Highlights from MACPAC January 2021 Public Virtual Meeting

Overview

On January 28 and 29, 2021, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its January 2021 public virtual meeting. This summary includes highlights from all 12 meeting sessions. Presentation slides and the agenda for this meeting can be found on the MACPAC website.

Session 1: Postpartum Coverage: Review of Draft Chapter and Recommendation Decisions

MACPAC staffer Martha Heberlein reviewed the Commission's upcoming chapter on extending Medicaid coverage for postpartum women and led a discussion among the Commissioners on remaining issues surrounding MACPAC's upcoming recommendation on extending postpartum coverage in anticipation of the Commission's vote occurring the following day. For a review of the Commission's past work on this topic, see Viohl & Associates' past summaries.

The upcoming MACPAC chapter on extending postpartum coverage reviews existing Medicaid and Children's Health Insurance Program (CHIP) coverage for pregnant women, discusses coverage disruptions among postpartum women that contribute to adverse healthcare outcomes, highlights postpartum health issues, reviews existing state and federal actions, and raises considerations in extending the postpartum coverage period. Given that the Commission is already in agreement that states should be mandatorily required to extend Medicaid coverage for postpartum women up to one year after giving birth, and that states should receive enhanced federal funding to fulfil this mandate, the Commission discussed remaining policy considerations, including the following:

- Should the mandatory extension apply to all postpartum women or should the extension of coverage be mandatory only for those individuals up to 133 percent of the federal poverty level (FPL) and optional above that threshold?
- What level of enhanced federal funding (90 percent or 100 percent match) should be provided to states?

Ms. Herberlein's presentation concluded with a review of the Commission's three draft recommendations up for voting. The three draft recommendations are:

1. Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period would receive an enhanced (90 or) 100 percent federal matching rate;
2. Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income, and;
3. Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

She explained details of each recommendation, including the rationale and implications behind each. See slides 6-14 of the MACPAC presentation for the full text of these recommendations, and the Commission's analysis of rationale and implications. Ms. Herbelein noted that each recommendation has the potential to effectively improve maternal health outcomes, but that each additional mandate will likely put increased fiscal strain on states and require additional financial support from the federal government.

Commissioners' Comments and Public Comment

An overwhelming majority of Commissioners supported a 100% match rate to be provided to states to cover the extension in postpartum Medicaid coverage. Additionally, a large majority of Commissioners supported all three recommendations and felt that the Commission's analysis thus far was sufficient to justify sending all three recommendations to Congress. During the public comment period that followed the Commissioners' comments, Commissioners heard testimony from several individuals who encouraged the Commission to approve all three recommendations, especially the first recommendation to extend postpartum Medicaid coverage to one year. Commissioners voted in a large majority to approve all three recommendations the following day.

Session 2: Medicaid Estate Recovery: Draft Chapter and Recommendations

MACPAC staffers Kristal Vardaman and Tamara Huson reviewed the Commission's upcoming chapter on Medicaid estate recovery. They highlighted key parts of the chapter and discussed recommendations in anticipation of the Commission's upcoming vote. They also briefly discussed the Commission's analytic work on this issue so far. For a review of the Commission's past work on this topic, see Viohl and Associates' summaries of MACPAC's December and September public meetings. These prior summaries cover the draft recommendations in-depth, including rationale and implications behind each.

MACPAC's chapter on Medicaid estate recovery will cover financial eligibility for long-term services and supports (LTSS), the legislative history and requirements of estate recovery, program administration, state variation in estate recovery policy, estate collections, and the effects of estate recovery on obtaining Medicaid coverage.

The three draft recommendations regarding estate recovery that MACPAC considered are:

1. Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law;
2. Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary were less than the capitation payment made to a managed care plan, and;
3. Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for: (1) any asset that is the sole income-producing asset of survivors; (2) homes of modest value; or (3) any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards.

Commissioners' Comments

Commissioners did not raise many outstanding issues with the draft recommendations in their commentary. Many expressed their support for all three recommendations, which Commissioners voted by large majority to approve the following day.

