Highlights from MACPAC December 2020 Public Webcast Meeting

Overview

On December 10 and 11, 2020, the Medicaid and Chip Payment and Access Commission (MACPAC) held its December 2020 public meeting webcast. 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: Panel: The Role of Medicaid in Improving Health Equity

MACPAC staff hosted a panel discussion on the role of Medicaid in improving health equity with Dr. Jamila Michener, associate professor of government at Cornell University, Dena Williams Hasan, director of policy and program support for the District of Columbia Department of Health Services, and Adrienne McFadden, vice president and chief population health officer of Humana's national Medicaid program. Panelists discussed ways to address various health disparities, including the disproportionate rates of COVID-19 infection, hospitalization, and death within communities of color and demographic disparities in health care outcomes.

Dr. Michener discussed Medicaid and health equity in the context of structural racism—that is, racism ingrained in systems through policymaking. She argued that race has been a central factor in shaping the policies, discourse, design, and implementation of Medicaid; for example, she highlighted evidence from a study correlating Medicaid expansion decisions with racial attitudes, which found that opposition to Medicaid expansion among white Americans correlated with higher racial resentment towards people of color. With this and a few other examples, Dr. Michener argued that racist attitudes towards Medicaid beneficiaries of color are linked to barriers to access and to care, since these attitudes can affect the likelihood of Medicaid expansion or shape the attitudes of public officials influencing and affecting program policies. She explained that the way people of color have been treated by Medicaid agencies and by policymakers has also fostered a spirit of distrust, especially among Black beneficiaries, that is now manifesting itself as mistrust of the COVID-19 vaccine.

Ms. Hasan explained how Medicaid is being used in the District of Columbia to fight homelessness and respond to the COVID-19 pandemic, two issues that disproportionately affect people of color in DC. She mentioned that the DC Department of Health Services (DHS) is currently aiming to launch a new Medicaid benefit utilizing Section 1915 waiver authority to provide housing navigation and stabilization services to address housing insecurity, a major social determinant of health. She said the DC DHS is also working on improving data sharing, since poor data systems have been a barrier for designing effective ways to care for homeless populations in the District of Columbia.

Ms. Hasan also described DC DHS's efforts to address the pandemic for the city's most vulnerable populations. The DHS's Pandemic Emergency Program for Highly Vulnerable Individuals (PEP-V) connects vulnerable populations, including those who are 55 and older, homeless individuals, and those with COVID-19 comorbidities with free transportation and lodging at hotels where they can quarantine and are offered access to medical and behavioral healthcare, as well as case management services.

Dr. McFadden talked about addressing healthcare inequities from her perspective as an executive at a major managed care organization. She described the different areas of work that Humana is doing to provide more culturally competent care and to address healthcare inequities, including:

- Integrating health equity into care by providing services that account for cultural and linguistic preferences;
- Collaboration with states, providers, community organizations, and other stakeholders to close gaps in social needs and deliver better care;
- Data analysis and quality improvement to better identify and address disparities in healthcare and the demographic factors with which they are associated;
- Removing barriers to care by addressing provider shortages, expanding telehealth services, and providing transportation for beneficiaries;
- Addressing implicit biases by fostering a culture of diversity and inclusion among Humana providers, and incorporating thorough implicit bias training throughout the onboarding process and on an ongoing basis, and;

- Incorporating an understanding of social determinants of health in care delivery.

She said she hoped Humana's efforts could serve as a model for other managed care organizations aiming to address healthcare inequities.

Commissioners' Comments

Commissioners asked the panelists questions and made comments throughout the panel discussion. At the end of their discussion period, two specific areas of interest were identified for the Commission to pursue in future meetings: addressing data gaps which make it difficult to identify and address healthcare inequities, and promoting value-based models that address social determinants of health, especially housing insecurity.

