Highlights from MACPAC April 2021 Public Virtual Meeting

Overview

On April 8th and April 9th, 2021, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its April 2021 public virtual meeting. This summary includes highlights from all 11 meeting sessions. Presentation slides and the agenda for this meeting can be found on the MACPAC website.

Session 1: High-Cost Specialty Drugs: Review of Draft Chapter and Recommendations

MACPAC staffer Chris Park discussed the Commission's work on developing recommendations to address the high costs associated with specialty and experimental drugs. He also reviewed the Commission's draft chapter and recommendations on this topic. Mr. Park explained that MACPAC developed its draft chapter and recommendations by convening and consulting with a technical advisory panel (TAP). This panel included drug policy and pricing experts from a variety of different backgrounds, including academia, industry, state government, advocacy, medicine, and drug manufacturing. TAP members identified key challenges associated with high-cost specialty drugs and suggested potential solutions. Mr. Park said elements of these potential solutions were incorporated into MACPAC's draft chapter for their upcoming June report to Congress and in the draft recommendations below. More details on the TAP's work with the Commission can be found in Viohl & Associates' summary of MACPAC's March meeting.

Mr. Park presented two draft recommendations:

1. Congress should amend Section 1927(c)(1) of the Social Security Act to increase the minimum rebate percentage on drugs that receive approval from the U.S. Food and Drug Administration (FDA) through the accelerated approval pathway under Section 506(c) of the Federal Food, Drug, and Cosmetic Act. This increased rebate percentage would apply until the manufacturer has completed the postmarketing confirmatory trial and been granted traditional FDA approval. Once the FDA grants traditional approval, the minimum rebate percentage would revert back to the amount listed under Section 1927(c)(1)(B)(i).

2. Congress should amend Section 1927(c)(2) of the Social Security Act to increase the additional inflationary rebate on drugs that receive approval from the U.S. Food and Drug Administration (FDA) through the accelerated approval pathway under Section 506(c) of the Federal Food, Drug, and Cosmetic Act. This increased inflationary rebate would go into effect if the manufacturer has not yet completed the postmarketing confirmatory trial and been granted traditional FDA approval after a specified number of years. Once the FDA grants traditional approval, the inflationary rebate would revert back to the amount typically calculated under Section 1927(c)(2).

Mr. Park argued that the recommendations address costs for states by effectively lowering the net price of high-cost experimental drugs until drug manufacturers verify their clinical benefits, and by increasing drug rebates. He explained the recommendations also provide an economic incentive to encourage manufacturers to complete confirmatory trials in a timely manner, and noted that the recommendations would maintain coverage requirements.

Commissioners' Comments

Commissioners were supportive of the draft recommendations. Several Commissioners said they felt that both recommendations effectively balanced states' interests in controlling costs and confirming the effectiveness of specialty and experimental drugs with manufacturers' interest in preserving the financial benefits of drug research and development. One Commissioner also said they felt the recommendations were sufficiently broad that Congress could still decide on the details (i.e. how much to increase inflationary rebates), which fits MACPAC's purview as an advisory board. MACPAC Commissioners voted to approve both recommendations the following day.

Session 2: Strategies for State Contracts with Dual Eligible Special Needs Plans

MACPAC staffers Kirstin Blom and Ashley Semanskee presented on the Commission's upcoming draft chapter covering strategies for state contracts with Dual Eligible Special Needs Plans (D-SNPs). This chapter will publish insights from the Commission's ongoing work on integrating care for dually-eligible beneficiaries (see Viohl &

Associates' past MACPAC summaries for more information). Ms. Blom and Ms. Semanskee explained that the Commission is focused on D-SNPs since they enroll more dually eligible beneficiaries than any other model, covering approximately 26 percent of the dually-eligible population. They discussed 13 strategies listed in the Commission's draft chapter that states can use to help further integrate care for beneficiaries with D-SNPs, which states can pursue under federal authority granted to them by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Six strategies can be used by any state:

1. Limit D-SNP enrollment to full-benefit dually eligible beneficiaries;
2. Direct contracting with D-SNPs to cover Medicaid benefits;
3. Require D-SNPs to use specific or enhanced care coordination methods;
4. Require D-SNPs to send data or reports to the state for oversight purposes;
5. Require state review of D-SNP materials related to delivery of Medicaid benefits, and;
6. Partner with D-SNPs to develop supplemental benefit packages that complement Medicaid benefits.