Session 3: Automatic Countercyclical Financing Adjustment: Review of Draft Chapter and Recommendation Decisions

MACPAC staffers Chris Park and Moira Forbes reviewed MACPAC's upcoming chapter on an automatic countercyclical financing adjustment mechanism for Medicaid and discussed the Commission's potential recommendation. For a review of the Commission's past work on this topic, see Viohl & Associates' summaries of MACPAC's December, September, and April public meetings.

MACPAC's chapter exploring an automatic countercyclical financing adjustment mechanism for Medicaid will review how Medicaid functions as a countercyclical program, an automatic stabilizer, and a fiscal stimulus mechanism. It will also discuss the Commission's analysis of a permanent Medicaid countercyclical financing mechanism based on the Government Accountability Office (GAO) prototype model (covered in depth Viohl & Associates' previous summaries), and consider additional policy issues.

MACPAC's recommendation for an automatic countercyclical financing adjustment mechanism reads as follows:

- Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission also recommends this policy change should also include:
  - An eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
  - An upper bound of 100 percent on countercyclical adjusted matching rates; and
  - Exclusion of countercyclical adjusted federal matching rate from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories).

Commissioners' Comments

After asking a few clarifying questions, Commissioners were unified in support of MACPAC making this recommendation to Congress. They voted in support of this recommendation the following day by a large majority.

Session 4: Design Considerations in Creating a New Unified Program for Dually Eligible Beneficiaries: Review of Draft Chapter

MACPAC staffer Kristin Blom reviewed content for the Commission's upcoming chapter on considerations for establishing a unified program for dually eligible beneficiaries. After briefly discussing background on existing integrated models of care, she laid out key design considerations with examples drawn from two stakeholder proposals. For a review of the Commission's past work on this topic, see Viohl & Associates' past summaries.

Existing integrated models of care, including Medicare-Medicaid Plans (MMPs), dual eligible special needs plans (D-SNPs), managed fee for service plans, and Program of All-Inclusive Care for the Elderly (PACE) programs help simplify care and create cost savings by coordinating Medicare and Medicaid benefits and simplifying program administration. However, these plans currently compete for membership with other non-integrated models that are similar, like D-SNP "lookalike" plans. The Commission is considering the creation of a new unified program for dually eligible beneficiaries to help better integrate care for beneficiaries in a more efficient system.

MACPAC's framework for a new unified program draws from two publically available proposals, one from the Bipartisan Policy Center (BPC) and one from the Dual Eligible Coalition. Based on these proposals, the Commission is considering policies related to eligibility, beneficiary protections, benefits, delivery systems, models of care, program administration, and financing. For next steps, MACPAC staff will collect feedback from Commissioners and external reviewers to further explore these policy issues and publish their insights in MACPAC's March 2021 report to Congress.

Commissioners' Comments

In their discussion, Commissioners discussed the challenges of determining eligibility for an integrated care program, weighing the value of consumer choice in selecting health plans, perverse financial incentives that cause beneficiaries to be enrolled in non-integrated "lookalike" plans, and other policy considerations. Staffers researching the issue said the discussion was sufficient to guide further research into these topics, and planned on fully exploring them in the March report.

Session 5: Panel: State Budget Outlook and Implications for Medicaid

After a brief introduction from MACPAC chair Melanie Bella, Commissioners heard a panel discussion on the outlook for state budgets and potential impacts on Medicaid. Panelists included Shelby Kerns, executive director for the National Association of State Budget Officers (NASBO), Emily Blanford, program principal at the National Conference of State Legislatures (NCSL), and Susie Perez Quinn, government affairs director for the National Governors Association (NGA).