Session 2: Extending Postpartum Coverage: Additional Analysis on Mandatory vs. Optional Approaches

Following up on an earlier discussion from MACPAC's October meeting (see Viohl & Associates' summary) MACPAC staffer Martha Heberlein discussed key considerations and remaining issues for the Commission as they prepare to make a recommendation on extending postpartum Medicaid coverage. In their October Meeting, MACPAC decided to recommend extending the postpartum coverage period in Medicaid for 12 continuous months after birth. In moving forward with this recommendation, the Commission is discussing what implications such a change would have for health equity, coverage, and continuity.

Disparities in health care coverage tend to contribute to racial and ethnic disparities in maternal and infant health outcomes. MACPAC hopes that by extending the postpartum coverage period to 12 months, the Commission can help reduce these disparities. Under the Commission's recommendation, up to 123,000 new mothers who were previously uninsured would continue to have health coverage through Medicaid or CHIP. This would encompass approximately 37% of Black, 36% of White, and 24% of Hispanic uninsured new mothers. Extending the postpartum coverage period could also address continuity of care issues during the first year postpartum, a critical clinical period.

The Commission is still considering some issues that could apply to their recommendation. First, the Commission must decide whether the 12-month postpartum coverage extension should be mandatory or optional for states. If the coverage extension was made optional, states could choose to extend the postpartum coverage period without filing a waiver with Centers for Medicare and Medicaid Services (CMS), but it is unlikely all 50 states would adopt the extension. Making the extension mandatory would ensure the greatest number of new mothers are covered, but could put a strain on some states' budgets. Regardless of whether the Commission recommends the extension be optional or mandatory, coverage would likely still vary by state unless certain benefits are also mandatory.

The other major remaining issue for the Commission is financing. An extension of postpartum Medicaid coverage would lead to an increase in state Medicaid spending. To support states, the Commission may consider recommending the federal government provide additional fiscal support. However, improved outcomes in maternal and infant health may lead to reductions in future spending.

Commissioners' Comments

The Commission will vote on a recommendation for an extension of the Medicaid postpartum coverage period at its January 2021 meeting. Based on feedback, it seems likely that MACPAC Commissioners will vote in favor of a mandatory 12-month extension of full postpartum benefits. Commissioners noted that it will be important to provide potential fiscal support to states, especially states with high concentrations of uninsured new mothers.

Session 3: Review of Interim Final Rule Affecting Medicaid Provisions of the Families First Coronavirus Response Act

MACPAC staffer Joanne Jee summarized key provisions from a CMS Interim Final Rule with Comment Period pertaining to the Families First Coronavirus Response Act (FFCRA). These specific provisions reinterpret the Medicaid continuous coverage requirement of the FFCRA and codify coverage policy for the COVID-19 vaccine. The interim rule took effect on November 2, 2020, with comments due on January 4, 2021. The Commission is considering whether to submit formal comments.

The FFCRA provides a temporary 6.2 percentage point increase in the federal medical assistance percentage (FMAP) to states and territories that meet specific "maintenance of effort" requirements, which include not increasing premiums over January 1, 2020 levels, covering COVID-19 related testing, services, treatments, and vaccinations without cost sharing, and not terminate coverage for any current beneficiary until the end of the month that the public health emergency (PHE) ends.

Before the interim rule, this provision of the FFCRA was interpreted to mean that states must maintain beneficiary enrollment with the same amount, duration, and scope of benefits in effect on or after March 2020 until the end of the month in which the PHE ends. Under the interim rule, this provision is now interpreted to mean that states must maintain Medicaid enrollment in one of three tiers for validly enrolled beneficiaries:

- Tier 1: Coverage that qualifies as minimum essential coverage (MEC);
- Tier 2: Non-MEC coverage that includes coverage for COVID-19-related services, or;
- Tier 3: Non-MEC coverage with limited benefits that does not include COVID-19-related services.

Beneficiaries are generally considered to be validly enrolled unless their eligibility determination was incorrect due to agency error or beneficiary fraud. However, individuals in a presumptive eligibility period who have not had a full determination are not considered validly enrolled.

