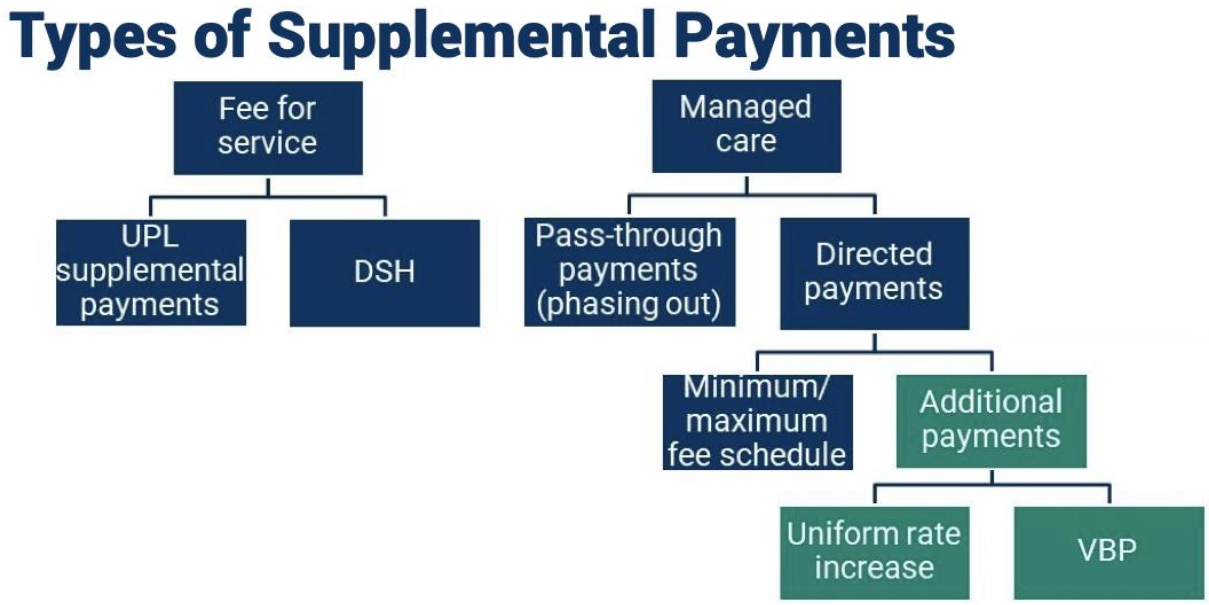
Highlights from MACPAC December 2021 Public Virtual Meeting

On December 9th and December 10th, 2021, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its December 2021 public virtual meeting. This summary includes highlights from all eight meeting sessions. Presentation slides and the agenda for the full December public meeting can be found on the MACPAC website.

Session 1: Transparency and Oversight of Directed Payments in Medicaid Managed Care

MACPAC staff members Michelle Millerick and Robert Nelb presented on key themes from a Mathematica report commissioned by MACPAC studying directed payments in Medicaid managed care. Their presentation covered the relationship between fee-for-service supplemental payments and directed payments, how directed payments impact certain providers, the growth of directed payments in Medicaid managed care, and oversight challenges. They also covered policy options to improve oversight and transparency for the Commission's consideration.

Ms. Millerick and Mr. Nelb's presentation began with a brief overview comparing fee-for-service supplemental payments with directed payments in Medicaid managed care. They noted that while supplemental payments are subject to an upper payment limit (UPL), directed payments have no limit, which may have contributed to the substantial growth of directed payments since they were introduced in 2016. They also noted that providers eligible for directed payments must provide services under the state's managed care contract and advance at least one of the goals of the state's quality strategy. Ms. Millerick and Mr. Nelb provided the graphic below showing how directed payments relate to other types of supplemental payments in Medicaid.



Mathematica's study reviewed approval documents authorizing directed payments and collected themes from state officials, providers, and managed care representatives interviewed in five states (California, Florida, Massachusetts, Ohio, and Utah). The study found that directed payments grew substantially and steadily since 2016, with the number of approved directed payment arrangements more than doubling since 2018. These directed payments include special payments made for COVID-19 services, value-based payments, and uniform rate increase payments.