Ms. Kerns explained that last year many states experienced budgetary shortfalls caused by the economic downturn and a drop in revenues resulting from the COVID-19 pandemic, but that their fiscal situation has generally improved since then. She said states addressed these shortfalls through a combination of across the board and targeted spending cuts, hiring freezes, and the use of "rainy day" funds to fill gaps. She also said a few states reduced capitation for Medicaid managed care plans. Ms. Kerns said that going into 2021, state budget makers still face a lot of uncertainty, as Medicaid enrollment, which lags behind changes in states' economies, continues to grow.

Ms. Quinn focused on states' unanticipated costs arising from the COVID-19 pandemic, including increased spending on National Guard activities, personal protective equipment and other healthcare supplies, and public health response. She explained that President Biden's recent memorandum authorizing full reimbursement for states' National Guard expenses and other emergency spending going forward will help ease their fiscal burden, but that states have accrued significant cost-sharing liabilities to date and it is not yet clear if the increased

federal assistance will be made retroactive (note: since the MACPAC meeting, President Biden announced 100% federal reimbursement would be made retroactive). Ms. Quinn also said that the likely extension of the public health emergency (PHE) through the end of 2021 would be helpful to states since the enhanced federal medical assistance percentage (FMAP) of 6.2 percent authorized last year by Congress is tied to the PHE. She also mentioned that the NGA had hoped that the enhanced match would be set at a higher level.

Ms. Blanford discussed a survey of states undertaken by NCSL and said that 29 states were not planning to make any additional adjustments to their current year budgets given improved revenue outlooks. She also said that some states have reduced benefits or increased cost-sharing due to budget constraints and that state legislators remained interested in the enhanced FMAP and how long it might be extended.

Commissioners' Comments

In response to Commissioners' questions, the panelists noted the importance of clear communication from the federal government to states on public health policies and federal assistance. In addition, several Commissioners voiced concerns about the profits announced by some of the investor owned managed care organizations (MCOs) in 2020 due to underutilization of services and whether this might require some rethinking of the way in which they are paid.

Session 6: Value-Based Payment for Maternity Services

MACPAC staffer Martha Heberlein examined the role of value-based payment (VBP) in improving the maternal health of Medicaid beneficiaries in a continuation of the Commission's work on maternal health. She reviewed the Commission's previous work on this issue, gave a brief overview of VBP models in the context of maternity services, and reviewed case studies conducted by RTI International that examined VBP models for maternity care in five states. For a review of MACPAC's previous work on maternal health, see Viohl & Associates' past summaries.

In prior MACPAC work, reviews of state Medicaid programs found that several states had implemented some kind of VBP model to improve maternal care:

- Four states implemented pay-for-performance programs, in which providers are given financial incentives to meet quality standards;
- 10 states implemented a single payment for the perinatal episode of care, which effectively bundles payments for all perinatal services into a single, fixed payment and takes into account quality and cost thresholds, and;
- Four states implemented a pregnancy Medical homes delivery model that aims to improve maternal health outcomes by addressing clinical, behavioral, and social aspects of care.

Ms. Heberlein noted that these states could serve as models for other states interested in implementing VBP for maternity services. MACPAC contracted with RTI International to conduct case studies of VBP models in Arkansas, Connecticut, Colorado, North Carolina, and Tennessee. To conduct these case studies, RTI International reviewed documents from these states, conducted telephone interviews, and recorded observations about program function. See slide 6 of the MACPAC presentation for an overview of the VBP models in these states.

The study found that these states' models shared some key characteristics:

- The VBP models in all five states are not designed to fundamentally change how maternity care is provided.
- The VBP models use payment to incentivize targeted quality improvements, although evidence is mixed on whether the models succeed in doing so.
- In the five states, payment incentives are not directly tied to reductions in specific outcomes measures, like maternal mortality, morbidity, or racial disparities; rather, they are often tied to standardizing clinical care practices.

Commissioners' Comments

The Commission felt that further research should be done to explore the efficacy of VBP models in achieving targeted quality improvements. While the Commissioners' generally agreed that VBP initiatives designed to encourage clinical standardization could potentially help reduce maternal mortality and health disparities, clinical

standardization should not be an exclusive purpose for these programs. The Commission will revisit the topic of VBP for maternity services in future meetings.