Seven strategies are only relevant for states with Medicaid managed care:

7. Selectively contract with D-SNPs or Medicaid managed care plans that offer affiliated plans;
8. Require complete service area alignment;
9. Require D-SNPs to operate with exclusively aligned enrollment;
10. Allow or require D-SNPs to use default enrollment;
11. Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization;
12. Incorporate Medicaid quality improvement priorities into the D-SNP contract, and;
13. Automate Medicaid crossover claims payment processes for payment of Medicare cost sharing.

In addition to these strategies, Ms. Blom and Ms. Semanskee discussed further analysis included in the upcoming draft chapter. They noted that states face some limitations that impede their ability to use D-SNPs as a vehicle for integration, including Medicaid carve-outs of long-term services and supports (LTSS), other integrated models that compete with D-SNPs, developing the capacity of states and health plans to offer a product for dually eligible beneficiaries in rural areas, and tradeoffs between increasing care integration and increasing enrollment.

For their future work on this topic, Ms. Blom and Ms. Semanskee said the Commission will explore the advantages and disadvantages of limiting enrollment in D-SNPs to full-benefit dually eligible beneficiaries, analyze barriers to state adoption of D-SNPs, and collect feedback from Commissioners.

Commissioners' Comments

Commissioners said they felt the strategies identified in the upcoming draft chapter were effective options for states to further integrate care using D-SNPs, and expressed their interest in continuing to pursue a bigger-picture solution for improving integrated care. The Commission will continue to explore the possibility of a new program for dually-eligible beneficiaries in their March report. One Commissioner re-emphasized the importance of gathering feedback from states to learn what they need to build state capacity in Medicare expertise so that they can facilitate the growth of D-SNP plans.

Session 3: Access to Mental Health Services for Adults: Draft Chapter and Recommendations

MACPAC Staffer Erin McMullen gave a presentation on the Commission's upcoming chapter on improving access to mental health services for adults in Medicaid. The chapter covers the need for mental health services, state-by-state coverage of mental health services, and barriers to access. Ms. McMullen also reviewed two draft recommendations pertaining to improving access to mental health services for adults, which the Commission approved the following day.

Ms. McMullen reviewed the tremendous need for mental health services among adult Medicaid beneficiaries. She noted that when compared to their privately insured peers, Medicaid beneficiaries were considerably more likely to report that they needed, but did not receive mental health treatment in a given year. Further, nonwhite Medicaid beneficiaries were even less likely to receive mental health treatment than their white peers in a given

year. She explained that several barriers tend to impede beneficiary access to care, including the ongoing shortage of behavioral health providers, geographic maldistribution of providers, and low rates of Medicaid participation among behavioral health providers. Ms. McMullen also underscored the importance of improving access, noting that having an untreated mental health condition correlates strongly with suicide and involvement with the criminal justice system.

Although the draft chapter provides a comprehensive look at mental health services for Medicaid adults, Ms. McMullen noted areas for future work by the Commission that are not covered by the draft chapter. She suggested the Commission could explore the overlaps between Medicaid and the criminal justice system, the availability of home-and-community based services for beneficiaries with behavioral health conditions, and access to behavioral health services for LGBT+ Medicaid beneficiaries.

Ms. McMullen then reviewed the Commission's two draft recommendations for improving access to mental health services for adults with Medicaid. They are as follows:

1. The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, and the Substance Abuse and Mental Health Services Administration, to issue joint subregulatory guidance that addresses how Medicaid and the State Children's Health Insurance Program can be used to fund a crisis continuum for beneficiaries experiencing behavioral health crises

2. The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, and the Substance Abuse and Mental Health Services Administration, to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in crisis in real-time. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of crisis services.

Detailed rationale and an analysis of these recommendations' implications can be found on slides 15-20 of Ms. McMullen's presentation.

Commissioners' Comments

Commissioners supported the two recommendations, which they voted to approve the following day. Several Commissioners also re-emphasized the importance of addressing the ongoing mental health crisis for adults, since suicide as a result of untreated mental illness still remains a significant cause of premature death among adults. One Commissioner also further urged the Commission to further examine and address racial and ethnic disparities in behavioral health care and underscored the importance of expanding cultural competency training as a way to address these disparities.

