Highlights from MACPAC March 2022 Public Virtual Meeting

Overview

On March 3rd and March 4th, 2022, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its March 2022 public virtual meeting. This summary includes highlights from all 8 meeting sessions. Presentation slides and the agenda for this meeting can be found on the MACPAC website.

Session 1: Directed payments in managed care: Decisions on recommendations for the June report to Congress

Presenter: Rob Nelb, Principal Analyst

Background:

- Following recent discussion by the Commissioners, MACPAC analysts presented five final recommendations for directed payments in managed care, for inclusion in the June report to Congress.
- For a detailed summary of the Commission's previous work and discussion on this topic, see Viohl & Associates' past MACPAC meeting summary.

Proposed recommendations: criteria, rationale and implications

- **Improve transparency of Medicaid spending** through the creation of directed payment approval documents, managed care rate certifications, and evaluations for directed payments that are publicly available on the Medicaid website.
  - **Rationale:** Directed payments continue to be a large (and growing) portion of Medicaid spending. The Center for Medicare and Medicaid Services (CMS) already publishes similar documents for other arrangements on its website and including these documents would help the public better understand directed payment objectives and justification.
  - **Implications:** No direct implication found by analysts on the federal level, however it could possibly involve administrative effort in making current data and supporting information publicly available. Increased transparency over time could lead to changes to directed payment methodologies.
- **Collection of new provider data by CMS** to assess whether the current managed care payments are reasonable and appropriate.
  - **Rationale**: Currently states are required to submit hospital-level DSH audits yet there is no protocol within CMS on how to properly monitor data. The collection of data would help CMS monitor and ensure that spending is consistent with what was approved.
  - **Implications:** May increase state administrative effort to compile all information, however it was noted during interviews with stakeholders that the majority of states already collect this information.
- **Increase transparency of directed payments** to produce more clarity on the goals and uses of directed payments. This recommendation would require states to quantify how directed payment amounts compare to previous supplemental payments.
  - **Rationale**: Currently the link between directed payments and access to goals is unclear. More transparency of directed payments would help inform how payments are evaluated and incorporated into managed care rates.
  - **Implications**: Very low implications for both states and the federal government. Greater transparency could eventually impact health plans and providers' payment methodologies.

- **Meaningful multi-year assessment of directed payments**, whereby HHS would require states to develop rigorous, multiyear evaluation plans of directed payment arrangements.
    - **Rationale**: MACPAC analysts expressed concerns that many states do not report on their directed payment evaluations. In some cases, performance on quality of care and access declined but payment arrangements were still renewed without changes. Establishing a multi-year evaluation plan would help improve states' ability to conduct meaningful assessments of performance.
    - **Implications**: Potential increase in states' efforts if they do not already have rigorous evaluations in place. Health plans and providers may be required to submit additional information as it pertains to quality and access measures.
- **Coordinated review of directed payments,** with the goal of creating a more meaningful oversight of directed payments. The Secretary of Health and Human Services should coordinate the review of directed payments and assessment of managed care capitation rates by clarifying roles and responsibilities for states, actuaries, and different divisions of CMS.
    - **Rationale**: Establish clear guidelines and clarification for who is responsible for reviewing directed payment amounts.
    - **Implications**: Providing clarity on who is responsible for overseeing directed payment amounts could impact the amount of directed payments approved by CMS in the future.

Commissioners' Comments
Commissioners voiced overall support for the recommendations provided. However, there was more disagreement on the specific verbiage of the recommendations and Commissioners requested tightening the language of the recommendations before final presentation in April.

Session 2: Improving the uptake of electronic health records by behavioral health providers: Decisions on recommendations for the June report to Congress
Presenter: Aaron Pervin, Senior Analyst
Background:
- In September 2021, MACPAC heard from an expert panel on electronic health records, to which Commissioners had asked for recommendations for access improvements.
- Healthcare IT plays a critical role in integrating care, but often behavioral health providers are left out of record modernization efforts. MACPAC analyst Aaron Pervin presented on barriers to electronic health records adoption by behavioral health providers, and how Medicaid can encourage adoption.

Barriers to electronic health records adoption:
- Behavioral health providers lack the capital needed to invest in making health records electronic.
- Even if they do have the capital, behavioral health providers do not know which products to purchase.

