

Highlights from MACPAC January 2022 Public Virtual Meeting

Overview

On January 20th and January 21st, 2022, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its January 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: Proposed approach to access monitoring recommendations for June report

Presenters:

Martha Heberlein, Principal Analyst and Research Advisor

Linn Jennings, Analyst

Ashley Semanskee, Analyst

Background:

- Following previous study and discussion by the Commission, MACPAC analysts discussed the goals and recommendations for implementing a monitoring access system for Medicaid beneficiaries. For a summary of the Commission's previous work on this topic, see Viohl & Associates' past MACPAC meeting [summaries](#).

Goals of proposed approach to monitoring access presented to the Commission:

- Actionable
- Timely
- Focused on Equity
- Efficient
- Comparable
- Adaptable

Recommendations presented to the Commission:

- Recommendation 1, set of **comparable measures**: Strive for developing an ongoing and robust monitoring access system that is established with timely and accurate data. The provided data should consist of a core set of measures for appropriately measuring acute care and long-term services.
- Recommendation 2, **access provider availability**: Design an access monitoring system that includes all aspects of access; potential access, realized access, and beneficiary perceptions and experiences.
- Recommendation 3, **prioritization of key populations**: Develop a monitoring system catered to populations and services where Medicaid already plays a pivotal role and where known gaps and disparities in access exist.
- Recommendation 4, **stakeholder input**: Design where stakeholders take the lead in developing a system that is meaningful to them and allows them to be involved with all aspects of implementation. That includes engagement with states, the plans, providers and beneficiaries.
- Recommendation 5, **field a beneficiary survey**: Arrange a recurring and ongoing beneficiary survey to gather information on beneficiaries' insights and personal experiences with current care.
- Recommendation 6, **further standardization T-MSIS**: Standardize and improve the Transformed Medicaid Statistical Information System (T-MSIS) data to allow for cross-state comparison and utilization of particular services, access to providers, and stratification of key demographic characteristics, such as ethnicity and race.
- Recommendation 7, **provide state technical support**: Create a new access monitoring system aimed at providing analytical support to ensure states are able to use the same accurate set of core data. Aimed at providing additional resources at the state level.

Commissioners' Comments

Commissioners broadly discussed the recommendations presented and confirmed moving forward with a package recommendation. A consensus was met on Recommendations 1, 2 and 6 but some Commissioners requested that consistent verbiage be incorporated when the final package is presented. The Commission is set to hear from additional panelists at its April meeting prior to final review and a vote on the draft chapter and final recommendations.

Session 2: Improving Vaccine Access: Review draft March report chapter and additional policy options

Presenters:

Amy Zettle, Senior Analyst

Chris Park, Principal Analyst and Data Analytics Advisor

Background:

- COVID-19 has highlighted the importance of vaccination in saving lives. Vaccine preventable diseases (prior to COVID-19, most notably the seasonal influenza) cost the US economy \$9 billion annually.
- Vaccines are not currently a mandatory benefit for adult enrollees in Medicaid, except for new adult enrollees added during the public health emergency (PHE).
- Legislation in Congress, the “Build Back Better” Act, would mandate that Medicaid cover all immunizations recommended by the American Committee on Immunization Practices (ACIP) without cost sharing.
- 24 states currently cover all ACIP recommended vaccines.
- There are significant disparities between Medicaid enrollees and those with private insurance in vaccination rates. However, within Medicaid there are also differences in vaccination rates across racial and ethnic groups.

Potential Solutions Explored:

- Numerous policy options to improve vaccination rates amongst Medicaid beneficiaries were explored and subsequently evaluated.
 - Policy A: Increase the FMAP (Federal Medical Assistance Percentage) for vaccine administration. This must be accomplished **statutorily**.
 - Policy B: Allow Medicaid providers to purchase vaccines at the federally negotiated price (this is a price the CDC negotiates with drug makers). This must be accomplished **statutorily**.
 - Policy C: CMS regulates vaccine payments to set minimum standards for payments to providers. This can be accomplished through **regulation**.
 - Policy D: Increasing the number of providers offering vaccines (e.g. offering more vaccines at pharmacies, at-home vaccination services etc.). This could be accomplished through **regulatory guidance**.
 - Policy E: Medicaid payment for vaccine counseling services, which are intended to reduce vaccine hesitancy and engage in proactive community outreach. Vaccine counseling includes but is not limited to paying primary care physicians to talk to patients about the benefits of vaccination. This could be accomplished through **guidance or statutorily**.
 - Policy F: Improve immunization information systems (IIS). CMS would allow and encourage the use of Medicaid funds for system improvements. These are mass databases of vaccination records that are often spotty and lacking critical information. This can be accomplished through **guidance**.
 - Policy G: CMS allows Medicaid resources to be spent on vaccine education and outreach. This can be accomplished through **guidance or statutorily**.