The study noted that there are currently 230 directed payment arrangements in effect across the states. States calculated spending estimates for 96 of these payment arrangements, with total projected spending of about $27.1 billion. Uniform rate increases accounted for about 80% of this projected directed payment spending. Ms. Millerick and Mr. Nelb noted that among states estimated spending amounts are often missing and there are often significant inconsistencies in states' estimates. Projected spending for the 96 arrangements with estimates exceeded total spending on disproportionate hospital share payments ($19.7 billion) and UPL supplemental payments ($19.1 billion).

States generally have used directed payments to preserve the ability to make supplemental payments to providers in managed care, preserving prior pass-through payments and continuing expiring Section 1115 demonstration waiver supplemental payments, especially since many providers noted that directed payments were important for their financial viability. However, states are increasingly using directed payments to make new supplemental payments.

The rapid growth of directed payments and their lack of an upper limit on spending has raised accountability concerns on the use of directed payments and their relationship to quality of care and access goals. At present, most directed payment arrangements are not evaluated, even after being renewed and operating for multiple years. For arrangements that are evaluated, results are often not publically available and results that are available are mixed. Obstacles including data lags, lack of alignment between access measures and payment goals, and disruptions caused by the COVID-19 pandemic have made it difficult to perform robust evaluations. Since the Centers for Medicare and Medicaid Services (CMS), did not anticipate such rapid growth in the use of directed payments, CMS has been slow to develop a clear evaluation process and issue guidance. Most recently, CMS issued a new template for directed payment evaluations and guidance for the use of directed payments in January 2021.

Following their review of the Mathematica study, Ms. Millerick and Mr. Nelb presented three potential policy approaches to improving oversight and transparency in the use of directed payments. These options include:

1. Making information on directed payments publically available, including approval documents, payment amounts, and evaluation results;
2. Establishing an upper limit on directed payments similar to the UPL, and;
3. Requiring more explicit explanations for how directed payments should relate to quality and access goals.

Commissioners' Comments
Commissioners agreed that better transparency practices were necessary for directed payments. One Commissioner remarked that contextualizing spending amounts with other data, like capitation rates in states, would be necessary for evaluating proper use of directed payments. Generally, Commissioners were supportive of policy options 1 and 3, and agreed that option 2 should be further explored.

Session 2: Mandated Report on Money Follows the Person Qualified Residence Criteria: Policy Options

Continuing on the Commission's previous evaluation of the Money Follows the Person (MFP) qualified residence criteria, MACPAC staffer Kristal Vardaman reviewed the Commission's previous work on the MFP program and facilitated a discussion among the Commissioners about potential recommendations for changes to the MFP qualified residence criteria. For a summary of the Commission's previous work on this topic, see Viohl & Associates' summary of MACPAC's October Public Meeting.

After a brief review of the Commission's discussion in the October public meeting, Ms. Vardaman discussed two policy options for the Commissioners' consideration.

The first policy option is to maintain the qualified residence criteria as it currently stands. Under these criteria, Medicaid beneficiaries who have been institutionalized for at least 60 days can be transitioned to a residence in the community only if the residence is a home owned or leased by the beneficiary or their family member or an apartment leased by the beneficiary, or is a community-based setting in which no more than four unrelated individuals reside. While these criteria are designed to protect beneficiaries, Ms. Vardaman noted that the existing criteria are not aligned with the home- and community-based services (HCBS) settings rule, and that they often limit the pool of eligible settings. Importantly, Ms. Vardaman noted that maintaining these current criteria would have no impact on the number of MFP transitions from institutions.

The second policy option is to align the MFP qualified residence criteria with the HCBS settings rule. The HCBS settings rule is generally more permissive than the MFP qualified residence criteria, so alignment would open up more settings for MFP transitions including larger congregate settings and assisted living facilities. Ms.

Vardaman noted that while this change could likely increase the number of transitions from institutions, the newly-allowed settings do not prioritize autonomous living arrangements.

