Highlights from MACPAC October 2020 Public Webcast Meeting

Overview

On October 29 and 30, 2020, the Medicaid and Chip Payment and Access Commission (MACPAC) held its October 2020 public meeting webcast. This summary includes highlights from all 10 meeting sessions. Presentation slides and the agenda for this meeting can be found on the MACPAC website.

Session 1: Restarting Medicaid Eligibility Redeterminations when the Public Health Emergency Ends

After a brief introduction by MACPAC staffer Joanne Jee, MACPAC hosted a panel discussion with Jennifer Wagner, director of Medicaid eligibility and enrollment at the Center on Budget and Policy Priorities, Rene Mollow, deputy director for health care benefits and eligibility at the California Department of Health Care Services, and Lee Guice, director of policy and operations at the Department for Medicaid Services of the Kentucky Cabinet for Health and Family Services. Their discussion focused on challenges associated with restarting Medicaid eligibility determinations when the public health emergency (PHE) ends, including logistical hurdles, continuity of care issues, and state budgetary concerns.

The provision of the Coronavirus Aid, Relief, and Economic Security (CARES) Act which ties enhanced Federal Medical Assistance Percentage (FMAP) funding to a "continuous coverage" requirement effectively forces states to suspend Medicaid eligibility redeterminations until the end of the PHE if they want to access these crucial funds.

Ms. Wagner noted that if not for the continuous coverage requirement, many Medicaid beneficiaries may have lost coverage. Since states will have to resume Medicaid redeterminations after the end of the PHE, Ms. Wagner said states should prepare by conducting renewals now to reduce the number of cases in states' backlogs before the end of the PHE. She also expressed her opinion that states and Medicaid managed care organizations (MCOs) should better communicate with their beneficiaries to minimize the impact of redeterminations on beneficiaries' lives. She also said it would be helpful for states to act now to address data gaps, and collect needed personal information from beneficiaries. Finally, she also argued that the Centers for Medicare and Medicaid Services (CMS) should immediately issue guidance pertaining to renewals to make it clear to states what flexibilities will be allowed (or required) when states are handling large numbers of redeterminations at the end of the PHE.

Ms. Mollow discussed her experiences tackling the challenges associated with the redetermination suspension period as an official with Medi-Cal, California's Medicaid program. She noted that Medi-Cal introduced new flexibilities to meet the continuous coverage requirement of the CARES Act and adopted a disaster state plan amendment to offer an additional period of presumptive eligibility for beneficiaries to limit confusion and maximize beneficiaries' continuity of care. She also explained that because of the pandemic, Medi-Cal county offices have increasingly limited capacity, making it difficult for Medi-Cal to perform redeterminations for the thousands of individuals in their care. She echoed Ms. Wagner's call for timely guidance from CMS regarding state redetermination flexibilities.

Mr. Guice explained that Kentucky handled the suspension of eligibility redeterminations by making modifications to Kentucky's automatic eligibility system and manually reinstating coverage for beneficiaries who were improperly disenrolled during the PHE. He said that while this has allowed Kentucky's Medicaid program to avoid many of the difficulties faced by other states, he explained that some increased flexibility (i.e. an extended special eligibility period) would be necessary to smoothly transition back to a normal redeterminations process at the end of the PHE.

Commissioners' Comments

Reviewing the panelists' comments, Commissioners highlighted three crucial needs for states going forward: 1) Additional flexibilities, 2) Clear guidance from CMS, and; 3) Ongoing advisory from the Commission and CMS in establishing new flexibilities and guidance. The Commission will make final decisions on the formal and informal comments they will make to CMS during MACPAC's December Public Meeting.

Session 2: Creating a New Program for Dually Eligible Beneficiaries: Key Considerations

MACPAC staffer Kristin Blom introduced a panel discussion following up on the Commission's earlier conversations about creating a new federal program for dually-eligible beneficiaries ("duals") to improve their integration of care. Panel participants included Kevin Prindiville, executive director at Justice in Aging, Mark Miller, executive vice president of healthcare at Arnold Ventures, and Charlene Frizzera, senior advisor at Leavitt Partners. Each panelist highlighted their top priorities and considerations for the Commission.

Mr. Prindiville argued that four key principles should guide the Commission: 1) Get people what they need, 2) Address equity and health disparities, 3) Expand access to home- and community-based services, and; 4) Preserve consumer choice. Mr. Prindiville argued that these four principles are crucial because they relate most directly to the needs of duals based on existing CMS data trends.

