Highlights from MACPAC April Public meeting

Overview:

On April 7th and 8th, 2022, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its April 2022 public virtual meeting. This summary includes highlights from all 9 meeting sessions. Presentation slides and the agenda for this meeting can be found on MACPAC's website.

Session 1: Access Monitoring: Review of Recommendations and Draft Chapter for June Report

Presenters:

- *Martha Heberlein, Principal Analyst and Research Advisor*
- *Ashley Semanskee, Analyst*
- *Linn Jennings, Analyst*

Background

- Recommendations for implementing a monitoring access system for Medicaid beneficiaries and their goals were brought to the Commission for final review before inclusion in the June report to Congress.
- For a detailed summary of the Commissioners' previous discussion on this topic, and the five goals of MACPAC's new proposal, please see Viohl and Associates' previous MACPAC summaries.
- MACPAC analysts presented five recommendations for a new access monitoring system, for final review, as well as the rationale and implications for each recommendation for the Commission to consider.

Draft Recommendations

- **Recommendation 1**: The Centers for Medicare & Medicaid Services (CMS) should implement an ongoing and robust access monitoring system composed of a core set of measures used for monitoring a range of services that are easily transferable and translated across states and delivery systems. The recommendation would better prioritize the services and populations for which Medicaid is the primary payer and where known access issues and disparities are present.
    - **Rationale:** The current systems in place do not adequately assess if both states and the federal government are providing sufficient funds. Furthermore, states have an obligation to be transparent with the services and needs of the Medicaid beneficiaries in their states. Therefore, creating a more streamlined monitoring access system would better allow for assessment of access to care across states and delivery systems, and create a more transparent access monitoring system.
    - **Implications:** On the federal level, costs could increase given the need for increased data collection, standardization, and reporting. The impact and costs on states would be minimized if the new system was built off of the data already collected by states.
- **Recommendation 2:** CMS should work consistently with stakeholders, including, but not limited to states, beneficiaries, health plans, providers, researchers, consumer groups, and other policy experts, in soliciting and incorporating their continual input. This will allow stakeholders and other outside experts to play a key role in the development and potential future modifications of the new access monitoring system.
    - **Rationale:** Give CMS the primary role in defining the goals, requirements and potential monitoring measures for the new monitoring access system. Would allow for a better-established system that is both meaningful and representative of the people it serves and ensure stakeholder engagement that goes beyond formal rulemaking requirements.
    - **Implications:** Costs could increase for CMS if additional staff time is needed to ensure a more meaningful assessment process. The goal is to design a system that promotes state and plan comparison by allowing more consistent and ongoing engagement from states, beneficiaries, and other stakeholders.
- **Recommendation 3:** CMS should establish a recurrent and ongoing federal Medicaid beneficiary field survey, conducted annually, to collect information on beneficiaries' perception of care.

    - **Rationale:** The components of monitoring access are reliant on the perceptions and experiences of the beneficiaries in Medicaid. Currently data and information on beneficiaries' experiences and interpretations of services under Medicaid are lacking. A federally mandated survey would capture their experiences and help fill current gaps in access domains.
    - **Implications**; CMS could potentially need more funding to conduct the surveys, therefore increasing federal costs. States would benefit by aiding in the design and fielding of the federal survey. New information on beneficiary experience would be included in the federal surveys and used to further identify existing barriers, leading the way for improvements.
- **Recommendation 4:** CMS should further standardize and improve the current Transformed Medicaid Statistical Information System (T-MSIS) to allow more meaningful cross-state comparisons of the use of specific services, access to providers, and stratification by key demographic characteristics.
    - **Rationale:** Currently T-MSIS is the only federal Medicaid data source for person-level information pertaining to eligibility, demographics, service use, and spending. Improving consistency would help streamline T-MSIS data to be more useful and reliable for access monitoring.
    - **Implications:** Aligning improvements to T-MSIS with existing federal work has the potential to minimize any additional federal costs. The alignment of T-MSIS data would also reduce the burden on states, as well as help to clarify access barriers and in turn, improve beneficiaries' access to services.
- **Recommendation 5:** CMS should assist states in collecting and analyzing access measures and provide analytical and technical support.
    - **Rationale:** During MACPAC analysis interviews, several stakeholders expressed their need for technical assistance as it pertains to guidance from states. States will need technical tools to improve the quality of data reported to T-MSIS and to collect and analyze additional access measures.
    - **Implications:** Technical assistance needed by states for improving access monitoring systems could be provided as part of existing data collection efforts. States would need additional technical support from CMS, therefore helping states meet the obligations and requirements of collecting and reporting data to better assess beneficiary access.