Session 7: Panel: The Role of Medicaid for People with Intellectual and Developmental Disabilities

The second day of MACPAC's January Public Meeting began with a panel discussion on the role of Medicaid for people with Intellectual and Developmental Disabilities (IDD). MACPAC staffer Kristal Vardaman introduced the panelists, including Sharon Lewis, principal at Health Management Associates, Melissa Stone, director of Arkansas' Division of Developmental Disabilities Services, and Elizabeth Weintraub, a senior advocacy specialist at the Association of University Centers on Disabilities.

Ms. Lewis noted that the Medicaid population with IDD is a culturally and racially heterogeneous population with a wide variety of needs. She explained that lack of access to home- and community-based services (HCBS) often affects every aspect of these individuals' lives, underscoring the importance of good case management, policy, and organization. Ms. Lewis said that states are increasingly moving to more person-centered practices that address social determinants of health, but that the quality of available care for Medicaid beneficiaries with IDD varies widely by state. Factors like low wages contribute to a nationwide shortage of IDD care workers, which makes it difficult to improve care in some states. She also noted that states faced ongoing challenges as they attempt to tackle the COVID-19 pandemic (that disproportionately affects individuals with IDD) and target inequities in the healthcare system while still trying to maintain or improve quality of care for individuals with IDD.

Ms. Stone described lessons learned from Arkansas' new model of managed care for individuals with IDD. She noted that even as the new model aimed to address the shortage of care workers for individuals with IDD by getting some types of providers to "cross over" to serving the IDD population, providers tended to be reluctant to expand their scope of practice; for example, behavioral health providers tended to prefer continuing to provide only traditional behavioral health services rather than branch into new IDD services. She said that Arkansas is still conducting ongoing efforts to address the workforce shortage.

Still, Ms. Stone noted that creating alternative ways for individuals with IDD to receive crucial services was helpful for improving care in Arkansas. For example, she noted that by providing additional regulatory flexibility to allow behavioral health providers to code for IDD services has resulted in much greater access to care for individuals with IDD during the pandemic. She also noted that six providers are currently enrolling as a new provider type that is geared toward behavioral health and IDD services.

Ms. Weintraub also noted that 2020 was an exceptionally difficult year for individuals with IDD. She explained that even as individuals with IDD have faced disproportionately high risks from COVID-19, they have still had to fight for fair access to treatment. She argued that as a first step, the Centers for Medicare and Medicaid Services (CMS) should be collecting more data from states about how COVID-19 is affecting Medicaid beneficiaries with IDD. She also argued that states should bear in mind many of the other social factors that affect health outcomes for individuals with IDD, like loneliness. She argued that now, more than ever, there is a moral imperative to provide adequate care for Medicaid beneficiaries with IDD. She also said there is still a lot of work to be done to close racial gaps in care for individuals with IDD, and implored states to focus on this priority.

Commissioners' Comments

In response to a Commissioner's comment, Ms. Weintraub highlighted the importance of meaningful inclusion in policy discussions, noting that in a lot of cases individuals with IDD have a token role in IDD policy discussions. She said stakeholders should really carefully consider the perspectives of individuals with IDD to help improve person-centered care. In discussion with the Commissioners, panelists also re-emphasized the importance of considering racial and ethnic disparities in IDD care, since people of color with IDD tend to be most at risk for negative healthcare outcomes.

Session 8: Voting on Recommendations for the March Report to Congress: Postpartum Coverage, Estate Recovery, and Automatic Countercyclical Financing Adjustments

MACPAC Commissioners voted on recommendations for their upcoming March report to congress covering the topics the Commission explored in the previous months. All seven recommendations were approved by large majorities. The recommendations and the vote totals for each are listed below.

Postpartum Coverage

Recommendation 1: Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant by a full year, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period should l receive an enhanced 100 percent federal matching rate. **Yes: 16; No: 0; Abstain: 0**.