Mr. Miller highlighted three key policy changes that his organization identified as important for improving integration of care for duals: 1) Increase financial and delivery system integration between Medicare and Medicaid, 2) Increase enrollment in integrated models, and; 3) Retain flexibility in integrated care delivery. He argued that these three policy changes best serve duals' diverse set of needs. Mr. Miller also argued that introducing additional beneficiary services into integrated models that address social determinants of health would help improve healthcare outcomes for duals.

Ms. Frizzera explained common themes from her consultancy's interviews with stakeholders. In addition to echoing some of the other panelists' suggestions, Ms. Frizzera highlighted the importance of state-federal partnerships, aligning incentives for value-based care, additional beneficiary protections, and supporting beneficiary engagement. She also acknowledged that states will likely need enhanced funding to cover the startup costs of new integrated care models.

Commissioners' Comments

Commissioners' believed the panelists' comments were useful for determining where gaps in care for duals exist. They felt that considerations raised by the panelists were helpful for proposing a framework for a more permanent solution for dually-eligible beneficiaries other than current integrated products that duals are currently offered. Ultimately, Commissioners decided to revisit the data from earlier studies of integrated care and decide what kind of recommendation to make during the Commission's January public meeting.

Session 3: Mandated Report on NEMT: Work Plan and Preliminary Plan

MACPAC staffer Kacey Buderi reviewed preliminary findings from the Commission's study on non-emergency medical transportation (NEMT) per a request from the Senate Appropriations Committee. Currently, all 50 states are required to provide NEMT through their state's Medicaid program, however, some states have received approval through Section 1115 waivers to exclude NEMT as a benefit for certain populations.

MACPAC's study consisted of three parts: 1) An environmental scan of state NEMT policies with semi-structured interviews of Medicaid officials, 2) Focus groups with beneficiaries who have used NEMT, and; 3) Analysis of administrative data on NEMT utilization and spending. Details of study methodology can be found in MACPAC's presentation (see slide 8). Ms. Buderi presented findings from the first part of this study, with findings from the second and third part of the study to be presented at future meetings.

From their environmental scan, the Commission gathered data on NEMT utilization, modes of transportation, delivery models, and coordination. The study ultimately identified opportunities for the federal government to improve the efficiency and effectiveness of NEMT programs. Preliminary data gathered suggested that states could benefit from sharing best practices with one another, the potential benefits of guidance regarding the use of transportation network companies (i.e. Uber and Lyft), and the potential benefits of new mechanisms to provide federal incentives to address provider shortages in rural areas. The study also raises the question of whether Congress should codify NEMT requirements in statute.

Commissioners' Comments

Commissioners felt preliminary data from this component of the study raised interesting questions, but ultimately, Commissioners decided to discuss further action on this topic at MACPAC's January meeting. MACPAC will review findings from the other components of this study at that time.

Session 4: Changes in Nursing Facility Acuity Adjustment Methods

MACPAC staffer Robert Nelb presented data on nursing facility acuity adjustment methods and its implications for state Medicaid programs. State Medicaid programs are the largest insurers of nursing facility services, and states have broad flexibility to design their own nursing facility payment methods. State Medicaid programs primarily use two models for acuity adjustments: resource utilization groups (which vary payment based on the amount of services patients access) and patient-driven payment models (which predict a patient's care needs based on their initial diagnosis).

In their study of nursing homes, MACPAC found that 33 states and the District of Columbia use resource utilization groups (RUGs) to adjust base payment rates for nursing facilities. 33 states also use RUGs to calculate the upper payment limit (UPL) for nursing homes based on the estimates of what Medicare would have paid. Other states use patient-driven payment models (PDPM) to determine base payments and UPLs. Starting October 1, 2019, Medicare changed its acuity-adjustment method from RUGs to PDPM. Widespread use of RUGs means that switching from RUGs to PDPM will be more challenging for Medicaid than it was for Medicare. For supplemental payments, CMS is requiring states to use PDPM for UPL demonstrations in fiscal year 2022 (FY 2022), and under PDPMs, UPLs may be much higher than when using RUGs.

MACPAC's study raises three key policy questions: 1) What resources do states need to support the development of nursing facility payment methods that promotes statutory goals? 2) What are the implications of using Medicare as an upper limit on Medicaid nursing facility payments? and 3) What is an appropriate benchmark for Medicaid nursing facility payment adequacy?