Session 4: Access to Behavioral Health Services for Children and Adolescents: Draft Chapter and Recommendations

MACPAC staffer Melinda Becker Roach presented on MACPAC's upcoming draft chapter on improving access to behavioral health services for children and adolescents. The chapter discusses the current need for behavioral health services among children and adolescents in Medicaid and CHIP and barriers to access. Ms. Becker Roach also discussed the Commission's two draft recommendations on this topic.

According to 2018 data from the National Survey on Drug Use and Health, nearly 20 percent of adolescent Medicaid beneficiaries experienced a major depressive episode in 2018, and about 12 percent of adolescent Medicaid beneficiaries had suicidal thoughts. Nearly 4 percent attempted suicide. Ms. Becker Roach argued that these statistics, highlighted in MACPAC's draft chapter, underscore the dire need for expanded access to behavioral health services. She noted that these statistics reflect that many youth with behavioral health conditions did not receive needed treatment.

Ms. Becker Roach explained that one key reason for this unmet need is limited availability of behavioral health providers for children and adolescents. She noted that MACPAC's draft chapter explores methods for improving

provider availability by examining access to care in various settings including providers' offices, schools, and behavioral health treatment facilities, and developing recommendations for addressing the provider shortage.

MACPAC's draft chapter also identifies key barriers to expanding access, including lack of state capacity to use available federal authorities for behavioral health services, and lack of necessary guidance, support, and expertise for expanding behavioral health services. The chapter argues that addressing the behavioral health needs of children and adolescents will require collaboration between multiple government partners, including the Center for Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Children and Families (ACF), as well as various state and local authorities.

Ms. Becker Roach then reviewed the Commission's draft recommendations for improving access to behavioral health services for children and adolescents. They are as follows:

1. The Secretary of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to issue joint subregulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program.

2. The Secretary of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to provide education and technical assistance to states on improving access to home and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services.

These recommendations reflect the need for a collaborative approach among government agencies to expand access to behavioral health services, and incorporate other insights from the draft chapter. Detailed rationale and an analysis of these recommendations' implications can be found on slides 14-19 of Ms. Becker Roach's presentation.

Commissioners' Comments

Commissioners were supportive of the two recommendations, which they voted to approve the following day. One Commissioner noted that the shortage of behavioral health providers has remained an ongoing issue for the Commission, and that perhaps the Commission's further work could more directly target this shortage. Another Commissioner suggested that pursuing the promotion of new delivery methods for behavioral health services for children and adolescents (i.e. mobile centers, expanding telehealth) could be an effective strategy to improve access.

Session 5: Electronic Health Records as a Tool for Integration of Behavioral Health Services: Review of Draft Chapter

MACPAC staffers Aaron Pervin and Erin McMullen discussed MACPAC's draft chapter on improving integration of physical and behavioral health services through the use of electronic health records (EHRs). The chapter reviews components of clinical integration and co-occurring conditions among Medicaid beneficiaries, health information technology's value in promoting clinical integration, and barriers to EHR adoption among behavioral health providers.

In MACPAC's draft chapter, the Commission identifies several key components of clinical integration, including:

- Care coordination or care management;
- Co-location;
- Data sharing;

- Formal or informal agreements with external partners;
- Screening and referral to treatment, and;
- Provider education and training.

MACPAC's chapter explains that many adults with mental illness also have other co-occurring physical health conditions, highlighting the need for improved integration between physical and mental health services. While historically services for behavioral health and physical health have been financed under separate systems, Mr. Pervin and Ms. McMullen explained that this funding structure creates unnecessary gaps in care and may often lead to conflicting treatment.

The draft chapter argues that certified EHR technology can strengthen clinical integration of physical and behavioral health care by facilitating behavioral health providers' access to state health information exchanges, enabling behavioral health providers to participate in value-based payment arrangements and improving state quality reporting.

Although adoption of EHR technology could improve integration and care outcomes for Medicaid beneficiaries, Mr. Pervin and Ms. McMullen explained that EHR adoption among behavioral health providers remains low. The draft chapter identifies various reasons for this low rate of adoption, including lack of capital to invest in expensive hardware, software, and training, data sharing complications as a result of HIPAA compliance, and lack of guidance for behavioral health providers on EHR suitability.

For next steps, the Commission intends to evaluate ways to address these barriers. Mr. Pervin and Ms. McMullen provided several suggestions, including incentive payments for EHR adoption, Section 1115 behavioral health demonstrations, enhanced federal match rates for behavioral health information technology, and use of authorities under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act to promote EHR adoption.