Commissioners' Comments

MACPAC Commissioner Dennis Heaphy, a disability advocate on the Commission, expressed his opposition to aligning the MFP qualified residence criteria with the HCBS settings rule, arguing that such an alignment "waters down" protections for people with disabilities and does not adequately prioritize their autonomy. Generally, Commissioners did not overwhelmingly support either policy option, which MACPAC chair Melanie Bella said could be an indication that the Commission should consider not making a recommendation on this issue. Instead, she suggested that the Commission could provide analysis of these policy options to Congress and instead opt to "add to the debate". The Commission instructed staff to conduct more analysis and consider if another policy option might be available that suggests changes to the qualified residence criteria without fully aligning it with the HCBS settings rule.

Session 3: Panel Discussion: Designing and Implementing an Approach for Monitoring Access to Care among Medicaid Beneficiaries

Continuing the Commission's earlier efforts, MACPAC Staffer Linn Jennings discussed considerations for designing and implementing a new system to monitor access to care among Medicaid beneficiaries. She provided a brief overview of the challenges faced with the current system, including differing requirements among delivery systems, limited comparability of measures across states, and minimal applicable information on key access measures. She also discussed strategies for engaging beneficiaries, plans, and other stakeholders to collect input for a new system. Ms. Jennings' full presentation can be found on the MACPAC website. For a summary of the Commission's previous work on this topic, see Viohl & Associates' past MACPAC meeting summaries.

Following her brief presentation, Ms. Jennings introduced the panelists, including Karen Llanos, director of the Medicaid Innovation Accelerator Program at the Center for Medicaid and CHIP Services (CMCS), Elizabeth Lukanen, deputy director at the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, Abigail Coursolle, senior attorney with the National Health Law Program, and Jennifer McGuigan Babcock, senior vice president for Medicaid policy at the Association for Community Affiliated Plans.

Ms. Llanos noted that CMS recently released a Request for Information (RFI) requesting input on the subject of improving access to care among Medicaid beneficiaries more broadly. She noted that improving systems for monitoring access to care among Medicaid beneficiaries has been a top priority of CMS for some time, and she said she hoped responses to the RFI could help CMS to find the best ways to apply data currently being collected and further develop useful additional measures.

To improve data availability, Ms. Llanos suggested consolidating data from a variety of different sources, including beneficiary feedback surveys, data on avoidable hospitalizations, and secret shopper data.

Ms. Lukanen argued that any monitoring plan established should seek to minimize the burden on state agencies. She suggested a phased approach, starting with developing datasets for a limited number of highly useful measures and later expanding to additional measures once the system is foundationally stable. She also suggested providing assistance to states to help them improve on existing measures they collect, noting that states have already expressed the need for considerable additional financial support and expertise to improve the robustness of their data under the current system.

To improve collection of data from beneficiaries, Ms. Lukanen suggested states should pursue partnerships with trusted community-based organizations to collect data. She noted that this aligns with the Commission's mission to promote health equity within Medicaid. She also argued that strong partnerships between the federal government, state governments, and community organizations would be crucial for developing a robust system for monitoring access to care among Medicaid beneficiaries.

Ms. Coursolle noted that adequate data was crucial for improving health equity among Medicaid beneficiaries, and said she was pleased that the Commission has prioritized improving data collection in the interest of health equity. She highlighted the importance of collecting good demographic data since such data is necessary for reliably measuring disparities in healthcare. Ms. Coursolle also highlighted other key indices needed to improve health equity, such as data on wait times, service adequacy, and facility adequacy.

Ms. Coursolle suggested performance on these measures could be improved by taking concrete steps toward increasing access for diverse beneficiaries, including ensuring language barriers are addressed by providing adequate access to interpreters in healthcare settings and by training providers in culturally competent care.

Ms. Babcock also discussed health equity and ways to improve standards for beneficiaries of Medicaid and CHIP. She said that a new federal framework for assessing access to Medicaid for beneficiaries should be centered on three principles:

1. Focus on addressing barriers Medicaid beneficiaries are currently facing;
2. Prioritize practicality and usability for new platforms, and;
3. Reflect CMS' broader goals.

Ms. Babcock also suggested several concrete steps for improving measurements and access to care, including mandating that states report on all CMS core measures, collecting additional data on whether facilities are accessible by people with disabilities, and improving data sharing by making crucial measures and Medicaid scorecards publically available.