Under the rule, states may transition a validly enrolled beneficiary with Tier 1, 2, or 3 coverage to a new eligibility group if it provides the same or a higher tier of coverage. States must also continue to cover a validly enrolled individual at the same tier level of coverage if they become ineligible for Medicaid before the end of the month in which the PHE ends. However, states can terminate coverage for individuals who were not validly enrolled and remain eligible for the increased FMAP.

States can also modify covered benefits, establish or increase beneficiary cost sharing, or increase beneficiary liability under post-eligibility treatment of income, although the preamble to the rule indicates states must provide proper advance notice, and indicates some additional restrictions. Given all these changes, the interim rule provides considerably more flexibility for states, while removing some coverage protections for beneficiaries.

States must still cover COVID-19 vaccinations without cost sharing during the PHE, with the exception of beneficiaries only eligible for limited benefits packages. However, after the PHE, states must only cover ACIP-recommended vaccines with no cost sharing for certain groups, including children under age 21, adults with alternative benefit plan coverage, and adults in states electing to receive the 1 percentage point FMAP increase on vaccine related spending for providing vaccines with no cost sharing. For other adult eligibility groups, including aged, blind, and disabled (ABD), parents and caretaker relatives, and pregnant women, cost sharing is allowed.

Commissioners' Comments

MACPAC intends to comment on this interim rule, but Commissioners did not fully agree on what to include in the comment. Commissioners generally agreed that it would be a good idea to recommend the administration extend the PHE period, but the Commission was divided on whether to ask CMS to further clarify provisions of this rule, since they were worried MACPAC's comments might become too broad to provide meaningful input. Ultimately, MACPAC chair Melanie Bella decided the Commission should continue the discussion about what to include in their comment after the public meeting.

Session 4: Highlights from the 2020 Edition of MACStats

In his brief presentation, MACPAC staffer Jerry Mi highlighted some key statistics from the 2020 edition of the Commission's *MACStats: Medicaid and Chip Data Book*.

Mr. Mi noted that for the first time, this year's edition of *MACStats* contains data from the Transformed Medicaid Statistical Information System (T-MSIS). The 2020 edition of *MACStats* uses the most recent T-MSIS data from FY 2018.

Key statistics on enrollment and spending are as follows:

- In FY 2018, more than one fourth of the US population was enrolled in Medicaid or CHIP for at least part of the year (approximately 86.6 million people enrolled in Medicaid, and approximately 9.4 million enrolled in CHIP).
- Excluding federal funds, Medicaid made up 16.3% of state budgets in FY 2018.
- Medicaid and CHIP accounted for 16.4% of national health expenditures, compared to 20.6% for Medicare in calendar year 2018.
- More data on enrollment and spending is included in Mr. Mi's presentation (see slides 5-9).

Eligibility criteria remained mostly unchanged between 2019 and 2020. Key statistics on eligibility are as follows:

- In 2018, 41% of all individuals enrolled in Medicaid had family incomes below 100 percent of the federal poverty level (FPL), and about 60% had incomes below 138% FPL.
- As of April 2020, 35 states and the District of Columbia are now covering non-disabled low-income adults up to 138% FPL.

Key statistics on beneficiary health, service use, and access to care are as follows:

- In 2018, children and adults with Medicaid or CHIP coverage were less likely to be in "excellent" or "very good" health than those who were privately covered.
- Children and adults with Medicaid or CHIP coverage were less likely to have at least one office-based visit to a doctor or health professional than those with private coverage, but more likely than those who were uninsured.
- Children and adults covered under Medicaid or CHIP report having at least one dental care visit at lower rates than those with private coverage, but at higher rates than those who were uninsured.

Session 5: A Countercyclical Medicaid Financing Adjustment: Moving Towards Recommendations

MACPAC staffers Moira Forbes and Chris Park gave a presentation following up on the Commission's earlier work on a recommendation for a countercyclical Medicaid financing adjustment mechanism. For a summary of the Commission's previous coverage on this topic, see Viohl & Associates' summary of MACPAC's September and April public meetings.