Evaluation of Policy Options

- The policies were evaluated by five metrics: ability to improve vaccination rates, potential to reduce racial disparities, impact on state spending, impact on federal spending, and operational complexity.
- Evaluations included conversations with stakeholders, experts and state Medicaid officials.

Policy option	Action required	Improve vaccination rates	Reduce racial disparities	State spending	Federal spending	Operational complexity
A. Increase FMAP for vaccine administration	Statutory	Low–medium	Low–medium	Decrease	Increase	Low–medium
B. Federal contract price	Statutory	Low	Low	Low decrease	Low decrease	Medium–high
C. Implement regulations for vaccine payment	Regulatory	Low–medium	Low	Increase	Increase	Low–medium
D. Increase the types of providers administering vaccines	Guidance	Low–medium	Low–medium	Increase	Increase	Low
E. Payment for vaccine counseling	Guidance or statutory	Low	Medium	Increase	Increase	Low
F. Immunization Information System support	Guidance	Low	Low	Increase	Increase	Low–medium
G. Medicaid resources for education and outreach	Guidance or statutory	Low	Medium	Increase	Increase	Medium

- Overall, the proposed actions were judged to have relatively modest (at best) impacts on vaccination rates.
- Many of the proposed policies create significant administrative burdens. Two policies with high administrative complexity were specifically highlighted. Policy B would require providers to seek rebates from vaccine manufacturers for the federally contracted price. Spending Medicaid dollars on vaccine education and outreach (Policy G) requires significant investment and program scaling for an uncertain benefit.
- More data is needed on whether states with more coverage for vaccination had improved outcomes.

Commissioners' Comments

Commissioners expressed support for increasing access to vaccinations, and a particularly strong consensus emerged around recommending policy options **D, F & G** to Congress and CMS for future action. Commissioners noted the lack of access to vaccinations in many disadvantaged and rural communities, and said that a broader variety of providers offering vaccinations offered a tangible way of improving access to vaccinations, although with a less certain impact on vaccine uptake. Poor information sharing was also highlighted as a barrier to proper vaccination. Often, people are over-vaccinated or mis-vaccinated because providers don't share vaccination records effectively. Commissioners expressed concerns about the administration of certain solutions, particularly compensation for vaccine counseling leading to Medicaid paying doctors for something they already do.

Session 3: Panel discussion: Update on restarting Medicaid eligibility redeterminations

Presenters:

Introduction:

- *Joanne Jee, Policy Director*

Panelists:

- *Melissa McChesney, Policy Advisor, Health and Policy and Advocacy, Unidos US 2*
- *Jeff Nelson, Director, Children's Health Insurance Program and Bureau of Eligibility Policy, Division of Medicaid and Health Financing, Utah Department of Health*
- *Jeremy Vandehey, Director, Health Policy and Analytics Division, Oregon Health Authority*

Background:

- The panel provided updates and hesitations from states as it pertains to the reinstatement of Medicaid eligibility redeterminations after the end of the Public Health Emergency (PHE). Policy director Joanne Jee provided updated background and introductory remarks to the Commission:
- With the COVID-19 PHE still in effect, states are continuing to receive a 6.2% percentage point increase in federal medical assistance and cannot disenroll beneficiaries. However many state officials are concerned about their states readiness and preparedness, as well as the potential loss of health coverage for Medicaid enrollees deemed ineligible once the PHE ends.

- The Administration has again extended the PHE through April 2022, but it is not known if that is a final date or if it will be extended again. States continue to grapple with the uncertainty of the timeline provided by the federal government and their ability to properly prepare for the transition post-PHE.
- Since the start of the PHE, Medicaid enrollment grew by 19% from February 2020 to June 2021. The uncertainty around the exact procedures states may be required to use once the PHE ends will not only affect the millions of Medicaid enrollees who may lose coverage, but also increases the administrative burden for states conducting eligibility reviews. .
- CMS recently provided guidance aimed at reducing the potential burden on states, which included extending timeframes for states' redeterminations.