Commissioners' Comments

One Commissioner suggested the Commission review privacy and HIPAA concerns with data sharing, since these privacy concerns tend to be a major barrier when it comes to behavioral health providers sharing sensitive client data. Commissioners said that care segmentation for beneficiaries with co-occurring conditions remains an issue, and the Commission intends to do further research on this topic going forward.

Session 6: Draft Chapter: Mandated Report on Non-Emergency Medical Transportation

MACPAC staffers Kacey Buderi and Aaron Pervin discussed key findings from MACPAC's congressionally-mandated study on non-emergency medical transportation (NEMT) and gave an overview of the topics included in the Commission's upcoming draft chapter on the topic. For a detailed overview of study methodology and the Commission's past work on this topic, see Viohl & Associates' past MACPAC summaries.

MACPAC's study of NEMT found that:

- NEMT plays a vital role in facilitating access to care for beneficiaries that utilize it, although the portion of Medicaid beneficiaries that utilize NEMT is relatively small;
- The extent to which NEMT programs meet the needs of beneficiaries varies widely across states and within states;
- States and other entities that administer NEMT benefits are engaged in efforts to improve program administration and integrity and beneficiary satisfaction;
- The needs and use of NEMT may be affected by changes in the use of telehealth, although the long-term effects of telehealth expansion are unclear and will require more data, and;
- NEMT is likely to continue to play a central role in helping beneficiaries' access care, especially when that care must be provided in person.

In addition to these key findings, Ms. Buderi and Mr. Pervin also reviewed NEMT topics that will be included in the upcoming draft chapter. MACPAC's chapter will include information about how NEMT enables access to healthcare by overcoming transportation-related barriers, characteristics of beneficiaries that use NEMT, an

overview of the kinds of medical services accessed through NEMT, an overview of NEMT delivery models, and other notable statistics to be reviewed by Congress.

MACPAC's draft chapter will also review issues with NEMT, including performance issues, state NEMT policies that create difficulties or access barriers for beneficiaries, coordination issues with other federally-funded transportation services, technological barriers in NEMT, and program integrity issues.

Ms. Buderi and Ms. Pervin noted that MACPAC's study ultimately concludes that NEMT provides a significant value to beneficiaries who utilize the benefit by helping them maintain their physical and mental health and promoting independence. They noted the study also concludes that some analyses of NEMT show cost savings or return on investment for the benefit. For next steps, they suggested the Commission could examine how the COVID-19 pandemic impacted NEMT and collect more information to study how increased access to telehealth affects NEMT utilization.

Commissioners' Comments

Commissioners' comments were brief. One Commissioner expressed interest in further studying the impact of NEMT on the dually-eligible Medicaid population. Commissioners encouraged staff to further investigate how use of telehealth and technology will impact access to care and utilization of NEMT services.

Session 7: Progress on Rebalancing: Lessons from the States

MACPAC Staffers Kristal Vardaman and Tamara Huson presented on federal and state government' efforts to rebalance Medicaid LTSS spending from institutional care to home- and community-based services (HCBS). They reviewed a study conducted by RTI International under contract by MACPAC, and raised policy considerations for supporting rebalancing efforts. Ms. Vardaman and Ms. Huson explained that rebalancing LTSS funding away from institutional care and toward HCBS has been a federal and state goal for decades. They noted that Medicaid programs have been spending more on HCBS than institutional services since fiscal year (FY) 2013, but that the percentage of Medicaid LTSS spending on HCBS varies considerably by state.

To support rebalancing, Ms. Vardaman and Ms. Huson explained that the federal government has been providing enhanced funding and technical assistance to states. MACPAC's study with RTI International explores additional ways the federal government can support state rebalancing efforts and examines the ongoing rebalancing efforts in states where HCBS spending remains under 50 percent of total LTSS spending.

MACPAC contracted with RTI International to identify factors that limited rebalancing in states where HCBS spending still makes up less than half of total LTSS spending, synthesize new strategies for the federal government to support rebalancing efforts, and to examine if any flexibilities introduced by states in response to the COVID-19 pandemic helped to expand access to HCBS in states with less developed HCBS systems.

To conduct this study, RTI International held structured interviews with state-level and national stakeholders from government, beneficiary advocacy organizations, provider organizations, and other experts in five states (Louisiana, Mississippi, New Jersey, North Dakota, and West Virginia). HCBS spending was below 50 percent as a proportion of total LTSS spending in FY 2016 for all five of these states.