Medicaid's role in encouraging electronic health records:
- There are multiple ways Medicaid can pay for electronic health records, but CMS has not issued guidance on what this might look like. Possible ways Medicaid can encourage behavioral health electronic health records adoption include:

  - Managed Care Organizations (MCOs) making direct incentive payments to encourage their behavioral health providers to adopt electronic health records.
  - Medicaid Information Technology Architecture (MITA) funding could be employed to support electronic health records adoption. However, MITA guidance has not been updated in over 15 years to allow for this.

Proposed MACPAC Recommendations

- **Recommendation 1:** The Secretary of Health and Human Services should CMS , the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the National Coordinator for Health Information Technology (ONC) to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability.
- **Recommendation 2:** The Secretary of Health and Human Services should direct SAMHSA and ONC to jointly develop voluntary standards for behavioral health information technology.

Commissioners' Comments

Commissioners were highly supportive of both recommendations, and wanted to go further and clarify that MACPAC is fully in support of integrative health technology and record sharing in all healthcare fields (not just behavioral health). Commissioners support starting out any electronic health records adoption with voluntary standards/rules that eventually lead to mandatory electronic health records.

Session 3: Leveraging Medicaid policy levers to promote health equity

Presenter: Audrey Nuamah, Senior Analyst

Background

- MACPAC is creating a chapter on health equity efforts.

Chapter Contents

The chapter will describe:

- The Center for Medicare and Medicaid Services's (CMS) current health equity efforts;
- The importance of data collection and reporting;
- The role of state leadership in health equity initiatives, as well as political and staffing challenges that hinder equity initiatives;
- The importance of beneficiary engagement in health equity initiatives, and what CMS can do to encourage beneficiary engagement;
- State efforts to build an equity focus into redeterminations and eligibility determinations;
- Delivery system levers, including efforts to integrate equity into managed care contracts through capitation withholds, incentives, and requiring MCOs to stratify quality data by race;
- Efforts to ensure a culturally competent healthcare workforce.

Commissioners' Comments

Commissioners supported the focus on health equity, with one commissioner suggesting CMS attempt to use its authority to impose racial diversity standards on health workforces. Commissioners highlighted the

importance of community health centers, which have boards composed of a majority of patient representatives. Commissioners expressed concern that MCOs were not contracting with community health centers enough, and described community health centers as a vital part of any equity initiative in healthcare delivery. Commissioners also addressed the role of welfare stigma in hindering equity efforts, as well as the importance of listening to parents, who advocate on behalf of their children in the Medicaid program. Commissioners agreed these topics were a good starting point for the chapter, which will be worked on by MACPAC staff for future presentation.

Session 4: Requiring states to develop an integrated care strategy for dually eligible beneficiaries; Review of draft chapter and recommendation for the June report

Presenters:

- *Kirstin Blom, Principal Analyst and Contracting Officer*
- *Ashley Semanskee, Analyst*

Background:

- Integrating care for the 12.3 million Americans that are dually eligible for Medicaid and Medicare in 2020 has the potential to improve care and reduce federal and state spending.
  - Only one million of dually eligible beneficiaries were enrolled in integrated care models in 2020.
- Full integrated care currently is available in less than 15 states. This could potentially be because states are in different stages of integrating coverage for dually eligible beneficiaries. States face a series of road blocks; including but not limited to a lack of staffing resources and Medicare knowledge and expertise.
- For a more detailed summary on previous MACPAC discussions on integrated care models for dually eligible beneficiaries, please see Viohl & Associates' previous summaries.
- The proposed strategy recommendations should focus on **three goals**:
  - Increasing enrollments
  - Increasing availability
  - Promoting greater integration of existing models
- Any strategy approved by the Commission should also focus on the ways in which it can promote health equity.

Key elements of fully integrated coverage:

- **Coverage of all Medicaid and Medicare benefits**; A fully integrated program should include all Medicaid and Medicare benefits for full-benefit dually eligible beneficiaries under one entity.
- **Care coordination**; Individualized care plans should be established by care coordinators and care teams in order to meet the unique needs of dually eligible beneficiaries enrolled.
- **Beneficiary protections**; The integrated model should offer beneficiary protections and resources similar to those included in the Medicare-Medicaid plans (MMPs) under the Financial Alignment Initiative (FAI), such as Ombudsman and a mechanism for beneficiary input.
- **Financial alignment;** Wherein a single entity receives payments to cover both Medicaid and Medicare.