In past meetings, MACPAC compared the effects of a prototype Government Accountability Office (GAO) model for a countercyclical Medicaid financing mechanism against the effects of Congressionally-authorized FMAP increases during prior recessions in 2003, 2009, and 2020. In their analysis, the Commission found that the gradual nature of each economic downturn made it difficult for Congress to be proactive in identifying state need and take early action, and that it was difficult for Congress to anticipate how long to leave an FMAP increase in place or how to specifically target assistance to states.

The GAO prototype adjusts the amount of federal relief granted based on state-level conditions. Based on modeling using data from past recessions, the GAO mechanism seems sensitive enough to respond to major recessions but not minor economic fluctuations. However, in some cases where there is a sharp economic decline, such as the 2020 recession caused by COVID-19, the model sometimes does not react as quickly as Congress potentially could.

Should the Commission choose to make a recommendation, as seems likely, they will base their recommendation off the GAO prototype. However, Commissioners are considering some key changes to the GAO prototype model for their own recommendation.

Commissioners' Comments

While Commissioners agreed that the GAO model should serve as the basis for their recommendation, most Commissioners agreed that the mechanism should make additional FMAP funds contingent on a maintenance of effort provision to ensure states do not make cuts to eligibility. Commissioners also considered two additional modifications to the GAO model: first, including a provision that caps the additional FMAP that can be provided to states, and second, including a provision that requires additional FMAP only be applied to expenditures eligible for regular FMAP, thereby providing the federal government the option to exclude services and

populations that already have higher FMAPs. There was no broad agreement among Commissioners on these provisions, so the Commission will consider them further in future meetings.

Session 6: Integrating Clinical Care through Greater Use of Electronic Health Records by Behavioral Health Providers

MACPAC staffers Aaron Pervin and Erin McMullen presented on improving integration of care between physical and behavioral health providers through expanding use of electronic health records (EHRs). Their presentation follows up on earlier work done on this topic by the Commission including a chapter in MACPAC's June 2018 report to Congress and their September 2019 comment letter in response to proposed rulemaking.

The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 introduced incentive payments to promote the use of EHRs among healthcare providers. While this law did increase the use of EHRs, it focused primarily on physical health providers. Barriers to clinical integration between physical health providers and behavioral health providers remained, such as regulatory and technological issues that make it difficult for behavioral health providers to receive and share data with physical health providers. The HITECH act also left out many providers that disproportionately serve the Medicaid population.

Today, behavioral health facilities that accept Medicaid have low rates of meaningful EHR adoption and use. By promoting meaningful use of EHRs among behavioral health providers, especially those who serve a large number of Medicaid patients, states can improve clinical integration between physical and behavioral health providers and potentially improve healthcare outcomes. Currently, several existing authorities could be used to support the use of EHRs using Medicaid funding:

- States have limited authority to offset certified electronic health record technology (CEHRT) with Medicaid funding;
- States can apply to CMS and use HITECH administrative funds to provide payments to facilities to share data with other providers, and;
- States can utilize authority granted through the SUPPORT Act to ask the Center for Medicare and Medicaid Innovation to administer Medicaid demonstrations that target EHR incentive payments to behavioral health providers and facilities.

Provided Commissioners are interested, MACPAC staff will further study this topic and consider developing policy options that build on HITECH by expanding EHR incentive payments to behavioral health providers.

Commissioners' Comments

MACPAC Commissioners indicated their interest on this topic, and encouraged MACPAC staff to further research their suggested policy options and present findings in future meetings. The Commission was not leaning toward any particular recommendation during this meeting, but Commissioners were curious about where regulatory policies (i.e. confusing 42 CFR Part 2 rules that deter information sharing) could be clarified and how to better utilize HITECH incentive payments for behavioral health providers.