Key findings emerged from RTI's International's study:

- Common barriers to rebalancing include constrained state capacity for HCBS program administration, lack of affordable and accessible housing, and LTSS workforce shortages. The study also found evidence that Medicaid has a structural bias toward institutions;
- States with relatively low levels of rebalancing face challenges common to all states, including a lack of executive and legislative champions for HCBS and nursing home industries that wield strong political influence;
- Several opportunities to further support rebalancing exist, including introducing presumptive Medicaid eligibility for HCBS, making the Money Follows the Person program and the Balancing Incentive Program permanent, assisting nursing facilities in diversifying their services, providing HCBS in alternative housing settings, and supporting HCBS workforce development, and;

- States found value in newly-introduced federal flexibilities in response to COVID-19. Increased use of assistive technologies and telehealth created new opportunities for access, but virtual service delivery still faces limitations.

Building on the findings from this study, Ms. Vardaman and Ms. Huson raised policy questions and considerations to be further explored by the Commission. They suggested that the Commission could further explore policies to address LTSS workforce shortages, the lack of access to affordable housing, and low levels of spending on rebalancing for people with behavioral health conditions. For next steps, MACPAC will explore design issues and costs associated with making HCBS benefits more available, examine issues related to LTSS eligibility policies, and monitor guidance on the HCBS settings rule and the results of CMS and state compliance assessment.

Commissioners' Comments

Commissioners felt that the policy considerations identified by Ms. Vardaman and Ms. Huson warranted further study, and instructed the staffers to move forward with their research.

Session 8: Ensuring Quality in Medicaid and CHIP

MACPAC staffers Joanne Jee and Naomi Shin reviewed Medicaid and CHIP managed care quality requirements, quality improvements, and quality measurements conducted by states, health plans, and CMS. They also summarized early findings from state performance measures.

Ms. Jee and Ms. Shin began by reviewing quality requirements and performance measures faced by Medicaid managed care organizations, including 42 CFR Subpart E regulations, state quality strategies, managed care entity quality assessment programs, performance improvement programs (PIPs), and external quality reviews. They noted that quality requirements can sometimes vary by state as states implement their own quality measures. Ms. Jee and Ms. Shin also noted that state Medicaid programs have pursued a variety of different quality improvement initiatives in specific areas, including maternal health, oral health, asthma, health disparities, treatment of substance use disorders, and value-based payments.

Following this review, Ms. Jee and Ms. Shin discussed preliminary data from state performance data on core set measures, analyzing performance improvements from 2017-2019. Data tables can be found in slides 6-8 of Ms. Jee and Ms. Shin's presentation. Data was collected through state Medicaid performance improvement programs and reporting of early and periodic screening, diagnostic, and treatment (EPSDT) rates.

The data suggests that the results of Medicaid PIPs are mixed. Ms. Jee and Ms. Shin explained that in some areas there was marginal improvement, but that current data ultimately shows that PIPs are not achieving significant and sustained improvement in outcomes and satisfaction. Analyses of EPSDT rates show a similar trend.

For next steps, Ms. Jee and Ms. Shin suggested that the Commission could consider making updates to MACPAC's quality chapter in their upcoming June report and take a closer look at the role of external quality review organizations. They also suggested additional research on the effectiveness of PIPs, addressing persistent healthcare disparities, and improving care for beneficiaries with complex health care needs.

Commissioners' Comments

Commissioners agreed that more analysis and research needed to be conducted in the areas highlighted by Ms. Jee and Ms. Shin, and noted that making substantive quality improvements in state Medicaid programs will remain a high priority for the Commission.

Session 9: Votes on Recommendations for June 2021 Report to Congress

MACPAC Commissioners voted on recommendations for their upcoming June report to congress covering the topics the Commission explored in the previous months. All six recommendations were approved by large majorities. The recommendations and the vote totals for each are listed below.

High-Cost Specialty Drugs

Recommendation 1: Congress should amend Section 1927(c)(1) of the Social Security Act to increase the minimum rebate percentage on drugs that receive approval from the U.S. Food and Drug Administration through the accelerated approval pathway under Section 506(c) of the Federal Food, Drug, and Cosmetic Act. This increased rebate percentage would apply until the manufacturer has completed the postmarketing confirmatory trial and been granted traditional FDA approval. Once the FDA grants traditional approval, the minimum rebate percentage would revert back to the amount listed under Section 1927(c)(1)(B)(i). **Yes: 16; No: 1; Abstain: 0**.