Commissioners' Comments

Commissioners agreed that an iterative approach was the best course of action for improving data where the Commission focuses on improving the robustness and availability of several crucial core measures and then later works to improve access to other measures. Commissioners directed staff to explore ways to improve the availability of data in crucial measures that are useful for comparison across states, including demographic, service adequacy, and facility adequacy data. Commissioners affirmed that improving health equity through better data was still a top priority of the Commission.

Session 4: Highlights from the 2021 Edition of MACStats

In a brief presentation MACPAC staffer Jerry Mi reviewed highlights from MACStats, the Commission's data book of the most recently available data on Medicaid and CHIP.

Overall, Mr. Mi noted that there were not many major changes in data trends from previous years. However, Mr. Mi noted that the National Health Interview Survey (NHIS) underwent a significant redesign in 2019, so users should be cautious about comparing new 2019 data reported in the 2021 edition of MACStats with NHIS data from previous years.

Mr. Mi highlighted key statistics from the report. Data in the 2021 edition of MACStats shows:

- In FY 2019, more than one-quarter of the U.S. population was enrolled in Medicaid or CHIP for at least part of the year (83.0 million in Medicaid, 9.7 million in CHIP);
- Excluding federal funds, Medicaid made up 15.8 percent of state budgets in SFY 2019; elementary and secondary education made up 24.5 percent, and;
- Medicaid and CHIP were 16.3 percent of national health expenditures compared to 21.1 percent for Medicare in CY 2019.

See Mr. Mi's full presentation on MACPAC's website for a complete list of highlighted statistics. Commissioners did not provide commentary for this session.

Session 5: Options to Strengthen Integration of Behavioral Health Services through Health Information Technology

MACPAC staffer Aaron Pervin presented on policy options to further the Commission's efforts to strengthen integration of clinical and behavioral health services through health information technology (IT). For a summary of the Commission's previous work on this topic, see Viohl & Associates' past MACPAC meeting summaries.

Mr. Pervin began his presentation with a brief overview of Medicaid's role in behavioral healthcare and how electronic health record (EHR) technology can support clinical integration of services through information sharing and care coordination. He also highlighted policy issues serving as barriers to further use of EHR technology in behavioral healthcare, noting that electronic health records (EHRs) are not generally designed for behavioral health, that states often lack guidance on how to use Medicaid to support behavioral and clinical healthcare integration, and that authority to introduce federal incentives for the adoption of EHR technology among behavioral health providers has not been sufficiently utilized.

Mr. Pervin then reviewed policy options for addressing these issues and discussed their implications. To address the issue of health IT standards not being built for behavioral health, the Office of the National Coordinator for Health Information Technology (ONC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) could issue certification requirements or jointly developed voluntary standards. These options could help standardize usage of EHR technology in behavioral health and ensure compliance with existing health IT standards, however, Mr. Pervin also noted that upgrades necessary to reach compliance could be costly and resource intensive.

To address the issue of unclear guidance on behavioral health interoperability, Mr. Pervin suggested CMS and SAMHSA could jointly provide guidance on how states can use Medicaid authorities to promote behavioral health interoperability. For example, such guidance could clarify how requirements for health system interoperability under Section 1115 waivers can be met when affected providers lack EHR systems and how to braid other federal resources with Medicaid funding to promote behavioral health interoperability.

Finally, Mr. Pervin suggested the Center for Medicare and Medicaid Innovation (CMMI) could use authorization initially granted by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment and Communities (SUPPORT) Act of 2018 to test new EHR incentive payments for behavioral health. In doing so, CMMI could provide a financial incentive to behavioral health providers to adopt EHR technology, although Mr. Pervin noted this would only support behavioral health providers participating in the demonstration project.

Commissioners' Comments

While Commissioners were not yet ready to make a formal recommendation, Commissioners generally expressed support for all of the above policy options. However, Commissioners also noted that additional financing for states will probably be necessary to implement these policies. The Commissioners directed staff to conduct further analysis on the impacts of these policies and their cost.