Draft Recommendation:

- MACPAC analysts presented their recommendation for all states to develop a strategy to integrate coverage. The strategy should include:

- An integrated approach
  - Eligibility and benefits coverage
  - An enrollment strategy
  - Beneficiary protections
  - Data analytics
  - Quality measurement
- The draft recommendation presented to the Commission:
  - "Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy, to be specified by the Secretary. The strategy should include the following components – integration approach, eligibility and benefits covered,enrollment strategy, beneficiary protections, data analytics, and quality measurement – and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries."

Commissioners' Comments and Vote
Overall approval by the Commission was shown for the recommendation presented. The Commission voted in favor of the recommendation and it passed.

Session 5: Managed care rate setting and actuarial soundness: Federal oversight and implications for efficiency, access, and value in Medicaid

Presenter: Moira Forbes, Principal Policy Director

Background
- With the growth of managed care, capitation rates paid to MCOs influence the efficacy of the Medicaid program more than ever, including the willingness of MCOs to contract with states, pay providers adequately, improve access to care and the ability to remain solvent.
- Capitation rates must be "actuarially sound."
- MACPAC analysts interviewed stakeholders including Center for Medicare and Medicaid Services (CMS) officials, actuaries, plan representatives and state officials to study how CMS implements the actuarial soundness standard and whether federal rate setting standards support adequate rates for the Medicaid program.

Findings:
- MACPAC found that the federal government provides states with substantial flexibility to align state spending and MCO outcomes.
- In doing due diligence on rate setting, CMS is mostly focused on whether rates are reasonably sufficient to cover the costs benefits and services provided and is not focused on assessing the overall adequacy of rates in supporting the Medicaid program as a whole.
- Federal procedures currently require substantial deference to state actuaries unless there is an egregious violation of federal standards.

- Federal rules neither encourage nor prevent states from using managed care payment approaches to advance program goals.
- MCOs would like more transparency in how rates are set, and generally do not think states provide this transparency.

Potential Changes:

Themes that emerged include reducing the amount of back and forth between states and CMS, as well as allowing CMS to focus on specific problematic areas of rates instead of needing to disapprove the rate as a whole. Specific policy changes suggested for potential MACPAC recommendations are as follows:

- **Rate review process changes**
  - Shortening the timeline of rate reviews
  - Developing a schedule for rate guide changes
  - Clarifying the roles of federal and state actuaries
- **Subregulatory guidance changes**
  - Guidance directing actuaries to account for emerging rate setting issues, such as social determinants of health and health equity.
  - Guidance on alignment of state directed payments with actuarial soundness requirements.
- **Federal statutory and rule changes**
  - Adding transparency requirements to the rate development process
  - CMS authority to approve parts of rates and defer decisions on other components of rates, instead of needing to accept or reject rates wholesale.

Commissioners' Comments

Commissioners asked about how considering prior year utilization patterns in rate setting can "roll over" equity issues that were baked into past rates, further increasing racial disparities. Commissioners also questioned how actuaries assess less quantitative factors in rate setting, such as access. According to the Commissioners, actuaries should be closely monitoring their assumptions to make sure they do not exacerbate inequalities. Commissioners also expressed support for the notion that states examine not only whether rates are too high but also if they are adequate (not too low) to support a healthy Medicaid program. Commissioners expressed interest in learning more about how MCOs learn about access issues amongst their beneficiaries and respond accordingly. Overall, Commissioners were interested and generally supportive of the proposed policy options as potential recommendations. Staff will incorporate the Commissioners' feedback for presentation of a revised set of recommendations at a future meeting.

Session 6: Risk mitigation and rate setting: Report on discussion at expert roundtable

Panelist: Chris Park, Principal Analyst and Data Analytics Advisor

Background:

- Currently capitation rates are created preemptively and remain in effect for the duration of the period. The need for risk mitigation and a rate setting came about during the COVID-19 pandemic.
  - The system currently in place can create challenges for states, managed care plans and providers if there are unanticipated changes in utilization and costs that differ from the assumptions used to generate the capitation rates (ex. COVID-19).

