Highlights from MACPAC September 2020 Public Webcast Meeting

Overview

On September 24-25, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its September 2020 public meeting. Due to the ongoing COVID-19 pandemic, this public meeting was hosted virtually. This summary includes highlights from all 11 meeting sessions. Presentation slides can be found on the MACPAC website.

Session 1: Estimating the Effects of a Prototype Countercyclical Financing Adjustment for Medicaid

Following up on earlier discussions from the Commission's April Public Meeting (see Viohl and Associates' summary here) MACPAC staffer Moira Forbes discussed MACPAC's latest research on introducing a counter-cyclical funding mechanism to provide states with an enhanced Federal Medical Assistance Percentage (FMAP) during economic downturns.

Background

MACPAC staff analyzed a prototype countercyclical funding model proposed by the Government Accountability Office (GAO) in 2011. Using the GAO model as a basis for a permanent countercyclical mechanism, MACPAC tested the model using data from January-June 2020 to find if such a model would be timelier and more effective than the typical Congressionally-authorized increases to the FMAP. The Commission reasoned that if the model was effective, it would trigger a substantial increase in the FMAP as a result of the economic slowdown caused by the COVID-19 pandemic reflected in the January-June data.

The GAO model utilizes unemployment data from the Bureau of Labor Statistics and the Bureau of Economic Analysis to compare each state's three-month employment-to-population ratio to the prior year, triggering an FMAP increase if there is a decline over two consecutive months in 26 states or more. The magnitude of the increase is determined by some state-level factors, including increases in state unemployment and reductions in total wages and salaries. FMAP returns to normal levels if fewer than half the states experience a decline over two consecutive months.

Findings

Based on January-June 2020 data, most states would receive an FMAP increase between 2-6 percentage points under the GAO model for the fourth quarter of Fiscal Year (FY) 2020. This FMAP increase would reduce FY 2020 state spending for all states between 1 and 4.8 percent compared to the baseline. However, the Families First Coronavirus Response Act, which included a congressionally-authorized increase to the FMAP, provided more fiscal relief to states than the GAO model, providing a longer period of assistance and a greater FMAP increase for most states.

Based on these findings, the Commission highlighted the pros and cons of utilizing a countercyclical financing mechanism like the GAO model. They noted that, an automatic FMAP adjustment does not depend on congressional action, possibly speeding crucial fiscal relief for states and removing any potential political obstacles. The GAO model also maintains assistance until the majority of states show improvement in unemployment levels, rather than relying on a fixed point in time (like the relief bill did) potentially helping financial assistance be more accurately tailored to an economic slowdown. However, as evidence from MACPAC's test using January-June 2020 data, FMAP increases could be slower-acting due to lags in data. Also, depending on a fixed formula means FMAP increases are dependent on some particular state-specific data points, so some states may not receive as much assistance as they would under a congressionally-authorized FMAP increase.

Commissioners' Comments

In their comments, Commissioners suggested further areas of research for designing an effective countercyclical mechanism for FMAP increases, including the potential inclusion of new factors in an ideal countercyclical mechanism. For example, one Commissioner noted that the GAO model does not account for changing medical costs. Another Commissioner noted that the pandemic-caused recession is unique because it caused a large number of government-employee furloughs, which the model also does not account for.

Generally, Commissioners agreed that the MACPAC's research on the GAO model should be published, and that the GAO model serves as a good baseline for MACPAC's future recommendations.

Session 2: Relief Funding for Medicaid Providers Affected by the COVID-19 Pandemic

MACPAC staffers Michelle Millerick and Robert Nelb discussed the Federal government's ongoing effort to provide financial relief for healthcare providers during the COVID-19 pandemic.

Background

Many providers are facing serious financial difficulties as a consequence of the COVID-19 pandemic. Providers are facing increased costs due to new measures intended to prevent the spread of COVID-19, decreased revenue as a result of patients deferring care, and new expenses associated with treating patients with COVID-19. Although telehealth has offset some revenue losses, providers are still not breaking even. Providers with a high share of Medicaid patients face added challenges including narrow operating margins that existed before the pandemic, serving populations disproportionately affected by the pandemic, and reliance on states experiencing their own funding challenges.

Federal Relief Efforts

The CARES Act and the Paycheck Protection Program and the Health Care Enhancement Act created a $175 billion fund to cover pandemic expenses and lost revenue, but that money has yet to be fully distributed. During "Phase 1" of distribution, funds were disbursed to Medicare-enrolled providers, hospitals, nursing facilities, and rural and tribal providers. Phase 2 funds are being distributed to Medicaid and CHIP providers, dentists, and assisted living facilities not eligible for Phase 1 general distribution. However, a lag in the collection of Medicaid provider enrollment data and other eligibility and processing issues have caused delays for providers attempting to apply for Phase 2 funds. According to MACPAC's data, about 38% of Medicaid and CHIP providers are potentially eligible. Details about distributed funding amounts and estimated distribution of relief funds can be found on slides 6-9 of MACPAC's presentation.

States and local governments are using other CARES Act funds to provide additional relief to providers. For example, the CARES Act authorizes $150 billion in grants for expenses related to the public health emergency, including costs that are not health-related. MACPAC plans to continually monitor federal relief funding as more data become available. The Commission will also further explore utilizing Medicaid authorities to secure additional funding and ensure the financial stability of Medicaid providers.