Commissioners' Comments

During the Commissioners' discussion, several Commissioners echoed the need to tighten the language on who was to be included in said "stakeholders," as it pertains to Recommendation 2. There were other concerns on the timeframe for Recommendation 3 and a request for clarity that it would be an annual survey. MACPAC analysts went back and tightened the language in response to the Commissioners' feedback and the recommendations were unanimously approved by the Commission during Friday's session and will be included in the June Report to Congress.

Session 2: Review of Centers for Medicare & Medicaid Services Request for Information on Access to Care and Coverage in Medicaid and CHIP

Presenter: Martha Heberlein, Principal Analyst and Research Advisor

Background

- On February 17, 2022, CMS released a request for information (RFI) seeking feedback on a variety of issues pertaining to access-related topics, including enrolling in and maintaining coverage, accessing services, and ensuring adequate payment rates.
- MACPAC analysts presented five objectives laid out in the RFI to the Commissioners, discussed areas of research previously conducted by the Commission, and sought their comments and feedback on material for inclusion in the RFI due to CMS by April 18, 2022.

Objectives:

- **Objective 1:** Seeks ways to ensure states are supported in ensuring Medicaid and CHIP reaches all eligible people.

    - **Areas of comment**; Include supporting recent research on streamlining eligibility processes and addressing the remaining barriers to enrollment. Current logistical concerns revolve around inaccurate beneficiary contact information that needs to be updated in a timely manner for both states and beneficiaries to respond.
- **Objective 2:** Ensure Medicaid and CHIP beneficiaries experience continued coverage by improving the redetermination process, opportunities for continued coverage, and minimizing gaps in coverage.
    - **Areas of comment:** Current preparation for the unwinding of the Public Health Emergency (PHE), as it relates to working directly with MCOs, spreading out renewals over a longer period, and updating beneficiary contact information. Please see Viohl and Associates' previous MACPAC summaries for a detailed summary of this topic.
- **Objective 3:** Ensure Medicaid and CHIP enrollees have continuous access to care. CMS seeks information on how to improve the redetermination process, continuity of coverage, and better communication with beneficiaries.
    - **Areas of comment:** Establishing consistent access measures that reflect the priorities of stakeholders and beneficiaries. Integration of "whole person care," by integrating physical and behavioral health, coverage for dually eligible individuals, and better understanding social risk factors.
- **Objective 4:** Requesting information on data sources to monitor access across delivery systems and programs.
    - **Areas of comment:** Merging of new and existing data systems to improve monitoring access across delivery systems and programs. Could be achieved by MACPAC recommendation of streamlining Home- and Community-Based Services (HCBS) data sources and Transformed Medicaid Statistical Information System (T-MSIS).
- **Objective 5:** Improving payment rates for current Medicaid and CHIP enrollees to ensure they are sufficient and transparent.
    - **Areas of comment**; Improving payment data availability, ensuring managed care oversight, and addressing payment arrangements unique to Medicaid.

Commissioners' Comments

Commissioners' were supportive of the topics presented by MACPAC analysts for inclusion in the comment letter to CMS. There was discussion among Commissioners on the format of the letter, whether to include their top priorities followed by those of lesser priority, but this was not agreed on. There was more consensus that the request from CMS was very broad, a "kitchen sink" response was deemed appropriate given all the pertinent information MACPAC has reviewed relevant to what is being requested. One Commissioner noted the importance of actuarial sound payments to ensure access. Another raised the issue of a need for more CMS guidance on the Telephone Consumer Protection Act (TCPA) and the ability of MCOs to utilize texting to alert beneficiaries on their enrollment status Commissioners agreed that MACPAC staff should prepare a draft letter to CMS that will be shared for review and incorporate feedback from each Commissioner prior to submission and posting on MACPAC's website.