Session 7 and 8: Access to Behavioral Health Services for Children and Adolescents

MACPAC staffers Erin McMullen and Melinda Becker Roach discussed behavioral health conditions and access to behavioral health services for children and adolescents. Following their presentation, three expert panelists further discussed the needs of children and adolescents, treatment conditions, and varying approaches states are using to facilitate access to care. The three panelists included John O'Brien, senior consultant at the Technical Assistance Collaborative, Dan Tsai, assistant secretary at MassHealth and Medicaid director for the Commonwealth of Massachusetts, and Kristine Herman, chief of the bureau of behavioral health at the Illinois Department of Healthcare and Family services.

According to data from the University of Minnesota's State Health Access Data Assistance Center, nearly one in four youths received some form of mental health services in 2018. Youth in Medicaid received treatment at similar rates as their peers with private coverage, but were more likely to receive non-specialty mental health services. However, data is still lacking in comparing behavioral health conditions and treatment rates across

racial and ethnic groups in Medicaid. According to the data, youth with behavioral health conditions seek treatment for a variety of reasons and require widely varying services.

For children and adolescents, behavioral health services are delivered in a variety of settings. Three of the most common settings tend to be the offices of healthcare professionals, school-based health centers, and specialty behavioral health treatment facilities. Foster care settings and juvenile detention centers also play a role. Care must be delivered in a variety of settings because of the limited availability of office-based treatment; according to the American Academy of Child and Adolescent Psychiatry, there is a shortage of child psychiatrists in all 50 states, the District of Columbia, and Puerto Rico.

Panelists' commentary reflected the data described by MACPAC staffers. They noted that youth and adolescent patients often receive treatment for a variety of reasons, including depressive episodes, suicidal ideation or attempts, feelings of fear and anxiety, and problems in their home, and they explained that state plans need to reflect the patient population's varied needs. Panelists also drew attention to the fact that youth and adolescents face social stigma as another barrier to care, which is not often captured by data.

Because of COVID-19, demand for behavioral health services is at an all-time high, and children and adolescents who typically access behavioral health services in school settings may not have access to those key services. Panelists underscored the importance of ensuring access for these children and adolescents through Medicaid behavioral health benefits in states. Shortages of providers and gaps in care were prevalent in all the panelists' states, but innovative solutions like waiver programs pursued in Illinois and Massachusetts and the expansion of telehealth have been effective in addressing these issues.

Commissioners' Comments

Commissioners' comments and questions were addressed throughout the panel discussion. Ultimately, Commissioners felt that this panel discussion provided useful context for further discussion about behavioral health access for children and adolescents. The Commission will revisit the topic in future meetings.

Session 9: Implications of the 2020 Election for Medicaid Policy

MACPAC staffer Anne Schwartz analyzed the implications of the 2020 congressional and presidential elections for Medicaid policy. She described priorities for the incoming Biden administration, potential action to be taken by the 117th Congress, and opportunities for MACPAC to share views with lawmakers.

Improving on the Trump administration's COVID-19 response will likely be the first priority for the Biden administration during the early months of his presidency. President-elect Biden will likely extend the public health emergency period, which will mean special flexibilities and benefits tied to the PHE will also continue. Other COVID-19 related priorities highlighted by the President-elect so far include increased coverage and access for testing and vaccination services, enhanced FMAP for states, and rescinding the "public charge" rule.

Beyond COVID-19, the Commission will seek opportunities to coordinate with the incoming administration. Top issues the Commission could weigh in on include caregiving, treatment of substance use disorder, and other specific administrative actions pertaining to Medicaid.

The 117th Congress will likely focus on "unfinished business" from the current Congress. COVID-19 stimulus and relief will no doubt be at the top of the docket, but gridlock between the House and the Senate may make it difficult to pass sweeping reforms. With this incoming Congress, MACPAC will seek the opportunity to educate new members and highlight key policy issues of interest and prior recommendations that have not yet been implemented.

Key topics for the Commission's potential letters to Congress include the need for additional federal funds for Medicaid and coverage of the COVID-19 vaccine after the PHE ends. In a letter to Congress, the Commission could also highlight prior MACPAC recommendations on issues including:

- State capacity to integrate care for dually eligible beneficiaries;
- Medicare Savings Programs;

- The Medicaid Drug Rebate Program;
- Coordination of Benefits with TRICARE;
- Recovery Audit Contractors, and;
- Disproportionate Share Hospital (DSH) allotments.

