economic consideration, type 1 diabetes is more prevalent than type 2 diabetes.

WHEREAS, poor glycemic control, elevated lipids, and other risk factors may put Hispanic and African American youth at risk for future diabetes-related complications like heart attacks, strokes, kidney failure, and vision loss.

WHEREAS, a diagnosis of COVID-19 increases a child's and an adult's risk of developing type 1 diabetes later in life.

WHEREAS, rates of type 1 diabetes increased 17% among US youth after the COVID-19 pandemic began especially in Hispanic and African American children.

WHEREAS, type 1 diabetes is increasing consequentially in each state across the USA.

WHEREAS, it is essential to promote awareness of type 1 diabetes and its impact on public health.

WHEREAS, the dedicated efforts of healthcare professionals, advocacy groups, and individuals living with type 1 diabetes play a significant role in addressing this global health concern. Whereas consistent with established medical guidance, screening for type 1 diabetes autoantibodies should occur in newly diagnosed adults with type 2 or gestational diabetes to rule out a type 1 diabetes diagnosis given the number of American adults diagnosed with type 1 diabetes in their 20s, 30s, and 40s.

WHEREAS, since 2024 nearly twenty states, including Arkansas, Florida, New Hampshire, Louisiana, Delaware and Tennessee took legislative, regulatory, or executive action to provide autoantibody screening resources to families to learn more about their risk of experiencing a type 1 diabetes diagnosis.

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WHEREAS, the 118th and 119th session of the United States Congress considered bicameral and bipartisan legislation to increase resources available federally and to states to increase familial awareness of the opportunity to screen for type 1 diabetes before discernable symptoms are present.

NOW THEREFORE, BE IT RESOLVED that the National Conference of State Legislatures recognizes the opportunity to help families understand the risk of type 1 diabetes via autoantibody screenings.

NOW THEREFORE, BE IT RESOLVED that the NCSL encourages the US Senate and House of Representatives to enact S. 4612 and H.R. 9000 from the 119th Congress while also including recommended funding for state education efforts around type 1 diabetes education awareness to implement 2024's and 2025's Labor HHS appropriations vehicles. These appropriations vehicles conclude Congress... "supports efforts to increase type 1 diabetes screenings at community health centers particularly among high-risk populations, especially given the advance in treatments that now can delay onset of the disease for several years if caught early enough."

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COMMITTEE: **HEALTH**

POLICY: **OPTION FOR STATES TO EXPAND USE OF CONTRACTORS TO ADMINISTER MEDICAID**

TYPE: **RESOLUTION**

WHEREAS, a federal-state partnership governs the Medicaid program under Title XIX of the Social Security Act, in which the federal government provides a policy framework, states and counties oversee ongoing operations and administration, and all partners share funding responsibilities

WHEREAS, Medicaid provides critical health services that help low-income individuals, mothers with dependent children as well as individuals who are aged, blind or with disabilities

WHEREAS, H.R. 1 requires most states and counties to administer Medicaid community engagement programs by January 1, 2027, and perform more frequent Medicaid eligibility redeterminations beginning in January 2027

WHEREAS, contractors play critical roles in most states in supporting and operating the Medicaid program, including assisting Medicaid beneficiaries in choosing managed care plans, customer service contact centers, document management, and development and management of information technology but are barred from eligibility determinations and redeterminations and performing fair hearings

WHEREAS, states have to address the need to balance permanent government staffing with demands that may surge up and down over time, such that contractors could be used to manage those surges

THEREFORE, LET IT BE RESOLVED that the National Conference of State Legislatures urges that:

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Congress adopt bipartisan legislation, such as the bipartisan Buddy Carter (R-GA) - Don Davis (D-NC), H.R. 6254, to modernize the Medicaid program to allow a greater role for contractors, at state option

Upon adoption of this resolution, a copy of this resolution shall be submitted to the Secretary of the United States Department of Health and Human Services, the Administrator of the Centers for Medicaid and Medicaid Services, and the Chairs and Ranking Members of the U.S. Senate Committee on Finance and the U.S. House Committee on Energy and Commerce, the public welfare requiring it.