Highlights:

- Melissa McChesney discussed issues and concerns in Texas. Each state has their own circumstances to consider and in certain states like Texas for example, with the lowest renewal rate in the country even before the PHE, the end of the PHE will overwhelm the current systems that were already struggling to keep up. Ms. McChesney emphasized the need for CMS to take the necessary steps to maintain the enrollment of Medicaid beneficiaries during the PHE. The timeframe established for renewals once the PHE ends could trigger immense loss of beneficiaries who are actually still eligible. She suggested the idea of attempting renewal coverage through a third party database which would reduce the burden on staff and eligibility systems by reducing the amount of renewals that are manually entered. One of the biggest renewal issues faced by the state is outdated addresses of enrollees. She contended that if a renewal database was established, a creation of targeted marketing (flyers, mail) could be utilized to reduce disenrollment.
- Jeff Nelson explained the challenges Utah is facing in keeping eligible enrollees on the rolls during and after the PHE. In 2021, Utah lost 41% of CHIP enrollees following a review of eligibility. The drop in enrollees was attributed to out of date addresses and enrollees not being well informed of or educated about their eligibility. These were problems faced by the state before the PHE and Mr. Nelson stressed the likelihood of these same issues affecting Medicaid enrollees once the PHE ends if nothing is done to change the process. There is an urgency for establishing a system that provides clear communication to enrollees as well as means to obtain accurate beneficiary information. Mr. Nelson argued the sharp drop in enrollees was also due to lack of time allowed for families to maintain their children's coverage. In addition, he noted it takes a skilled set of staff to process applications and currently 15-20% of the state workforce in Utah is not yet adequately trained in processing Medicaid or CHIP renewals.
- Jeremy Vandehey discussed similar issues in Oregon and offered his insight on the administrative burdens there. Mr. Vandehey stressed the danger of significant disenrollment once the PHE ends and noted that per their state's estimates, Oregon is forecasted to lose 300,000 eligible beneficiaries. He made the case that Commissioners should have a sense of urgency about pushing for policy changes that result in a more streamlined set of requirements and communication processes going forward. Mr. Vandehey also proposed a two year continuous eligibility process that would also help reduce the high level of churn. Transitioning to a two-year eligibility process would help prevent gaps in coverage for Medicaid-eligible members. He cited statistics from his state that indicate that historically one in five of Medicaid enrollees who lose coverage are in fact still eligible, but due to lack of proper protocols and sufficient staffing, enrollees do not get informed of their status. He emphasized the need for stabilizing coverage for eligible enrollees for a longer period of time. Currently in Oregon, there is no smooth transitioning process in place, outreach is still conducted manually via the individual marketplace, so there is not enough time for states to smoothly transition all qualified eligible members once the PHE expires.

Commissioners' Comments

The Commissioners' discussed in great length the many concerns and recommendations presented by the panelists. It was agreed that this was a topic worth addressing; however, there is still more data and research needed to fully address potential recommendations for easing transition to other health coverages and mitigating unnecessary coverage losses. It was agreed by the Commission to closely monitor the process of restarting Medicaid eligibility redeterminations and staff will bring the topic back to the Commissioners when it is timely and appropriate.

Sessions 4: Requiring states to develop a formal strategy for integrating care for dually eligible beneficiaries

Presenters:

Kirstin Blom, Principal Analyst and Contracting Officer

Ashley Semanskee, Analyst

Background:

- 12.3 million Americans are dually eligible for Medicare and Medicaid. However, only 10% of beneficiaries are enrolled in integrated care models.
- In October 2021, the Commission discussed a proposed recommendation to Congress to require each state to develop a strategy for full integration of care, as well as for Congress to provide ample funding to each state in order to do this.
- MACPAC has produced a [databook](#) on dually-eligible individuals, to help inform recommendations going forward. The data book includes information on enrollment and spending, characteristics of dually eligible individuals, Medicare and Medicaid spending by LTSS use, continuity of care and managed care use.
- Most information in the databook is limited to the fee-for-service population.
- States are in different stages of integrating Medicare and Medicaid coverage

Draft Recommendation 1

- Draft recommendation 1 asks Congress to mandate that states integrate dual-eligibles into a managed fee-for-service or a fully integrated dual enrollment special needs plan (FIDE SNP).
- Coverage should be tailored to subpopulations, and CMS should provide guidance on implementation including specifying which Medicaid benefits would be covered by the integrated plan. Outreach to beneficiaries, providers and stakeholders would be vital.
- Dual-eligibles would have access to an ombudsman and a unified appeals and grievance process
- States would have two years to develop their strategy and would be required to update strategies continuously every 3-5 years.
- The strategy should ensure beneficiary protections, as well as robust data management and quality measurement.

Draft Recommendation 2

- Draft recommendation 2 asks Congress to appropriate funding to help states integrate their dual eligibles.
- Funding could be provided through an increased FMAP or grants.