Commissioners' Comments

Commissioners agreed that this new administration will likely signal a significant shift in healthcare priorities and policy, especially with congressional gridlock inadvertently causing more governing to be done by executive order. MACPAC Chair Melanie Bella said that based on the Commission's varied interests, it is likely that MACPAC may send two or three letters to Congress on issues including COVID-19 response and integrating care for dually eligible beneficiaries. The Commission will determine which topics to send letters on at a later time.

Session 10: Medicaid Estate Recovery: Updates on Analyses and Draft Recommendations

Following up on the Commission's earlier meeting session (see Viohl & Associates' summary of MACPAC's September meeting), MACPAC staffers Kristal Vardaman and Tamara Huson presented on MACPAC's recent work on estate recovery, including a discussion of key themes from stakeholder responses collected since the September meeting. As of this meeting, MACPAC collected survey responses from 10 states, and reviewed state plan information for all 50 states and the District of Columbia. In general, these responses followed the same patterns as responses gathered before the September meeting; the average size of estates recovered and state use of optional policies remained consistent.

Some key themes emerged from stakeholder interviews. First, views on whether estate recovery should be made optional were mixed. While beneficiary advocates and elder law attorneys favored eliminating estate recovery or making it optional, Medicaid and other state officials argued it would be difficult to forgo the revenue it brings in. Estate recovery does appear to negatively affect access to long-term services and supports (LTSS).

Beneficiaries and the general public tend to have low awareness and understanding of Medicaid estate recovery policies, which often exacerbates equity concerns. For example, many beneficiaries do not know they can apply for a hardship waiver to exempt themselves from Medicaid estate recovery. However, even with awareness of some policies, equity issues can still persist; the ability to prove hardship usually requires the assistance of an attorney, which many poorer beneficiaries cannot afford. Recovery for managed LTSS capitation payments are also difficult to understand and appear to be inequitable.

The Commission is considering three options for draft recommendations regarding estate recovery, and each recommendation comes with its own set of implications:

- Draft Recommendation 1: Recommend that Congress makes estate recovery optional. States could forgo estate recovery if they found that the return on investment for estate recovery is low, as it is many cases. Decreased revenue could be offset by lower administrative costs. This could also help some states address the equity concerns associated with estate recovery, since some poorer beneficiaries could be excluded.
- Draft Recommendation 2: Recommend that Congress allow states with managed LTSS programs to pursue estate recovery based on the cost of care provided to beneficiaries. This could help avoid circumstances in which individuals' estates are pursued for more than the cost of care that was provided to them. It would also grant states more flexibility and make the estate recovery process easier to understand for heirs.
- Draft Recommendation 3: Recommend that the Secretary of the Department of Health and Human Services set minimum standards for hardship waivers with some key considerations, including if an estate claim would remove the sole income-producing asset of survivors, if the home is of modest value (roughly half of the average home value in the country) and other compelling circumstances. This could also help address equity concerns without setting up mandatory guidelines for states.

The Commission will review these options and vote on a recommendation at the January 2021 public meeting.

Commissioners' Comments

Commissioners felt that equity concerns were a top priority, and also felt states need additional flexibilities, especially in cases where states are mandatorily required to recover estates that are worth less than administrative costs associated with recovery. Although Commissioners were not yet ready to make a recommendation, they felt all three recommendations (with some modifications) were worthy of additional discussion at the January meeting.

Session 11: Quality Rating Systems in Medicaid Managed Care

MACPAC staffer Amy Zettle gave a presentation on existing quality rating systems (QRSs) in Medicaid Managed Care, federal Medicaid requirements, and a summary of recent findings from a Mathematica study analyzing this issue.