- As it stands, capitation rates remain in effect for a one year rating period. Changes to the rate before its annual renewal generally involve an extensive recertification and reapproval process.
- Nearly 70% of Medicaid beneficiaries are in comprehensive managed care arrangements.
- The implementation of a risk mitigation strategy could account for the innate uncertainty in rate setting by limiting MCO gains and losses.

Roundtable:

- MACPAC conducted a roundtable with federal and state officials, actuaries representing states, MCOs, and provider organizations for a discussion focused on the distinctive features used to identify shocks and risks, as well as existing useful tools or additional tools needed, and process improvement.
- Several types of risk mitigations strategies and their applications were addressed during the roundtable:
    - **Minimum medical loss ratio (MLR)**; States could reallocate funds if an MCO does not meet the minimum MLR. This was not favored by plan representatives in the majority of states.
    - **Two sided risk corridor**; State and MCOs share losses and gains within certain bounds, through a two-sided risk corridor. Shown to be successful for long-term shocks and when the uncertainty is spread among beneficiaries and services. This was recommended by CMS during the Public Health Emergency (PHE).
    - **Acuity adjustment**; Retroactive adjustment to the capitation rates during or after the rating period. Useful if needed to make a midyear rate change, but requires access to data that may not be immediately available.
    - **Risk adjustment**; Adjust capitation payments to MCOs to make up for differences in acuity across plans.
    - **High-cost risk pool**; Collective funding from the risk pool based on the number of claims or individuals to meet pool criteria.
    - **Per event payment or carve outs**; Potential exclusion of specific costs from capitation payments and instead, payments are made when incurred or the state carves out services or populations and pays on a fee for service basis. This has shown to be the most effective approach in certain situations such as the sudden introduction of hepatitis C drugs or more broadly to a specific condition or population (i.e. children with cystic fibrosis).
    - **State directed payment**; State directs MCOs to pay providers based on specific rates and methods.
- MACPAC analysts voiced a need for CMS to provide more detailed guidance to states and actuaries on documentation requirements necessary to gain mid-year approval of risk mitigation strategies.

Potential policy options:

- **Expedited rate review;** CMS could implement an expedited rate review process that would be activated only under certain situations. Similar to Appendix K that states can use during emergency situations by requesting an amendment to 1915(c) waivers.
- **Multi-year risk mitigation**; Allowing risk mitigation to combine financial experience over multiple rating periods could reduce some administrative complexity and the number of financial settlements.

Commissioners' Comments

Commissioners agreed on the need for risk mitigation and rate setting. However there was much debate on the complexity of this topic and the need for further information. For example, some Commissioners stressed the need for managed care organizations to be monitored more closely when extenuating circumstances like the pandemic dramatically change utilization, leading to suggestions that this type of situation be viewed from a retroactive perspective. Commissioners also emphasized the need for more risk mitigation case studies and clarification on multi-year risk mitigation.

Session 7: Considerations in redesigning the home- and community-based services benefit

Panelists:

- *Asmaa Albaroudi, Senior Analyst*
- *Kristal Vardaman, Policy Director*

Background:

- Historically, Medicaid has a structural bias towards institutional care. Coverage of institutional care is mandatory, but coverage of home and community based services (HCBS) is optional.
- The current complicated system of waivers and state plan authorities affiliated with HCBS is difficult for both states and beneficiaries to navigate.

MACPAC Roundtable:

- MACPAC hosted a roundtable around streamlining HCBS benefits to encourage HCBS over institutional care, with the purpose of supporting diversion from institutions and simplifying administrative complexity.
- Key takeaways from the roundtable:
    - Potential benefit structure; a tiered model operating around a core HCBS benefit, supplemented by higher tiers with more extensive services given the needs of the beneficiary.
    - Core HCBS benefit should promote beneficiary-centeredness and equitable access to services.
        - The Core benefit should improve equity while also addressing the diverse needs of beneficiaries.

Roundtable Proposed Core HCBS Benefit:

- Should include a core benefit that supports a meaningful community environment and promotes person-centeredness. Some roundtable participants suggested a budget based model– rather than a standard set of services– to be tailored to beneficiaries' needs.
- Should increase access to and incentivize the use of enough HCBS services to avoid institutional care. Based on the roundtable discussion, a few examples of such core services include housing supports, personal care services, and transportation.
- Should improve equity in offerings across states while encouraging state innovation, resulting in administrative simplification and allowing for better comparisons across states.
- Could be optional or mandatory, but needs to take equity concerns into consideration.