Commissioners' Comments

MACPAC Commissioners discussed the policy questions raised by Mr. Nelb's presentation, and thought they constituted a good starting point for the Commission to further explore this issue. In order to make a recommendation, the Commission will continue to communicate with states to find how best to serve their needs for additional resources and other assistance. The Commission will revisit this issue in their upcoming public meetings.

Session 5 & 6: Access to Mental Health Services for Adults in Medicaid

MACPAC staffers Erin McMullen and Melinda Roach presented on Medicaid beneficiaries' ability to access mental health services. Following their presentation, MACPAC hosted a panel discussion with mental healthcare policy experts, including Sandra Wilkniss, director of complex care policy and senior fellow at Families USA, Melisa Byrd, senior deputy director of the District of Columbia Department of Health Care Finance, and Dorn Schuffman, director of the Certified Community Behavioral Health Clinics Demonstration Project at the Missouri Department of Mental Health. The summary below incorporates commentary from the presentation and the panel discussion.

Diverse mental health needs among beneficiaries highlight the need for a properly-tailored continuum of care. While coverage of specific services vary among state Medicaid programs, some services, including mental health screening and assessment, outpatient mental health services, and inpatient psychiatric treatment are currently covered in all 50 states. In most states (43 out of 50) Medicaid is accepted by over 85% of mental health treatment facilities, although services offered by these facilities vary. About a quarter of these facilities offered some kind of telehealth services before the pandemic, although that number has greatly increased since then. However, although access to mental health services has improved with the expansion of telehealth, there are still shortages of mental health professionals in many areas in the United States.

States are still pursuing opportunities for improving mental health services in Medicaid. States followed CMS guidance issued in 2018 to enhance the delivery system of mental health services for adults with serious mental

illnesses and children with severe emotional disturbances, pursuing program changes including improving access to a continuum of care, ensuring quality of care, improving care coordination, early identification and engagement in treatment, and reducing lengths of stays in emergency departments. States are also expanding the use of Certified Community Behavioral Health Clinics.

Commissioners' Comments

Given the drastic increase in demand for mental health services since the start of the pandemic, Commissioners noted the increased importance of discussing improvements to mental health services access for Medicaid populations. Commissioners discussed allowing states to retain some tele-behavioral health flexibilities after the pandemic and how to support states' efforts to make improvements in their mental health programs. The Commission will consider a recommendation during future meetings.

Session 7: Considerations in Expanding Postpartum Coverage

MACPAC staffer Martha Heberlein gave a presentation on the Commission's follow-up work on expanding postpartum coverage. For summaries of MACPAC's previous coverage of this topic, please see Viohl & Associates' summaries of MACPAC's earlier public meetings. After a quick review of state Medicaid programs' current postpartum coverage, Ms. Heberlein discussed postpartum health issues and state and federal actions to address these issues. She noted that one-third of pregnancy related deaths occur after birth, that 10-25% of pregnant women may have chronic illness, and that there is a high prevalence of perinatal mood and anxiety disorders in pregnant women.

To address these issues, 11 states have expanded or sought to expand coverage beyond the typical 60-day postpartum period. Additional states have or are considering an extension. Federally, the US House of Representatives passed H.R. 4996, a law giving states the option to extend the postpartum coverage period from 60 days to a full year, regardless of eligibility pathway; however, the Senate has yet to act on this legislation. MACPAC will likely make a recommendation to extend the postpartum period. They are considering whether to recommend that this extension should l be mandatory or a state option.

Commissioners' Comments

The Commission agreed to recommend Congress extend Medicaid's postpartum coverage period to 12 months with full benefits for new mothers, although they were still divided as to whether to recommend the expansion be mandatory or optional for states. The panel also agreed that Medicaid coverage for these mothers should align with the state Children's Health Insurance Program. Commissioners remained concerned over what fiscal impact making such an extension mandatory would have on states, noting that some states will need increased financial resources to make such an expansion. However, another Commissioner noted that making the extension optional could lead to continuing disparities between states and Medicaid subpopulations.