Session 3: Medicaid's Role in Advancing Health Equity: Review of Draft Chapter for June Report

Presenter: Audrey Nuamah, Senior Analyst

Background

- MACPAC is creating a chapter on Medicaid health equity efforts. Following feedback from Commissioners at the March meeting, analyst Audrey Nuamah presented the draft chapter prepared for the June report to Congress.

Key Concepts

- The chapter addresses both the meaning of health equity and policy levers to promote health equity available to policymakers. Key concepts include:
    - The definition of health equity
    - The difference between structural and interpersonal racism

    - The disproportionate number of people of color enrolled in Medicaid
    - Health outcome disparities affecting people of color, including higher maternal mortality and lower utilization of primary care
- The chapter also describes levers for improving health equity and commends CMS's recent focus on the issue. CMS levers include:
    - Outreach and enrollment grants focused on reducing racial disparities
    - Guidance to states in addressing social determinants of health, including via 1115 waivers
- Finally, the chapter addresses state equity efforts, as well as the organizational and political challenges that come with orienting state Medicaid programs around equity. For instance, states often need buy-in from political leadership (the Governor) and a dedicated staff for equity efforts in order to ensure that the issue is addressed. State policy levers include:
    - Managed care organization (MCO) contract capitation payments and withholds, to ensure that MCOs meet equity benchmarks
    - MCO contract requirements, such as the development of equity plans or social determinant of health (SDOH) initiatives
    - Data collection requirements for MCOs, including a requirement that quality data be stratified by race
    - Increased use of Medical Care Advisory Committees (MCACs), which are beneficiary advisory panels
    - Cultural competency training for workers interacting with the Medicaid system
    - Approaching the end of the public health emergency (PHE) and Medicaid redetermination process with an equity lens, focused on identifying and reducing barriers to enrollment that disproportionately impact people of color

Commissioners' Comments

Commissioners were broadly supportive of the draft chapter, which incorporated their feedback from the March meeting. Commissioners commented on the importance of policymakers supporting the development of a culturally competent workforce, and suggested language about the potential funding levers available for training this workforce. Commissioners also suggested content about the role language barriers play in access to Medicaid, as well as inadequate access to dialysis care being a driver of poor health outcomes. During public comment, a representative from Michigan's Department of Health and Human Services (DHHS) noted that the state already breaks down quality data by race, and requested more study on how other states report quality data. MACPAC staff will include the Commissioners' comments and circulate a final draft of the chapter internally for approval before inclusion in the June report.

Session 4: Acting to Improve Vaccine Access for Adults Enrolled in Medicaid: Review of Recommendations and Draft Chapter for June Report

Presenters:

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

Background

- MACPAC has been evaluating recommendations to improve access to and uptake of vaccines by Medicaid beneficiaries. While policies 3, 4 and 5 largely enjoyed broad support at this meeting (and during the March meeting), policies 1 and 2 were controversial amongst Commissioners due to their perceived role as "unfunded mandates" that would deprive state officials of their ability to prioritize spending decisions.

Draft Recommendations

- **Recommendation 1**: Congress should amend Section 1902(a)(10)(A) of the Social Security Act to make coverage of vaccines recommended by the Advisory Committee on Immunization Practices a mandatory benefit and amend Sections 1916 and 1916A to eliminate cost sharing on vaccines and their administration.

- **Recommendation 2:** The Centers for Medicare & Medicaid Services should implement payment regulations for vaccines and their administration. Payment for vaccines should be established at actual acquisition cost and a professional fee for administration, similar to the payment requirements established for outpatient prescription drugs under 42 CFR 447.512(b) and 447.518(a)(2).
- **Recommendation 3:** The Centers for Medicare & Medicaid Services should issue federal guidance encouraging the broad use of Medicaid providers in administering adult vaccinations.
- **Recommendation 4**: The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort with the Centers for Medicare & Medicaid Services (CMS), the Office of the Assistant Secretary for Health, and the Centers for Disease Control and Prevention to provide guidance and technical assistance to improve vaccine outreach and education to Medicaid and CHIP beneficiaries. Additionally, CMS should release guidance on how to use existing flexibilities and funding under Medicaid and CHIP to improve vaccine uptake.
- **Recommendation 5:** Congress should provide additional federal funds to improve immunization information systems (IIS). In addition, Congress should require the Secretary of the U.S. Department of Health and Human Services to coordinate efforts across relevant agencies within the department to release federal guidance and implement standards to improve IIS data collection and interoperability with electronic health records and state Medicaid management information systems (MMIS). The Centers for Medicare & Medicaid Services should also provide guidance on matching rates available and ways to integrate IIS and MMIS to be eligible for the 90 percent match for the design, development, installation, or enhancement of MMIS and the 75 percent match for the ongoing operation of MMIS.