Commissioners' Comments

Commissioners will vote on final recommendations at their April meeting. Commissioners emphasized the need to consider equity when drafting final recommendations, and the need to highlight the importance of this process to CMS and Congress. Commissioners also expressed concerns about Medicare-Medicaid Plans (MMPs) not being able to transfer current enrollees into the other integrated models, as well as how to ensure care is being integrated instead of reduced. Commissioners generally informally agreed to the draft recommendations.

Session 5: Review of proposed rulemaking affecting Dual Eligible Special Needs Plans

Presenters:

Kirstin Blom, Principal Analyst and Contracting Officer

Ashley Semanskee, Analyst

Background:

- CMS has issued a notice of proposed rulemaking concerning federal regulations on Dual Special Needs Plans (D-SNPs). CMS' fact sheet and proposed rule can be found [here](#).
- MACPAC staff has identified areas for potential comment on the rule.
- CMS is aiming to improve integration of Medicaid and Medicare coverage for people enrolled in D-SNPs. CMS proposes that many MMP features be applied to D-SNPs. If the proposed rule becomes final, CMS suggests that MMPs convert to D-SNPs.

Rule:

- Some MMP features must be applied to D-SNPs under the proposed rule. These include:
 - Enrollee advisory committees
 - Health risk assessments including questions on social determinants of health
 - Unified appeals and grievance procedures
 - Exclusively aligned enrollment for all FIDE SNPs. Exclusively aligned enrollment is when enrollment in the FIDE-SNP is limited to full benefit dually eligible individuals. Some states do not currently have this.
 - FIDE-SNPs are required to cover Medicare cost sharing (something already a part of capitated contracts)
- The rule also includes:
 - Codification of the ability of states to use contracts with D-SNPs to require integrated member materials
 - Continuation of Medicare benefits pending appeals
 - Streamlining of plan oversight by giving states access to CMS information on D-SNPs

Commissioners' Comments

Commissioners expressed broad support for the efforts by CMS to improve integration. Concerns were raised about ensuring enrollee committees provide authentic representation, that CMS has a clear integration strategy, and Commissioners suggested commenting on the need to avoid disruption of care. Commissioners repeatedly emphasized the need for states to have federal support and ample time to implement any changes. A public commenter suggested that, from her interpretation, the rule still allows for non-fully integrated plans and doesn't completely eliminate MMPs. There may still be opportunities for states to use MMPs despite the overall pro-D-SNP direction from CMS. Commissioners agreed and suggested it was worth paying close attention to the final rule. MACPAC staff will consider Commissioners' comments and draft proposed comments for review at a later meeting.

Session 6: Mandated report on Money Follows the Person (MFP) qualified residence criteria: review of draft chapter for March report***Presenters:***

Kristal Vardaman, Policy Director

Background:

- Commissioners have discussed Money Follows the Person (MFP) policy issues several times over the last several months, most recently the different policy options and advantages and disadvantages of the existing MFP qualified residence criteria and potential implications. To view past summaries of the Commission's previous work on this topic, see Viohl & Associates' previous [MACPAC highlights](#) from October 2021.
- The MFP demonstration program has proven to help beneficiaries in institutions return safely to their community in participating states.
- MFP was first authorized by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and has helped over 100,000 participants transition back to their community.
- There are currently certain specific setting qualifications needed in order to participate in MFP, those are:
 - Owned or leased home in the beneficiary's name or family member
 - An apartment with an individual lease
 - A community based setting where no more than four other unrelated residents reside.
- The Consolidated Appropriations Act of 2021 asked MACPAC to conduct a study on settings that are available to MFP participants and settings that qualify for Home and Community-Based Services (HCBS) payment under the settings rule. MACPAC analyst Kristal Vardaman presented these settings to the Commission in an overview draft chapter for potential inclusion in the March report to Congress.

Rule:

- The HCBS settings rule is defined by the characteristics of a setting, versus the community settings, and is broader than the resident criteria under MFP. HCBS proposed resident experience rule is intended to be distinct from institutions and instead focused on facilitating community integration. The settings are

defined as eligible based specifically on the nature and quality of the individual's experience, instead of solely based on the physical location, as is the case currently under the MFP program.

- With no sufficient data on assessing the tradeoffs of changing MFP's current criteria, MACPAC analyst Kristal Vardaman noted the only data sufficient to make an assessment is largely based on stakeholder perspectives conducted by a program director survey and interviewee process.
 - **MFP Program director survey** found that roughly 70% of program directors believed the criteria of MFP directly align with the HCBS settings rule.
 - **Interview process** conducted through a series of interviews with federal and state officials, provider organizations and other experts, found mixed opinions from stakeholders. Stakeholders in favor of the current residence criteria preferred the concise, clear and enforceable requirements of MFP. While those in favor of aligning MFP to HCBS resident requirements, thought it best to establish a single line of rules and communication to avoid confusion and operational challenges.