Recommendation 2: Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) by a full year, regardless of changes in income. **Yes: 17; No: 0; Abstain: 0.**

Recommendation 3: Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related coverage pathways. **Yes: 17; No: 0; Abstain: 0.**

Estate Recovery

Recommendation 1: Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law. **Yes: 13; No: 2; Abstain: 2.**

Recommendation 2: Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary were less than the capitation payment made to a managed care plan. **Yes: 17; No: 0; Abstain: 0.**

Recommendation 3: Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for: (1) any asset that is the sole income-producing asset of survivors; (2) homes of modest value; or (3) any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards. **Yes: 15; No: 1; Abstain: 1.**

Automatic Countercyclical Financing Adjustments

Recommendation 1: Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission also recommends this policy change should also include an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment, an upper bound of 100 percent on countercyclical adjusted matching rates, and exclusion of countercyclical adjusted federal matching rates from services and populations that receive special matching rates (e.g., for the new adult group) or are otherwise capped or have allotments (e.g., disproportionate share hospital payments, territories). **Yes: 17; No: 0; Abstain: 0.**

Session 9: MACPAC Study on Non-Emergency Medical Transportation

MACPAC staffers Kacey Buderi, Aaron Pervin, and Mike Perry reviewed key findings from a congressionally-mandated MACPAC report on non-emergency medical transportation (NEMT). The findings described in this session build on preliminary data from MACPAC's earlier environmental scan of state NEMT policies, which was reviewed during MACPAC's October public meeting (see Viohl and Associates' Summary here). This presentation reviews findings from two additional parts of the study: analysis of transformed Medicaid statistical information system (T-MSIS) data, and focus groups with beneficiaries that utilize NEMT benefits.

T-MSIS data that was utilized for this study captures rides billed for with NEMT codes within the Healthcare Common Procedure Coding System. The findings are presented as ride-days, so it is worth noting that the actual number of door-to-door rides are much higher.

The T-MSIS data shows that in 2018, about 61.5 million ride days were coded for with about 3.2 million total NEMT users. Users varied by eligibility group, mode of transportation and diagnostic category. Slides 9-15 from the MACPAC presentation break down these statistics in detail.

Key takeaways from the data analysis are as follows:

- NEMT is used extensively by a relatively small number of beneficiaries;
- Compared to other eligibility groups, aged and disabled people make up the largest group of users;
- Beneficiaries with end-stage renal disease use NEMT most frequently;
- NEMT users' mode of transportation is usually a van or taxi, which includes Uber and Lyft, and;
- The most common NEMT destinations are home or a physicians' office.

MACPAC contracted with PerryUndem, a research contractor, to collect focus group data for their NEMT study. PerryUndem conducted eight teleconference focus groups in six states: Arizona, Connecticut, Georgia, Indiana, Massachusetts, and Texas. The focus groups included a diverse group of participants who varied by race, ethnicity, and gender. Research participants either had or cared for someone who had a variety of chronic conditions that required frequent in-person health care visits.

The focus group study found that individuals who utilized NEMT faced various transportation barriers to accessing care prior to using NEMT. For example, some did not have a car or driver's license, or some lacked specialty vehicles such as a wheelchair-accessible van. These beneficiaries reported that NEMT benefits were absolutely crucial for managing their chronic health conditions; some participants told stories about missing appointments due to transportation barriers or expressed their belief that NEMT benefits were crucial to their lives. Some beneficiaries with disabilities or physical limitations also reported that they believed NEMT benefits helped improve their mental health and helped foster independence by reducing reliance on family members.

Although beneficiaries' experiences with NEMT were mostly positive, experience varied widely by beneficiary, and interviewed beneficiaries provided suggestions for how to improve the benefit. Many said that the program could be strengthened by improving the dispatching process, preventing overcrowding on shared vehicles, reducing excessive wait times, implementing stronger driver background checks, and implementing new technologies like an app to help schedule appointments and track rides.