Recommendation 2: Congress should amend Section 1927(c)(2) of the Social Security Act to increase the additional inflationary rebate on drugs that receive approval from the U.S. Food and Drug Administration through the accelerated approval pathway under Section 506(c) of the Federal Food, Drug, and Cosmetic Act. This increased inflationary rebate would go into effect if the manufacturer has not yet completed the postmarketing confirmatory trial and been granted traditional FDA approval after a specified number of years. Once the FDA grants traditional approval, the inflationary rebate would revert back to the amount typically calculated under Section 1927(c)(2). **Yes: 16; No: 1; Abstain: 0**.

Behavioral Health Services for Adults

Recommendation 1: The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration to issue joint sub-regulatory guidance that addresses how Medicaid and the state Children's Health Insurance Program can be used to fund a crisis continuum for beneficiaries experiencing behavioral health crises. **Yes: 17; No: 0; Abstain: 0.**

Recommendation 2: The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in crisis in real-time. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of crisis services. **Yes: 17; No: 0; Abstain: 0.**

Behavioral Health Services for Children and Adolescents

Recommendation 1: The Secretary of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to issue joint sub-regulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and the state Children's Health Insurance Program. **Yes: 17; No: 0; Abstain: 0.**

Recommendation 2: The Secretary of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to provide education and technical assistance to states on improving access to home- and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and the state Children's Health Insurance Program. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services. **Yes: 17; No: 0; Abstain: 0.**

Session 10: Update on Transformed Medicaid Statistical Information System

MACPAC staffers Aaron Pervin and Chris Park presented an update on the effort to improve data quality of the Transformed Medicaid Statistical Information System (T-MSIS). This presentation is a continuation of the Commission's earlier work on this topic, which was presented at MACPAC's October 2019 public meeting.

T-MSIS is the only federal Medicaid data source for individual beneficiary-level information on eligibility, demographics, service use, and spending. As of February 2021, all states and two territories are regularly submitting data to T-MSIS. Mr. Park and Mr. Pervin explained that since calendar year 2016, the quality of the data available on T-MSIS has steadily improved as more states have begun submitting data for different

beneficiary categories each year. They noted that as T-MSIS data has improved, T-MSIS has been increasingly used in the Commission's policy analyses, including MACPAC's 2020 MACStats book and their mandatory report to Congress on NEMT.

However, Mr. Park and Mr. Pervin also explained that T-MSIS is more reliable for particular categories. For example, larger, aggregated categories like total enrollment and total spending statistics on T-MSIS are more accurate than enrollment data for specific eligibility groups or spending for specific service categories. This is because larger categories allow for spending adjustments to match data reported by states on Form CMS-64.

Mr. Park and Mr. Pervin said additional improvements must be made to improve T-MSIS' accuracy on more specific categories of data, like population-specific or service-specific data. For these categories, CMS cannot make similar easy adjustments to match data on CMS-64 forms. Mr. Park and Mr. Pervin further explained issues with example data categories on slides 9-10 of their presentation.

Additionally, Mr. Park and Mr. Pervin explained that there is more work to be done to validate and improve encounter data. Although more and more states are submitting encounter data than in 2019, in some cases not enough plans in a state are reporting sufficient encounter data to put together a complete data set for a state (for example, CMS identified eight states as having inpatient encounter data that is either a "high concern" or "unusable").

Mr. Park and Mr. Pervin then discussed ongoing analytical challenges and gaps in T-MSIS data. For example, data on race and ethnicity is frequently reported as unknown or missing to T-MSIS. Further, T-MSIS only contains data from eligibility records and claims, which does not cover information only available through surveys, like measures of unmet need and beneficiary satisfaction.

Mr. Park and Mr. Pervin noted that going forward, T-MSIS data will be used in a variety of applications, including the 2021 edition of MACStats that will be released later this year, updates to the data book for beneficiaries dually eligible for Medicare and Medicaid, analysis of the Money Follows the Person Program, and analysis of utilization of preventive services among beneficiaries with a behavioral health diagnosis. For next steps to improve T-MSIS, MACPAC will assess the completeness and accuracy of additional data categories submitted to T-MSIS.

Commissioners' Comments

Commissioners encouraged MACPAC staff to continue to assess the accuracy and completeness of T-MSIS data, since they noted that data is a crucial component for identifying and addressing issues in Medicaid. One Commissioner noted that improving ethnic and racial reporting remains an ongoing priority for the Commission, since accurate data on race and ethnicity will be necessary for addressing persistent disparities in healthcare.