Session 8: Required Annual Analysis of Disproportionate Share Hospital Allotments

MACPAC staffer Aaron Pervin reviewed MACPAC's statutorily required annual analysis of disproportionate share hospital (DSH) payments. A $4 billion reduction to DSH allotments is planned in FY 2021, with an additional $8 billion in DSH allotment reductions planned in each fiscal year from 2022-2025. DSH allotment reductions for this year were delayed until December 11 in the continuing resolution recently approved by Congress. In their analysis, MACPAC found that there is no meaningful relationship between DSH allotments and measures of need, before or after reductions. In addition to analyzing the impact of DSH payment allotment reductions, MACPAC's study also makes updates to statutorily required data elements, including the number of uninsured individuals, amounts and sources of hospital uncompensated care costs, and hospitals with high levels of uncompensated care that also provide essential community services. See MACPAC's presentation (slides 4-8) for a detailed breakdown of MACPAC's data. A chapter containing data from MACPAC's analysis will be published in MACPAC's upcoming March report. Per congressional requirements, staff will continue to monitor this issue going forward.

Commissioners' Comments

Commissioners' comments were brief, and ultimately the Commission decided to further discuss this issue when findings are published in MACPAC's March report.

Session 9: Addressing Costs of High-Price Drugs

MACPAC staffers Amy Zettle and Chris Park gave a presentation on addressing costs of high-price drugs, which are making up an increasing share of state's Medicaid budgets. For the latter half of the presentation, Caroline Pearson, senior vice president at NORC at the University of Chicago, shared work done under contract with MACPAC to inform Commissioners' discussions.

States are having increasing difficulty managing the high costs associated with specialty drugs. Pediatric gene therapies, especially for sickle cell disorders, tend to be the most expensive drugs for Medicaid programs. Adult gene therapies also represent disproportionately high costs for Medicaid programs, although these drugs are more often purchased by Medicare. Accelerated-approval drugs and drugs for sensitive populations also tend to drive costs in both programs. These expensive drugs, like pediatric gene therapies and cell therapies, have potentially high impacts on patients' lives, but current cost containment and pharmacy benefit tools are ineffective at managing their costs.

Gene and cell therapies present issues for states including high list prices and up-front costs and state budget volatility, although investment in these drugs typically yields a long-term benefit for patients. However, accelerated-approval drugs face the issue of limited evidence regarding their efficacy, but still drive costs. Generally, states also lack negotiating power to secure lower prices for drugs for vulnerable populations. MACPAC intends to continue to develop strategies for states to address the costs of high-price drugs, and will continue to monitor and comment on legislation aiming to manage high drug prices.

Commissioners' Comments

Commissioners said they supported publishing results of MACPAC's studies of high-cost pharmacy drugs. The Commission will continue to work on this issue in their next two public meetings in December and January.

Session 10: Secretary's Report to Congress on Reducing Barriers to Furnishing Substance Use Disorder Services Using Telehealth and Remote Patient Monitoring for Pediatric Populations

MACPAC staffer Joanne Jee presented on MACPAC's comments on, and findings of the Secretary of the Department of Health and Human Services' (HHS) report to Congress on reducing barriers to substance use disorder (SUD) services using telehealth and remote patient monitoring for pediatric populations under Medicaid. This report was initially mandated by the SUPPORT Act. The report found that there are knowledge gaps about the use of telehealth for SUD treatment for pediatric populations, given that most data currently focuses on tele-behavioral health or general health services. MACPAC noted that analysis of best practices for tele-behavioral health that could apply to pediatric SUD treatment include ensuring organizational readiness, engaging staff, using synchronous modalities, using support staff, and using telehealth in school-based programs.

However, there still is insufficient data comparing telehealth and in-person visits. Lack of data effectively comparing utilization and costs creates barriers for improving care. Current data shows that quality of tele-behavioral health remains similar to comparable in-person services, and that users of telehealth services generally are satisfied with the service they receive (although satisfaction can vary based on patient and provider access to technology, and by patient demographics).

The report helps the commission identify existing barriers to improving care for pediatric populations receiving SUD treatment via telehealth, and begin to work on solutions. Reforms to payment policy, improvements in access to technology, and addressing workforce and capacity constraints could help improve quality of and access to care. MACPAC will consider commenting on the need for additional research and data, greater information on state Medicaid approaches for using telehealth for SUD treatment services for pediatric populations, and other non-Medicaid barriers to telehealth use.

Commissioners' Comments

Commissioners agreed that gaps in data and crucial information make it difficult for the Commission to make a recommendation at this time. MACPAC will follow-up on potential recommendations at the December public meeting, and will likely recommend that more resources are used to collect additional data.