Many beneficiaries grew anxious when asked what would happen if they lost NEMT benefits. Many said they were worried their health would deteriorate, and some even said they worried that they would die. Beneficiaries overwhelmingly favor keeping NEMT benefits regardless of the program's shortcomings.

Commissioners' Comments

Commissioners felt focus group feedback was useful for guiding the discussion on NEMT benefits. Many Commissioners felt that the reported experiences of NEMT-utilizing beneficiaries indicated the importance of Congress maintaining NEMT as a mandatory benefit, and felt that the Commission should focus its efforts on improving and streamlining the program. One Commissioner suggested that MACPAC further explore the idea of promoting technology-driven approaches as an alternative to traditional NEMT, such as Uber and Lyft.

Session 10: Integration of Care for Dually Eligible Beneficiaries: New Analyses

MACPAC staffers Kirstin Blom and Ashley Semanskee reviewed new analyses conducted by Health Management Associates (HMA) and Mathematica under contract with MACPAC on ways to increase availability of and enrollment in integrated care for individuals dually eligible for Medicare and Medicaid. For a review of the Commission's past work on integrating care for dually-eligible beneficiaries, see Viohl and Associates' past summaries.

Across multiple states, HMA and Mathematica interviewed stakeholders including beneficiary advocates, federal and state officials, Medicaid enrollment brokers, Medicare advantage plan representatives, Medicaid managed care plan representatives, and Medicare agents and brokers. In their work, they examined the role of Medicare agents and brokers in assisting dually eligible beneficiaries with coverage choices, and explored opportunities for states to maximize their D-SNP contracting authorities. They found that:

- Medicare agents and brokers are increasingly interested in marketing and selling D-SNPs;
- Stakeholders held mixed views on the value added by Medicare agents and brokers, and;
- Dually eligible beneficiaries often lack access to a single reliable source of information that can help them compare all available coverage options, instead receiving enrollment advice from a variety of potentially biased sources, including Medicaid enrollment brokers, Medicare agents and brokers, and State Health Insurance Assistance Programs (SHIPs).

These findings could suggest that improving coordination between Medicare agents and brokers and Medicaid enrollment brokers could help improve enrollment in integrated plans. HMA and Mathematica's study also identifies ways states can maximize their existing authority to promote integration and enrollment in D-SNPs. After interviewing state stakeholders, Mathematica compiled a list of states' contracting strategies that encourage integration, including restricting D-SNP enrollment to only full-benefit dually eligible beneficiaries, requiring D-SNPs to send data or reports to the state for oversight purposes, and selectively contracting with D-SNPs that offer Medicaid managed care plans. See slides 13-14 in the MACPAC presentation for a full list.

Finally, HMA and Mathematica's work identifies opportunities for changes in state policy to assist with integration. For example, the study suggests that states could require D-SNPs to enroll full-benefit and partial-benefit dually eligible beneficiaries in separate plan benefit packages, that states could review Medicaid information in D-SNP materials, and that states could require D-SNPs to use specific coordination methods.

For next steps, the Commission will discuss potential draft recommendations which will be considered at the March 2021 Commission meeting and voted on during the April 2021 meeting.

Commissioners' Comments

Commissioners did not yet settle on specific draft recommendations, although they discussed ways to improve coordination between Medicare agents and brokers and Medicaid enrollment brokers, setting regulations on brokers, and their earlier plans to create a new program specifically for dually-eligible beneficiaries. The Commission will continue the discussion on draft recommendations offline and decide on draft recommendations during their March 2021 meeting.

Session 11: Payment and Coverage of High-Cost Specialty Drugs: Report from Technical Advisory Panel

MACPAC staffer Chris Park reviewed analysis from a technical advisory panel that the Commission convened in 2020 on high-cost specialty drugs. The panel analyzed the specialty drug pipeline in order to identify drug types that are challenging for Medicaid programs to manage, identify alternative coverage and payment models for these drugs, and explore the effects of each model on stakeholders.