Session 11: Panel Discussion: What States are Learning from Expanded Use of Telehealth

MACPAC staffers Joanne Jee and Michelle Millerick moderated a panel discussion with state Medicaid officials on what states are learning from expanded telehealth flexibilities introduced in response to the COVID-19 pandemic, and what telehealth policies in the Medicaid program should look like after the public health emergency (PHE) concludes. Panelists included Dr. Chethan Bachireddy, chief medical officer at the Virginia Department of Medical Assistance Services, Dr. Tracy Johnson, Medicaid director for the Colorado Department of Health Care Policy and Financing, and Dr. Sara Salek, chief medical officer for the Arizona Health Care Cost Containment System (AHCCCS). Commissioners' comments and questions throughout the panel discussion are incorporated in the summary below.

Dr. Bachireddy argued that COVID-19 demonstrated the ability of telehealth to ensure equitable access to care. He noted that since the start of the start of the PHE, use of telehealth in Virginia Medicaid has risen over 15-fold, with the largest volume of telehealth services being used to address the needs of beneficiaries with behavioral health and substance use disorders. As a result of positive outcomes resulting from telehealth expansion, Dr. Bachireddy explained that state lawmakers in Virginia are increasingly interested in continuing to expand telehealth by removing restrictions on telehealth originating sites and authorizing new telehealth modalities.

For future efforts to expand telehealth, Dr. Bachireddy identified some key goals for policymakers and areas for possible federal policy development. He argued that ensuring equitable access to care while maintaining service quality must be a central goal of telehealth policy. He also suggested policymakers should aim to increase and sustain providers' willingness to offer services via telehealth by establishing appropriate incentives and providing regulatory certainty. To achieve these goals, Dr. Bachireddy suggested that federal policymakers should support state evaluation of telehealth policies, create standards around audio-only telehealth billing, issue guidance on how Medicaid agencies can more effectively address telehealth infrastructure, and provide funding for value-based payment models.

Dr. Johnson described changes to Colorado's telehealth policies as a result of the COVID-19 pandemic and highlighted priorities for Colorado's lawmakers considering permanent changes to telehealth policies going forward.

Dr. Johnson explained that since the start of the PHE in March 2020, Colorado expanded coverage of telemedicine to include the telephone-only modality for certain health services and expanded telehealth for federally qualified health centers, rural health clinics, Indian health services, and community mental health services. Providers were also made able to provide physical therapy, occupational therapy, home health, hospice, and pediatric behavioral health services remotely. Payment parity was established as Colorado policy expanding telehealth required reimbursement for telemedicine services as the same rate as in-person services.

Dr. Johnson also noted that expanding telemedicine has helped improve access to care and health care equity for many populations. Children, adults with opioid dependence, generalized depression and anxiety, and chronic diseases, and adults with disabilities were the most frequent users of telehealth in Colorado.

Going forward, Dr. Johnson said state policymakers will focus on distinguishing between emergency-only and permanent policies, monitoring access, quality, equity, costs, and utilization of telehealth services, monitoring federal policy changes, and aligning payment policies.

Dr. Salek reviewed telehealth policy changes in Arizona and described policy considerations for Arizona policymakers. She noted that Arizona began expanding telehealth before the pandemic in October of 2019. Policymakers broadened regulations on the allowable place of service for distant and originating sites and broadened coverage for telemedicine, remote patient monitoring, and asynchronous telehealth services. Policymakers also gave Medicaid managed care organizations the flexibility to manage their own networks and leverage telehealth strategies.

Dr. Salek explained that since the beginning of the pandemic AHCCCS continued to pursue changes to telehealth policy and monitor the progress of existing changes. AHCCCS held multiple provider and stakeholder forms, created a temporary code set for services delivered via telephone, and added multiple codes for services delivered virtually.

Dr. Salek concluded by highlighting key considerations for Arizona policymakers as they plan for after the PHE ends. She said policymakers will have to evaluate the clinical appropriateness of utilizing telehealth for some services, the impacts of telehealth expansion on access, and the availability of high-speed internet and its effect on healthcare equity in telemedicine. Dr. Salek noted that current AHCCCS telehealth flexibilities are extended through September 2021, and that AHCCCS intends to make a final decision on which flexibilities to make permanent by July 2021.