Session 6: Panel Discussion: Applying a Health Equity Lens to Medicaid

MACPAC staffer Audrey Nuamah introduced MACPAC's panel discussion on applying a health equity lens to Medicaid. She noted that most Medicaid beneficiaries are people of color, and that a wide variety of individuals who are part of marginalized populations receive care covered by Medicaid, underscoring the Commission's obligation to examine inequities within Medicaid and make recommendations for addressing them. Ms. Nuamah then introduced the expert panelists, including Cara James, president and CEO of Grantmakers in Health, Monica Trevino, director of the Center for Social Enterprise at the Michigan Public Health Institute, and Patrick Piggott, associate director, investigations at North Carolina Medicaid.

Ms. James stressed the importance of having a common definition of health equity among policymakers and researchers, and suggested use of the definition provided by a report from the Robert Wood Johnson Foundation defining the term as "that everyone has a fair and just opportunity to be as healthy as possible".

To help achieve health equity, Ms. James said the Commission should focus on improving the availability of demographic data within the Transformed Medicaid Statistical Information System (T-MSIS). She also suggested further assessing the ability of existing data collection practices to identify inequities in Medicaid. To improve data collection, Ms. James suggested state Medicaid agencies partner with trusted community organizations to gather on-the-ground perspectives from beneficiaries.

Ms. Trevino said Medicaid policy makers should focus on identifying and addressing obstacles to care. She argued that beneficiaries are the most reliable data source when it comes to identifying these obstacles, and urged the Commission to further pursue beneficiaries' perspectives. Mr. Piggott said he agreed with this assessment and added that policymakers lacking beneficiaries' perspectives will likely "get it wrong" in their efforts to improve health equity.

Ms. Trevino also discussed efforts to build health equity into Medicaid contracts with managed care organizations (MCOs). She noted that the Michigan Public Health Institute began having conversations with MCOs in early 2010 preparing them for health equity criteria that would soon be introduced in MCO contracts by Michigan's Medicaid program. She argued that including MCOs in the discussion enabled MCOs to be better prepared and more effective in meeting equity criteria and suggested that this method could be used as a model for other states looking to introduce equity criteria in managed care contracts

Mr. Piggott highlighted health equity initiatives in North Carolina, including health equity advancement payments. He explained these are targeted payments made to providers who serve beneficiaries living in high-poverty areas of the state, and noted that while this program was still in its early stages, initial results seemed encouraging. Mr. Piggott also suggested exploring similar incentives for MCOs interested in voluntarily investing in initiatives that advance health equity goals.

For the development of other initiatives to improve health equity, Mr. Piggott stressed the importance of gathering perspectives from people of color and other individuals historically marginalized by healthcare systems. He also suggested that policymakers should take an interest in encouraging more people of color to become healthcare providers.

Commissioners' Comments
Commissioners asked for additional feedback from the panelists about how to promote health equity efforts in Medicaid. Panelists further elaborated on the ideas they shared during the panel discussion section of the meeting. Panelists reemphasized the importance of building trust in the healthcare system within communities of color and further exploring efforts to build equity goals into MCO contracting. MACPAC will further explore this topic in the January meeting and plans to develop recommendations on improving health equity in Medicaid for their June report to congress.