In their analysis, the technical advisory panel looked closely at high-cost drugs likely to have the greatest potential health benefits for Medicaid beneficiaries that could also fiscally strain state Medicaid programs. They identified three groups of drugs that could have a great effect but could pose challenges to Medicaid programs:

1. Cell and gene therapies;
2. Drugs receiving accelerated approval, and;
3. Specialty drugs for sensitive populations.

The panel identified unique challenges and potential solutions for each of these drug groups, which are laid out in detail on slide 5 of the MACPAC presentation.

The panel also identified two payment models that could be used for two groups of these drugs: first, a differential rebate model for accelerated approval drugs, and second, creating a new benefit for cell and gene therapies.

Under the differential rebate model for accelerated approval drugs, accelerated approval drugs would be offered with a higher rebate applied until the drug gets full approval; this could help lower Medicaid spending while there is limited evidence of the clinical effectiveness of certain experimental drugs and create an incentive for manufacturers to complete confirmatory trials. This means providers could get evidence from confirmatory trials in a timelier manner. This model also preserves incentives for manufacturers to pursue accelerated approval for drugs, but potentially limits access to some drugs for beneficiaries.

As a way to pay for cell and gene therapies, Medicaid could carve-out coverage of cell and gene therapies from the Medicaid Drug Rebate Program (MDRP) into a new benefit. This would allow for new coverage, payment or rebate requirements for these special drugs without disrupting the existing structure of the MDRP and create more flexibility in coverage requirements for these drugs. As an added benefit, doing so would address states' concerns about high up-front costs and budget volatility associated with these drugs by increasing rebates and/or federal funding for them, pooling utilization nationally to increase predictability, and consolidating purchasing power. Overall, this unified approach to coverage and payment for cell and gene therapies could improve beneficiaries' access to such treatments.

For next steps, MACPAC staff are collecting feedback from Commissioners on these two models and will determine whether to move forward with either model as a potential recommendation.

Commissioners' Comments

Commissioners felt that both models seemed promising as potential recommendations, and will direct staff to conduct further research in preparation to make recommendations.

Session 12: Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP

In the final session of MACPAC's January public meeting, MACPAC staffer Erin McMullen described how states and managed care organizations are implementing requirements from the Mental Health Parity and Addiction Equity Act (MHPAEA). She reviewed a brief background on the MHPAEA and discussed MACPAC's analysis of the effectiveness of the MHPAEA ensuring access to mental health services in Medicaid.

The MHPAEA requires coverage for substance use disorder (SUD) and mental health benefits be no more restrictive than coverage generally. In 2016, CMS issued a final rule that clarified the application of MHPAEA to Medicaid and CHIP, requiring states and managed care plans to analyze limits place on mental health and SUD treatment benefits in Medicaid and CHIP. Still, there are gaps in information about MHPAEA implementation in Medicaid and CHIP that raise important policy questions; for example, what challenges do state Medicaid and CHIP agencies and Medicaid MCOs face in implementing MHPAEA? Also, has MHPAEA improved access to behavioral health care for Medicaid and CHIP beneficiaries?

MACPAC's analysis of these policy questions aims to address gaps in information and better inform stakeholders on the effectiveness of MHPAEA. To conduct this analysis, MACPAC staff conducted semi-structured interviews with Medicaid officials, managed care organizations, and beneficiary advocates in Hawaii, Maryland, and Oregon. MACPAC also interviewed officials from CMS and other national organizations.

In these interviews, stakeholders reported that MHPAEA has helped raise awareness and generate state-level conversations regarding access to behavioral health care, although MHPAEA-required parity analyses have not led to large-scale changes to states' behavioral health benefits. Generally, MACPAC also found that other Medicaid policies are more relevant in ensuring access to community-based services.

Commissioners' Comments

Given the high costs associated with requiring states to conduct parity analyses, some MACPAC Commissioners wondered if resources could be better spent targeting improving access to community-based services for mental and behavioral health treatments for Medicaid beneficiaries. The Commission intends to revisit mental health and addiction care access in future meetings.