Rationale:

- Ms. Vardaman presented rationale for both retaining the existing MFP criteria and changing criteria to align with the HCBS settings rule:
 - **Retaining** existing criteria would establish more autonomy for beneficiaries, allowing them more control of their settings while transitioning. Maintaining existing criteria could also incentivize states to promote HCBS' infrastructure development.
 - **Aligning** MFP and proposed HCBS resident experience criteria could create a constant set of rules for states to follow. Therefore reducing operational challenges and establishing a clear line of communication for federal funding, and lessen the burden on participants as it would create a single set of rules for all participating states to follow.

Commissioners' Comments

Generally, Commissioners agreed that the draft summary presented appears too narrow and does not adequately capture the diverse opinions of the participating evidence. It was noted during discussions that MFP serves as an example of how demonstration programs can influence overall Medicaid policy by developing constituencies for long-term changes. However, after months of discussing the advantages and disadvantages of the existing MFP qualified residence criteria, the Commission concluded that there is not sufficient evidence supporting alignment of MFP residential criteria with the HCBS settings rule.

Session 7: Panel discussion: Beneficiary engagement and elevating consumer voices in Medicaid policymaking

Presenters:

Introduction:

- *Moira Forbes, Principal Policy Director*

Panelists:

- *Kate McEvoy, Program Officer, Milbank Memorial Fund*
- *Cara Stewart, Director of Advocacy, Kentucky Voices of Health*
- *Catherine Simone, Consumer Advisory Council Member, Commonwealth Care Alliance*

Background:

- This panel focused on ways to improve stakeholder participation and involvement in Medicaid policymaking, and featured a discussion between Catherine Simone (a member of the Massachusetts' Medicaid program's advisory council), Kate McEvoy (former Connecticut Medicaid director) and Cara Stewart (Kentucky healthcare advocate and Medicaid outreach specialist).

Highlights:

- Ms. Simone emphasized the difficulty many Medicaid beneficiaries face in advocating for themselves within the program. She was especially grateful for Massachusetts' generous Medicaid program, which has helped her with a myriad of physical and behavioral health issues, but noted how often despite the efforts of the state to expand services many beneficiaries are simply unaware of them. For her, having a care manager (a Medicaid employee directly responsible for her care) instead of a "faceless" toll free phone number has made a big difference. Simone advocated for more oversight of Managed Care Organizations (MCOs). She also mentioned how the stigma of receiving Medicaid can inhibit beneficiaries from engaging in advocacy.

- Ms. Stewart noted that while many beneficiaries perceive they are not qualified to speak about Medicaid issues, they are indeed the most qualified to speak on the program given their lived experiences. Ms. Stewart, who helps manage the advisory board for Kentucky’s Medicaid program (known as KYNect), emphasized the importance of soliciting direct feedback from Medicaid recipients. For instance, she noted how informal advisory groups where beneficiaries feel empowered to discuss their opinions are often more effective than formal ones. Stewart discussed the value of giving participants in these groups the perception that their feedback is important and will be taken seriously. . Stewart strongly advocated for protections for beneficiaries from the whims of politics. She noted a prior administration in Kentucky was overtly hostile to Medicaid beneficiaries, many of whom stopped participating in feedback panels. Minimizing administrative burdens on beneficiaries should also be a major priority. Stewart argued that state governments should be mandated to verify beneficiary information using its own databases before asking beneficiaries for that information. This would minimize needless enrollment churn.
- Ms. McEvoy spoke to her experience as a Medicaid director in involving enrollees. Connecticut beneficiaries took their own initiative to help improve behavioral health offerings by providing input, which she described and supported. According to Ms. McEvoy, another group of disabled beneficiaries took it upon themselves to organize and help the state write a plan amendment. McEvoy emphasized the importance of public communication. She noted that fraud in the Medicaid program is much lower than many in the public realize. All panelists agreed that this perception of fraud harms efforts to engage beneficiaries and productively expand Medicaid. McEvoy also suggested issues of diversity be viewed through an intersectional lens, and cautioned against expecting any one group of beneficiaries, such as disabled persons, to only speak to disability issues rather also gaining their perspectives on the overall Medicaid program.

Commissioners’ Comments

Commissioners thanked the panelists for their input and agreed wholeheartedly about the importance of centering beneficiaries in policymaking. Commissioners emphasized the importance of diversity, improving information sharing with beneficiaries, and orienting policymaking around those experiencing the worst outcomes and not the Medicaid program writ large. Public comment echoed Ms. Stewart’s proposal for more guardrails on political meddling in Medicaid programs.