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COMMITTEE: **HEALTH**

POLICY: **RESOLUTION ON THE DEFINITION OF MEDICAL FRAILTY**

TYPE: **RESOLUTION**

WHEREAS, the implementation of any federal definition of medical frailty must balance clinically sound standards with administrative feasibility; and

WHEREAS, health vulnerability is influenced by medical diagnoses, behavioral health conditions, functional limitations, and nonmedical factors that may affect an individual's ability to maintain health, access care, participate in employment, and engage in community life; and

WHEREAS, a definition of medical frailty should be clinically appropriate, flexible, and administratively workable, and should include individuals with serious, complex, disabling, unstable, or functionally limiting conditions; and

WHEREAS, such a definition should include, but not be limited to, individuals with:

- Serious mental illness and disabling behavioral health conditions;
- Substance use disorders;
- Serious chronic diseases requiring ongoing medical management, including cancer, HIV/AIDS, end-stage renal disease, heart failure, chronic obstructive pulmonary disease, diabetes with complications, neurological disorders, and autoimmune diseases;
- Physical, intellectual, and developmental disabilities;
- Functional limitations affecting activities of daily living, independent living, communication, mobility, cognition, or self-management; and
- Episodic or fluctuating conditions that may not be consistently reflected in claims data but substantially affect functioning; and

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WHEREAS, nonmedical factors can contribute to an individual's level of frailty when they materially affect health status, functional capacity, or the ability to access care; and

WHEREAS, such factors may include severe food insecurity, housing instability, homelessness, transportation barriers, social isolation, and limited caregiver support when those conditions affect health, independence, or the ability to comply with program requirements; and

WHEREAS, these conditions often coexist with chronic disease, disability, and behavioral health conditions and may substantially impair an individual's ability to obtain care, maintain health, participate in employment, or engage in community activities; and

WHEREAS, repeated verification of lifelong or permanent disabilities and chronic conditions may create unnecessary administrative burdens for beneficiaries, providers, and state Medicaid agencies without improving program integrity;

NOW, THEREFORE, BE IT RESOLVED, that the National Conference of State Legislatures (NCSL) urges the Centers for Medicare & Medicaid Services (CMS) to preserve state flexibility to identify medically frail individuals using clinically appropriate, administratively feasible, and fiscally responsible approaches that recognize serious medical, behavioral health, and functional limitations affecting an individual's health status and ability to function independently; and

BE IT FURTHER RESOLVED, that CMS should allow states to consider nonmedical factors, such as food insecurity, housing instability, homelessness, transportation barriers, social isolation, and limited caregiver support as supporting evidence of medical frailty when those factors materially affect an individual's health status, functional capacity, ability to access care, or ability to comply with program requirements; and

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BE IT FURTHER RESOLVED, that CMS should provide states with flexibility to use clinically appropriate and administratively efficient methods to identify medically frail individuals, including functional assessments and other reliable evidence beyond claims data, while supporting accurate eligibility determinations and responsible stewardship of Medicaid resources; and

BE IT FURTHER RESOLVED, that federal guidance should provide clear parameters while avoiding overly prescriptive requirements that limit states' ability to administer Medicaid programs efficiently, maintain program integrity, and respond to the needs of their populations; and

BE IT FURTHER RESOLVED, that CMS should allow states to use longer certification periods or permanent designations for disabilities or chronic conditions determined by a licensed physician or other qualified medical professional to be permanent, lifelong, or unlikely to improve, where clinically appropriate and consistent with program integrity; and

BE IT FURTHER RESOLVED, that federal policies should minimize unnecessary administrative burden on beneficiaries, health care providers, and states while ensuring that eligible medically frail individuals retain timely access to needed health coverage and services; and

BE IT FURTHER RESOLVED, that CMS should provide states with sufficient time, technical assistance, and operational flexibility to implement medical frailty determinations in a manner that is accurate, administratively feasible, and minimizes unnecessary coverage disruptions; and

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BE IT FINALLY RESOLVED, that CMS should provide clear standards and safe harbors to ensure states are not penalized for good-faith implementation decisions made under compressed timelines and evolving federal guidance.

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