Implications

- **Recommendation 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 $1-5 billion over five years. About half the states would need to cover approximately 1-3 vaccines they don't currently cover, and 15 states would need to remove cost sharing requirements.
- **Recommendation 2:** Provider participation (and hence access) would increase. Federal and state spending could increase (no CBO score has been made for this).
- **Recommendation 3:** Federal and state spending could increase depending on the state response to the guidance. Beneficiary access could also improve.
- **Recommendation 4:** Outreach could supplement provider efforts. Federal and state spending could increase.
- **Recommendation 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

Discussion (and a robust debate) focused on the first two recommendations. Some Commissioners expressed concern about MACPAC viewing issues "in a silo," as opposed to viewing all the conflicting priorities facing Medicaid policymakers. This was particularly relevant to Recommendation 1, which would increase state spending and strip policymakers of their ability to make decisions about which vaccines are important to cover. Other Commissioners disagreed, saying that MACPAC should focus on protecting Medicaid beneficiaries and states should be required to cover all ACIP-recommended vaccines, just as Medicaid must cover all life-saving drugs. By an 11-4 vote, Commissioners voted to adopt recommendations 1 and 2. Unanimously, Commissioners voted to adopt recommendations 3, 4 and 5.

Session 5: Oversight of Managed Care Directed Payments: Review of Recommendations and Draft Chapter for June Report

Presenter: Rob Nelb, Principal Analyst

Background:

- Following recent discussion by the Commission, MACPAC analysts presented their final draft of recommendations for oversight of Managed Care directed payments for inclusion in the June report to

Congress, which included changes requested by the Commission during the March public meeting, as well as supporting context and information.
- For a detailed summary of the Commissioners' previous discussion on this topic, and the five goals of MACPAC's new proposal, please see Viohl and Associates' previous MACPAC summaries.

Examples of Directed Payments in states:
- Adjusting base rates payments: Florida requires Managed Care Organizations (MCOs) to pay nursing facilities no less than fee-for-service (FFS) rates; Massachusetts allowed temporary rate increases during the Covid-19 Pandemic.
- Preserving prior supplemental payments: Utah has chosen to preserve a prior pass through payment to hospitals and California is currently transitioning its Delivery System Reform Incentive Payment (DSRIP) initiative into to a directed payment approach.
- Making new supplemental payments: Florida carved out $1.8 billion in new payments to hospitals not tied to quality; Ohio has tripled their payments to hospitals and allotted 10% of payments to achieve quality goals.

Directed payments oversight:
- **Pre-print approval:** Submission by states of a standard application form. CMS recently made changes to its pre-print and revised their forms to help streamline the review process.
- **Capitation rate development:** Following approval of directed payments by CMS, they are incorporated into capitation rates, which must be certified as actuarially sound.
- **Evaluation:** States are required to develop proper procedural plans for their directed payment arrangements, however currently very few are available and results of evaluations are not accurate.

Proposed recommendations: criteria, rationale and implications
- **Recommendation 1:** 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. 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.
- **Recommendation 2:** Collection of new provider data by CMS to assess whether the current managed care payments are reasonable and appropriate.
    - **Rationale**: Includes Commissioners' previous recommendation to include provider-level supplemental payment data that enable analysis and is made publicly available in a standard format.
- **Recommendation 3:** 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. They would also need to show that existing payments are necessary for health plans to meet network adequacy requirements and other existing access standards.
    - **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.
- **Recommendation 4:** Meaningful multi-year assessment of directed payments, whereby HHS would require states to develop rigorous, multiyear evaluation plans of directed payment arrangements that significantly increase provider payments higher than the rates described in Medicaid state plans.
    - **Rationale**; Currently, many directed payment rates do not have evaluation results, therefore it is unclear how evaluations are being reviewed. In some examples viewed by MACPAC analysts, performance on quality measures declined, yet arrangements were approved without any

changes. Multi-year evaluations would help ensure states conduct adequate and meaningful assessments of performance.