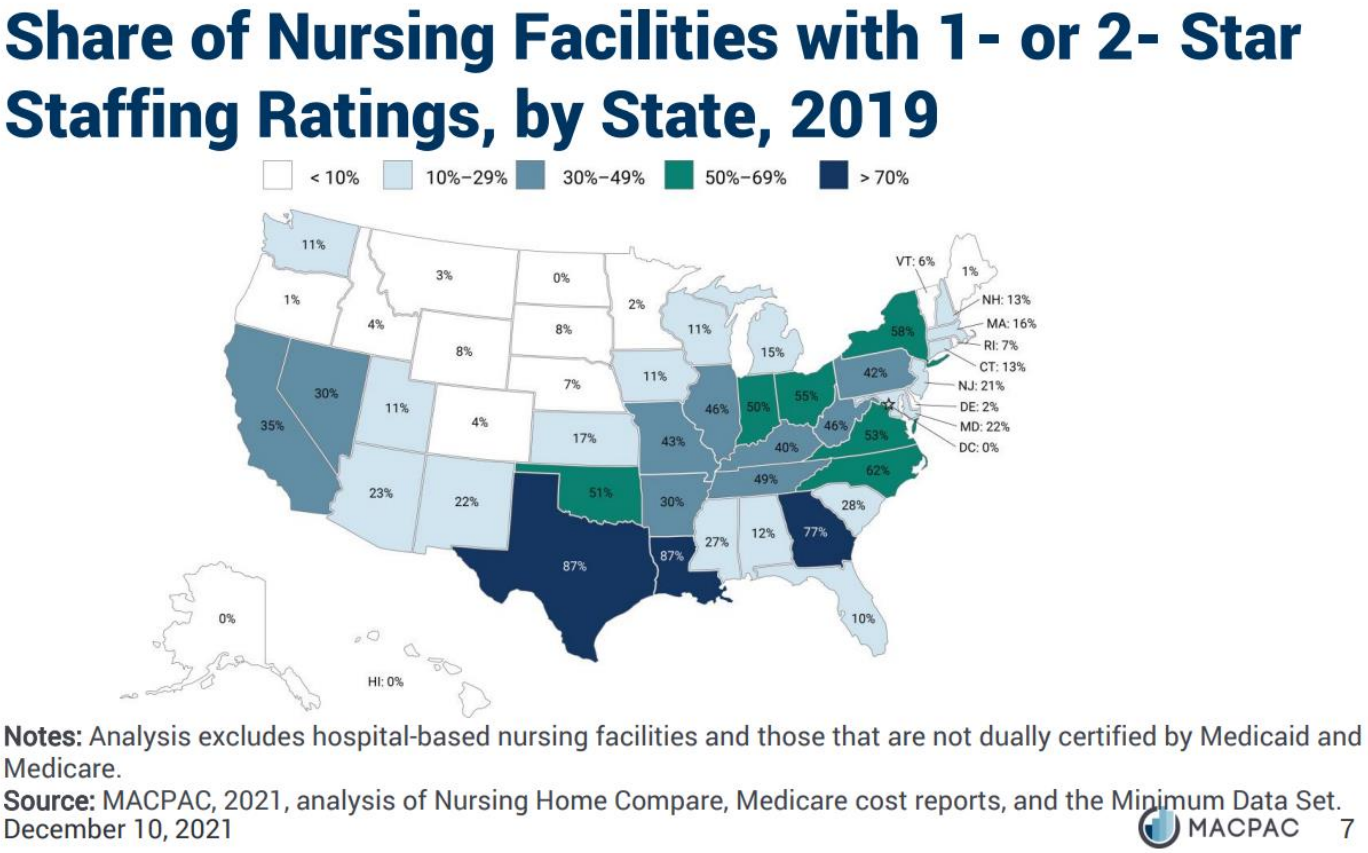
Session 7: State Policy Levers to Address Nursing Facility Staffing Issues

MACPAC staffer Robert Nelb reviewed state policy approaches to address staffing challenges faced by nursing facilities with a special focus on the role of Medicaid payment policies. He began the presentation with a brief background on nursing facility staffing and staffing challenges, then discussed current state policies, policy considerations to address nursing facility staffing challenges, and next steps for the Commission.

Mr. Nelb noted that Medicaid was the primary payer for 59 percent of nursing facility residents according to MACPAC's most recent data from 2019, highlighting the crucial role that Medicaid payment policies have in financing nursing facilities. He then discussed staffing practices and challenges in nursing facilities. He explained nursing facilities are typically staffed by registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs). These staff work together to provide care for residents of nursing facilities. In 2001, a CMS expert panel recommended that nursing home residents receive at least 4.1 hours per resident per day (HPRD) to reduce the risk of harm for long-stay nursing facility residents.