Existing QRSs rate health plans on a variety of measures to help inform beneficiaries, incentivize plan performance, and create accountability. Currently, QRSs only exist for Medicare Advantage, Qualified Health Plans, and Medicaid managed care in 13 states. All states will have to adopt a QRS within three years of forthcoming guidance from CMS, with the option to adopt the federal framework and methodology or develop an alternate system. If states choose to adopt an alternate system, they must use certain mandatory performance measures to be identified by CMS and receive prior approval.

MACPAC contracted with Mathematica to study how states are designing and using their QRSs and how they compare to existing QRSs. The commissioned study examined five states (Florida, Michigan, Ohio, Pennsylvania, and Texas) and was conducted via interviews with state officials, health plans, external quality review organizations, enrollment brokers, consumer advocates, CMS, and other national experts.

Mathematica's study found that many QRSs are designed with the intention of helping beneficiaries understand performance differences among offered health plans, however it is unclear whether Medicaid beneficiaries use quality ratings when selecting a health plan. The study also found that most states reported aligning QRS measures with other payment initiatives to boost plan performance. Unlike Medicare Advantage, the study showed that states do not directly use QRSs for oversight and accountability purposes.

Based on stakeholder interviews, the study found that states generally support greater alignment of QRSs across states and programs but would like future rulemaking to allow for flexibility. MACPAC plans to publish their findings from the Mathematica report in 2021, and monitor and potentially comment on future CMS rulemaking on Medicaid and CHIP QRSs.

Commissioners' Comments

Commissioners' comments were brief. Commissioners expressed support for more research on this topic, and suggested reviewing this issue in a later meeting to help states prepare for the forthcoming CMS guidance. MACPAC may also revisit this issue after the guidance is issued to help make recommendations for states designing QRSs.

Session 12: Themes from Interviews on the Development of Nursing Facility Payment Methods

Following up on his earlier work from MACPAC's October meeting (see Viohl & Associates' summary) MACPAC staffer Robert Nelb reviewed themes from MACPAC-contracted RTI International's interviews with officials and stakeholders in seven states (Alabama, Colorado, Kansas, New York, Rhode Island, Utah, and Wisconsin), and findings about how states are changing their payment policies in response to the COVID-19 pandemic and recent changes in Medicare nursing facility payment policy.

Findings from stakeholder interviews on the characteristics of nursing facility payment polices can be found on slide 6 of Mr. Nelb's presentation. Of the seven states, four states (AL, CO, KS, and WI) use facility costs as the basis for rates, while the other three (NY, RI, and UT) use the price of care. Six out of seven states (all but Alabama) use resource utilization groups (RUGs) for their acuity adjustment method. Alabama began a quality-based supplemental payment program starting in October 2020.

States have been slow to move from cost-based to price-based and value-based payment methods. One reason for this could be that value-based initiatives were limited to pay-for-performance incentives, which meant states were not discussing efforts to meaningfully adopt alternative payment models. Past value-based payment demonstrations were met with mixed results. In the seven states studied by RTI, managed care organizations paid nursing facilities according to fee-for-service rates and methods.

As of October 1, 2019, Medicare stopped using the RUG method of acuity adjustment (the method most Medicaid programs use). State stakeholders interviewed were still in the early stages of assessing this change, and said they could benefit from more analysis on how new acuity adjustment models would affect payments to providers. They also expressed concerns about limited state capacity for changing acuity adjustment models.

As a result of the COVID-19 pandemic, many states made temporary rate increases to nursing facilities during the pandemic, however, it is not clear that this rate increase is sustainable since many study states used CARES Act grants to fund this increase, which expire on December 30. After noting staffing and quality issues raised by the COVID-19 pandemic, some stakeholders are calling for long-term changes to Medicaid payment policies.

The Commission plans to publish RTI International's report from these interviews on MACPAC's website.

Commissioners' Comments

MACPAC Commissioners agreed that findings from RTI International's interviews should be published, and offered feedback for future work. One Commissioner suggested continuing to explore value-based payment options for nursing facilities, while another Commissioner suggested exploring issue areas raised by the COVID-19 pandemic, including using payment reform to improve on staffing and quality of care issues.