- **Recommendation 5:** Coordinated review of directed payments, with the goal of creating a more meaningful oversight of directed payments. The HHS Secretary 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; CMS should provide additional guidance concerning the roles and responsibilities of who is responsible for reviewing directed payment amounts, if capitation rates are sufficient to comply with access standards either before or after directed payments are taken into account, and assistance on what additional federal review may be needed after CMS's initial review.

Commissioners' Comments

Commissioners provided overall support for the inclusion of their previous edits and suggestions for the recommendations. The commissioners voted unanimously for the draft recommendations, which will be included in their June report to Congress. While there was strong support calling for more transparency and evaluation of directed payments, several Commissioners noted that Medicaid financing is very complicated and there are good reasons why provider taxes and directed payments are part of the program.

Session 6: Encouraging Health IT Adoption in Behavioral Health: Review of Recommendations and Draft Chapter for June Report

Presenter: Aaron Pervin, Senior Analyst

Background

- In September 2021, MACPAC heard from an expert panel on the use of electronic health records by behavioral health providers, after which Commissioners had asked for recommendations on ways to increase their adoption. In March, Commissioners discussed these draft recommendations for inclusion in the June report to Congress.
- 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 adoption of electronic health records by behavioral health providers, and presented redrafted recommendations for Commissioner approval.

Behavioral Health & IT

- Behavioral health providers have been excluded from previous integration efforts, and often cannot share patient records with physical health providers. Providers are often short on capital, and even when they have funds available, they lack the knowledge to purchase the necessary products.
- Done correctly, proper health IT systems can foster integration, improve data sharing and promote quality care.
- There is currently no industry standard for behavioral health IT.
- States are allowed to deploy different Medicaid authorities to encourage electronic health record adoption but lack a playbook from CMS on how to effectively wield these authorities. Potential avenues include:
    - Center for Medicare and Medicaid Innovation (CMMI) demonstrations
    - Medicaid Information Technology Architecture (MITA) funding
    - Directed payments via MCOs

Draft Recommendations

- **Recommendation 1**: The Secretary of Health and Human Services should direct CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and Office of the National Coordinator for Health IT (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 broadly supportive of both recommendations and had few comments. Commissioners expressed hope that voluntary health IT standards could eventually become mandatory for participation in the Medicaid program. Both recommendations were approved unanimously, without debate.

Session 7: Updated Analyses of Churn and Coverage Transitions

Presenters:

- *Rob Nelb, Principal Analyst*
- *Linn Jennings, Analyst*

Background

- MACPAC is seeking to explore the issue of Medicaid churn, and potentially draft recommendations for minimizing churn.
- Analysts from MACPAC presented an updated analysis of newer churn T-MSIS data and examined outcomes of "churned" beneficiaries.
- MACPAC linked T-MSIS data with federal exchange enrollment data to explore coverage transitions.
- MACPAC also examined the impact of churn on hospitalization for those with ambulatory care sensitive conditions (ACSC). Dually-eligible beneficiaries were excluded from the analysis.
- Churn is defined as when a beneficiary disenrolls then re-enrolls in Medicaid within 12 months. Churn can have different causes:
    - Income fluctuations
    - Administrative barriers
- Churn costs states money on administration and leaves beneficiaries with reduced access to care.
- MACPAC identified some "best practices" in states with low rates of churn. These include:
    - 12 months of continuous eligibility
    - No mid-year eligibility checks
    - Heavy use of ex parte (automatic) renewals

Findings

- Roughly 8% of beneficiaries experienced churn within a year.
- Churn rates were higher for people of color.
- After an episode of churn, beneficiaries were almost twice as likely to be hospitalized compared to baseline rates.
- Longer gaps in coverage equated to higher rates of hospitalization.
- Very few (<4%) of those churned were covered by an exchange plan. Most were uninsured during the churn period.
- Churn without enrollment in exchange plans (despite subsidies) was particularly pronounced with those at the cusp of Medicaid eligibility in expansion states (around 138% of the poverty level).
- Researchers found that hospitalization may incentivize an effort to re-enroll in Medicaid.