CMS' Nursing Home Compare website issues a star rating based on how staffing rates, measured in HPRD, compare to other facilities, with a two-star rating equivalent to less than 0.5 HPRD of care from an RN and 3.6

HPRD of total direct care. According to the most recent data from 2019, 72 percent of nursing facilities were unable to provide 4.1 HPRD or greater as a result of low staffing rates. The below map, included in Mr. Nelb's presentation, illustrates low staffing ratings by state:



In addressing these challenges, Mr. Nelb noted that some states pursued policies including:

- Increasing Medicaid payment rates to help facilities hire more direct care staff and pay them higher wages;
- Changing Medicaid payment methods to incentivize facilities to spend more of their revenue on staff by introducing policies such as cost-based payment policies, wage pass-through policies, and value-based payment incentives, and;
- Encouraging states to introduce state minimum staffing standards that exceed federal requirements.

Mr. Nelb noted that MACPAC's review of current state policies found that:

- 38 states and DC have minimum staffing standards (of which only 11 states and DC have a minimum standard greater than 3.0 HPRD);
- 32 states and DC use cost-based Medicaid reimbursement;
- 10 states have wage pass-through policies, and;
- 14 states have value-based payment incentives tied to staffing.

Using these findings as basis, MACPAC attempted to analyze which state policies helped explain the variation in staffing rates by state. Generally, the Commission found that increased Medicaid payment rates are associated with higher staffing rates, which was consistent with the Commission's previous research (however data on this topic was limited).

Mr. Nelb also noted that the COVID-19 pandemic underscored and exacerbated staffing challenges and also catalyzed some of the above staffing policy changes. However, it is unclear if some staffing policy changes, like the introduction of hazard pay for nursing facility direct care workers, will continue after the end of the public health emergency.

For next steps, Mr. Nelb noted that the Commission plans to publish a state policy compendia, and if there is interest from Commissioners, pursue drafting a chapter commenting on Medicaid's role in addressing staffing issues such as:

- The effects of low staffing on access and quality of care;
- Medicaid's role in addressing health disparities;
- The need for payment methods that create appropriate incentives;
- The relationship between state policies and federal staffing requirements, and;
- Opportunities to align efforts to improve nursing facility staffing with efforts to improve the home- and community-based services (HCBS) workforce.

Commissioners' Comments

Commissioners overwhelmingly agreed that they were interested in pursuing a draft chapter covering Medicaid's role in addressing staffing issues in nursing facilities. They encouraged MACPAC staff to begin creating a conceptual framework for developing policy recommendations, especially in the area of payment incentives. They also directed staff to collect more information on staff experiences and working conditions.

Session 8: Next Steps on Access Monitoring

MACPAC staffer Ashley Semanskee concluded the MACPAC meeting by summarizing the discussion on considerations for monitoring access to care among Medicaid beneficiaries. She provided a high-level perspective on goals of access monitoring, key elements of an access monitoring system, and discussed the Commission's next steps.

Ms. Semanskee identified five key goals for data systems:

1. Measures collected should be meaningful to beneficiaries and actionable for states and plans;
2. Measures should be comparable across delivery systems and states;
3. Data should be collected and analyzed in a timely manner so that states can effectively detect problems and intervene appropriately;
4. Data collection practices and requirements should minimize administrative burden on states and build on existing systems and data, and;
5. Data systems should be adaptable to allow for modification and updates over time.

She then highlighted key access measures for an effective access monitoring system. She identified three different data domains as crucial for access monitoring:

1. Provider availability and accessibility;
2. Beneficiary utilization, and;
3. Beneficiary perspectives and experiences.

Ms. Semanskee noted that close partnerships between federal and state government officials will be critical to designing an effective access monitoring system and noted that these officials should seek to engage stakeholders and beneficiaries as much as possible as they work. She also noted that the design process should be as transparent as possible. Moving forward, the Commission will continue to have an advisory role in key design considerations like process and timeline, prioritization of tasks and goals, and cost containment.

For next steps, MACPAC staff will present the overall structure for a new approach to access monitoring and possible options to address concerns in January. Staff will collect feedback from Commissioners and stakeholders on key elements and priorities of an access monitoring system.

Commissioners' Comments

Commissioners noted that beneficiary perceptions and experiences will continue to be a key area of interest for the MACPAC. They also suggested that staff should further explore ways to standardize beneficiary surveying practices so that the most effective data can be collected from beneficiaries from a single survey and to minimize redundancy.

MACPAC chair Melanie Bella thanked staff for their work and concluded the meeting.