MACPAC analysts presented the graph below for Commissioners to view and draw upon for their discussion:

Issues for Discussion

Design Element	Questions
Services	• How can a core benefit support meaningful community living, improve access to, and incentivize HCBS use? • To what extent (if any) should the benefit be standardized and tailored to account for diverse HCBS needs across states?
Administration and monitoring	• Would a core HCBS benefit work with/replace the current system of state plan options and waivers? How would waiting lists be treated? • Should it be structured as a mandatory or optional benefit? • What elements of a core HCBS benefit would promote equity, address disparities? • Which entity (e.g., state Medicaid agency, other state agencies) could have responsibility to administer the core HCBS benefit? • How would a core HCBS benefit be incorporated into MLTSS programs?
Eligibility	• Should financial and functional eligibility pathways be modified for eligibility of a core HCBS benefit?

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Commissioners' Comments

Commissioner's discussed the considerations presented and agreed that this is a topic worth more discussion. However, there are still several issues, as it pertains to benefits under a tiered approach, that need to be further addressed. Another issue discussed at length by Commissioners was the budgetary aspects of HCBS and the complexity of a tiered approach with the multi-complex, differing needs of beneficiaries. Another session will be dedicated to this topic at MACPAC's April meeting.

Session 8: Access to vaccines for adults enrolled in Medicaid: Decisions on recommendations for the June report to Congress

Presenters:

- *Amy Zettle, Senior Analyst*
- *Chris Park, Principal Analyst and Data Analytics Advisor*

Background

- At the January 2022 MACPAC meeting, Commissioners were presented with several draft recommendations for improving Medicaid beneficiary vaccine access and uptake.
- After commentary, staff prepared draft recommendations to Congress for Commissioners' review.

Draft Recommendations

- **Policy 1:** Congress makes all Advisory Committee on Immunization Practices (ACIP) recommended vaccines a mandatory Medicaid benefit, instead of just new adult enrollees under the Affordable Care Act (as currently stands). This could be done through a statutory change.
- **Policy 2:** CMS sets standards on vaccine payment rates to ensure adequate provider payment. One way to do this would be to align pharmacy and vaccination reimbursements to establish a level of parity. This could be done through a regulatory change.

- **Policy 3:** CMS takes steps to encourage a broader variety of providers, such as pharmacists, to offer vaccines. This could be done through regulatory guidance.
- **Policy 4:** The Department of Health and Human Services (HHS) provides guidance and technical assistance to improve vaccine outreach and education to Medicaid and CHIP beneficiaries.
- **Policy 5:** Congress requires HHS to issue federal guidance to improve immunization information systems (IIS) and allocates funding to support these efforts.

Policy Implications

- **Policy 1:** All adults in Medicaid would have access to recommended vaccines, regardless of eligibility pathway. This mirrors a provision in the House-passed "Build Back Better Act" supported by President Biden. The Congressional Budget Office (CBO) predicts this will cost $2 billion over 10 years.
- **Policy 2:** Provider participation (and hence access) would increase. Federal and state spending could increase.
- **Policy 3:** Federal and state spending could increase depending on the state response to the guidance. Beneficiary access could also improve.
- **Policy 4:** Outreach could supplement provider efforts. Federal and state spending could increase.
- **Policy 5:** Federal spending would increase by the amount allocated by Congress. Beneficiaries would have more complete immunization records. States could share IIS data with health plans to support vaccination efforts.

Commissioners' Comments

Commissioners expressed support for potentially requiring providers to enter vaccine records into an IIS, to improve care coordination. Significant debate focused on policies 1, 2 and 3, which some Commissioners thought amounted to recommending an unfunded mandate on states. Other Commissioners disagreed, saying that the merits of increasing access to vaccination outweigh any potential for unfunded mandates. After an informal vote called by the chair, it became clear that the vast majority of Commissioners supported all five recommendations despite the unfunded mandate concerns. Commissioners will formally vote to approve all five recommendations at their April meeting.