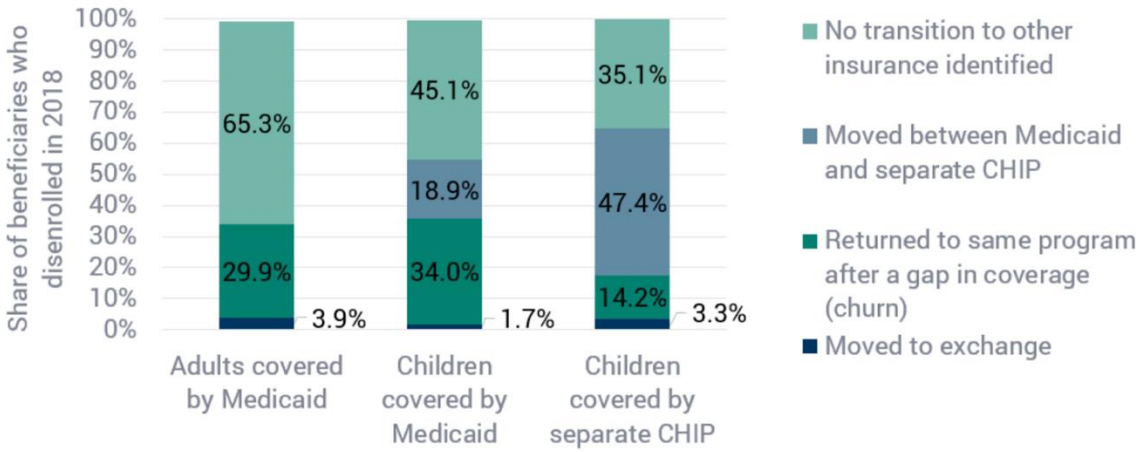


Figure illustrating outcomes for those churned (adults, children in Medicaid, children in CHIP)

- While based on pre-pandemic data, similar trends may present themselves again with the expiration of the public health emergency (PHE).
- If Commissioners are interested, MACPAC staff recommended exploring potential policy recommendations around:
    - 12-month continuous eligibility
    - Eliminating mid-year data checks
    - Incentivizing automatic (ex parte) renewals
    - Incentivizing a "warm handoff" between public coverage programs (e.g., better coordinating notices)
    - Improved data monitoring by CMS
- CMS may release a rule this summer on eligibility and enrollment policies, which MACPAC can comment on.

Commissioners' Comments

There is a strong appetite amongst Commissioners for draft recommendations on minimizing churn, particularly with the potential for Medicaid policy provisions in a new reconciliation bill passed by Congress. The end of the public health emergency (PHE) in particular was mentioned as an impetus for increased efforts to minimize churn. Commissioners urged staff to also examine churn amongst Medicare/Medicaid dual-eligibles, who are particularly vulnerable to lapses in care. Staff will revisit this issue at a future meeting with draft recommendations for review.

Session 8: Understanding Medicaid Managed Care Procurement Practices Across States

Presenters:

- *Moira Forbes, Principal Policy Director*
- *Sean Dunbar, Principal Analyst*

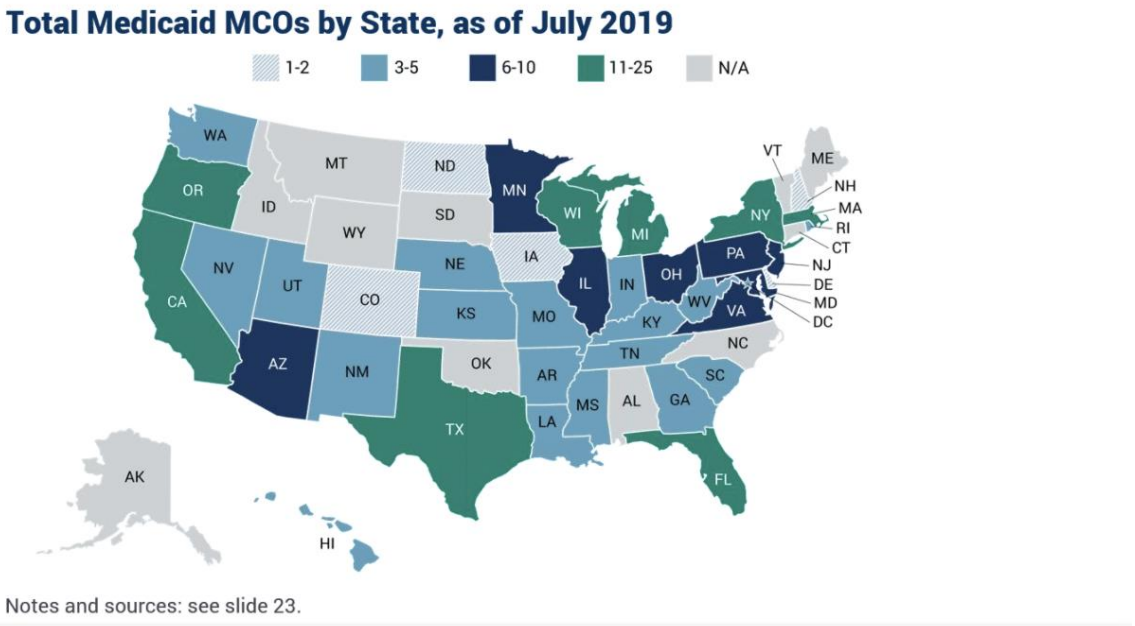
Background

- MACPAC retained an outside firm to conduct a study on managed care procurement practices in the states.
- Stakeholders, including plan representatives and state officials, were interviewed to garner an understanding of managed care contract procurement processes and how states further their Medicaid policy goals via this process.

Findings

- Context:
    - Managed care is the dominant delivery system for Medicaid.
    - Managed care contracts are some of the largest contracts a state can award, and are infrequently put up for bid.

- More than half of Medicaid funds are spent on MCOs, and MCOs cover 70% of all beneficiaries.
- The plurality of states contract with 3-5 MCOs, but exact numbers vary.



Overview of number of Medicaid MCOs by state.

- Half of managed care enrollment was centralized in six large multistate firms (Anthem, Centene, CVS Aetna, Molina, UHC, and WellCare) as of 2019. (Note: Centene has since acquired WellCare).

- Findings:
  - States have high flexibility to contract with MCOs, with little oversight and interference from CMS.
  - States look to MCOs for cost predictability and accountability, but not necessarily cost savings.
  - States look to procurements to implement large scale policy changes in their Medicaid programs. Changing a contract via a contract amendment is not preferred for policy change.
  - A procurement process takes 18-24 months, and state staff strongly prefer the timeline not be shortened. State officials emphasized the value in having the time to develop a strong RFP that incorporates all goals.
  - States prefer to have MCOs compete on program elements and value, not explicitly on price. States place a high premium on past results and adequate answers on specific populations.
  - State officials place a premium on minimizing contract protests. However, some plans are so large that protests are seen as a “cost of doing business.” Current state tools to discourage meritless protests (e.g., requiring 1% of the contract as a down payment in case the protest is unsuccessful) are largely ineffective.
- Best Practices/Potential Changes:
  - Long contracting cycles, so that states have adequate time to prepare an RFP that incorporates all program goals.
  - Transparency and public engagement throughout the contracting process.
  - The federal government could offer an enhanced match for procurement activities, to give states the resources they need for a fair and effective procurement.
  - Additional CMS authority over state procurement (this not unprecedented; CMS already exercises authority over Medicare advantage procurement, for example).
  - Federal contracting standards and state readiness reviews by CMS.

- During both the presentation and Commissioners' discussion, no mention was made of MCO perspective.

Commissioners' Comments
Commissioners were very interested in exploring this issue further for recommendations. Commissioners asked questions about how an enhanced federal match for procurement activities would work and expressed strong support for more public engagement ahead of time. Commissioners also expressed an interest in making sure RFP bid commitments made during procurements are written into contract requirements and knowing more about how quality performance factors into RFP reviews. Some Commissioners expressed skepticism about CMS having more direct oversight of state procurement processes, given its relative lack of experience. Commissioners also expressed interest in learning more about contract protests and how disruptive they are to state Medicaid operations, as well as the difference in quality between organizations that have Medicaid-only plans and those who offer both Medicaid and commercial plans. How provider payment issues factor into procurements was mentioned by one Commissioner as an area of interest. Several commissioners were interested in procurements making health equity an important component. MACPAC will be addressing this issue in the future following resounding interest from Commissioners.

Session 9: Review of HHS Reports to Congress: (1) Managed Care and the Institutions for Mental Diseases Exclusion; and (2) Best Practices for Prescription Drug Monitoring Programs
Presenters:
- *Melinda Becker Roach, Senior Analyst*
- *Lesley Baseman, Senior Analyst*

Background:
- MACPAC analysts presented two potential reports for comment by the Commission since MACPAC considers such comments when they pertain to issues that the Commission has previously addressed.
- **The two reports**:
  - HHS report concerning Medicaid payments for services provided for beneficiaries in institutions for mental diseases (IMDs) under the in-lieu-of other services authority under managed care.
  - HHS report relating to best practices for prescription drug monitoring programs, including strategies for collaborating with Medicaid.
- MACPAC analysts highlighted findings from the reports and potential areas for MACPAC's comments.

HHS Reports to Congress:
- **Report to Congress on managed care coverage for beneficiaries in institutions for mental diseases (IMD)**: **Mandated by Congress in Section 12002 of the 21st Century Cures Act (P.L. 114-255).**
  - IMD is a unique Medicaid definition for hospitals, nursing facilities, or other institutions with more than 16 beds primarily serving patients with mental illness or substance use disorder (SUD).
  - As of 2016, states can pay for services in IMDs as ILOS, however services must be medically appropriate, cost effective, voluntary for the beneficiary, and the stay does not exceed 15 days in a given month.
  - Many states currently use IMD ILOS authority and in 2019, 32 states reported establishing capitation payments for beneficiaries in IMDs in lieu of covered services.
  - Analysts found a mixed effect on capitation payments. Roughly half the states reporting said use of the IMD ILOS authority led to an increase in rates and roughly half reported a decrease
  - The average number of IMD stays per Medicaid beneficiary covered as an ILOS by state ranged from 1.0 to 2.8 stays, while the average length of stay in general ranged from 4.2 to 23.2 days. The average length of stay was fewer than 10 days in 80% of states reporting data.
  - MACPAC analysts emphasized IMD ILOS authority as an important path to covering beneficiaries in IMDs and noted the Commission's previous discussion on the role of IMDs in addressing gaps in the continuum of care for beneficiaries with behavioral health/SUD conditions. The report raises questions about state and plan practices, as well as the experience of beneficiaries

- **Report to Congress on prescription drug monitoring program best practices: Mandated by Congress in Sections 5042(b) and 5042(c) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271).**
    - Best practices for the use of Prescription Drug Monitoring Programs (PDMPs)
    - Best practices for protecting the privacy of Medicaid beneficiary information in PDMPs
    - Model practices for data sharing agreements between state Medicaid programs and PDMPs to prevent fraud, waste, and abuse and to improve health care for individuals transitioning in and out of Medicaid coverage
- Current challenges implementing qualified PDMP requirements under the SUPPORT Act include a lack of coordination between Medicaid and PDMPs. Especially when considering that not all Medicaid programs and PDMPs are within the same state agency. Both federal and state laws restrict the level of accessibility of Medicaid staff to view PDMPs data.
    - It was highlighted by analysts that a large issue was insufficient time; states were given only two years to implement qualified PDMPs and use the enhanced federal funding. Two years was not enough time to gather data that would help to identify best practices specific to Medicaid and PDMPs.

Commissioners' comments

Commissioners' expressed interest in both report topics and discussed MACPAC's previous work on these issues. Given that both topics only require a letter of comment, minor feedback was given to the MACPAC staff to prepare a draft letter highlighting previous research and findings.