Commissioners' Comments

One Commissioner noted that providers may face a second wave of financial distress after the pandemic when the FMAP ends and federal funding returns to its normal levels. The Commissioner expressed their belief that MACPAC should continue to monitor providers' situation given that their financial distress could impact access and capacity. Another Commissioner suggested MACPAC further explore opportunities for providers to incorporate value-based or up-front payments in their practices. Commissioners agreed that MACPAC should continue to monitor this situation, confirm what barriers the federal government faces in providing relief to providers, and communicate with states to find where states could benefit from the Commission making additional recommendations with respect to Medicaid funding authorities.

Session 3: Medicaid's Response to COVID-19

MACPAC originally discussed flexibilities states were using in response to the COVID-19 pandemic during their April Public Meeting (see Viohl and Associates' summary here). Following that meeting, the Commission explored which of these flexibilities, if any, states should permanently retain. MACPAC sent letters to states regarding the provider relief fund and the public health emergency, cataloged Medicaid changes to state telehealth policies, and created a webpage on Medicaid's response to COVID-19. MACPAC staffer Joanne Jee presented on the Commission's work and findings so far.

Updates on Medicaid's Response to COVID-19

Rapid expansion of telehealth flexibilities was a key characteristic of states' Medicaid response to COVID-19. Providers quickly exercised these new flexibilities, with many states seeing a large increase in the use of

telephonic health and tele-behavioral health services. Many states also increased their use of telehealth technologies in Substance Use Disorder and Opioid Use Disorder treatment. Some states, including New York and Ohio, put into place new rules supporting continued use of telehealth after the pandemic. While the expansion of telehealth services has been well-received, states considering permanent expansion of telehealth will need to consider how to ensure equitable access to telehealth services, the privacy limitations of telehealth, and other long-term considerations.

States have also exercised new emergency flexibilities for long-term services and supports during the pandemic. Some states have expressed interest in retaining these emergency flexibilities granted by the Center for Medicaid and Medicare Services (CMS), including self-attestation for HCBS and further flexibility on retainer payments.

Additional Medicaid flexibilities related to closing ethnic and racial disparities in COVID-19 health outcomes remain a central focus of the Commission. MACPAC will also investigate disparities between dually-eligible beneficiaries and Medicare-only beneficiaries (currently, dually-eligible beneficiaries have more cases and hospitalizations than Medicare-only beneficiaries).

Commissioners' Comments

Commissioners agreed that MACPAC should continue to survey states for information on which flexibilities would be beneficial to maintain, and agreed that states should remain mindful of how increased flexibilities will affect state budgets, access, and health outcomes. MACPAC Chair Melanie Bella suggested MACPAC further discuss state Medicaid authorities and flexibilities with expert organizations like the National Association of Medicaid Directors (NAMD), the National Governors Association (NGA), and Advancing States to prepare to make a recommendation to Congress.

Session 4: Update on Medicaid Estate Recovery Analyses

As a continuation of MACPAC's work on Medicaid Estate Recovery Analysis (see MACPAC's 2015 Issue Brief and MACPAC's presentation at their December 2019 Public Meeting) MACPAC staffers Kristal Vardaman and Tamara Huson discussed MACPAC's analysis of Medicaid estate recovery policies.

Background

For certain categories of Medicaid beneficiaries, including those who were permanently institutionalized, those who received Medicaid when they were age 55 or older, or those who held long-term care insurance policies under certain circumstances, Medicaid recovers assets from those beneficiaries' estates as reimbursement for care provided to them. Current policy requires states to seek asset recovery for reimbursement of nursing facility services, HCBS, and hospital services and prescription drugs related to a nursing facility stay or while receiving HCBS. States must recover some or all of the payments for these benefits when they are provided through managed care. Some exemptions apply; for example, states must exempt or defer recovery if a beneficiary has a surviving spouse and must have a process to grant hardship waivers.

As part of their nationwide analysis of Medicaid estate recovery policies, MACPAC reviewed state plans for 38 states and the District of Columbia, analyzed the aggregate amounts collected by states, and surveyed a sample of 15 states for information about the size of estates, the number of hardship waivers processed and granted, and program administration costs.

Findings

From their review of state plans, MACPAC discovered that information on hardship waivers is difficult to compare across states. For example, some states use CMS sample criteria while some use their own criteria. Cost-effectiveness of estate recovery also varies between states. While many states pursue any estate where the amount of the recovery exceeds administrative costs, others use specific thresholds (i.e. $500 or $1,000).

According to MACPAC's analysis of aggregate collections, Medicaid programs reported collecting approximately $733.4 million from beneficiary estates in FY 2019. These recoveries accounted for a small percentage of national Medicaid fee-for-service LTSS spending (0.53%-0.62% from FY 2015-2019).

To date, only six out of 15 states completed MACPAC's survey of estate recovery programs. According to data from that survey, the national average recovery amount per estate ranged from $2,768 to $71,556, but generally, states that recovered from fewer estates had higher average recovery amounts. Survey data from three out of the six responding states showed few hardship applications were processed (ranging from 27-89 among those states) and fewer were granted (ranging from 17-41 among those states). Administrative costs for recoveries were typically under 10% of the total amount recovered.

Ongoing Concerns and Policy Considerations
MACPAC remains concerned with the potential "chilling effect" estate recovery policies can have on beneficiaries' use of LTSS, reasoning that estate recovery policies could deter individuals from seeking LTSS if they wish to protect their assets to pass on to their heirs. The state survey showed that two interviewees said some people chose to forgo Medicaid services for this reason.

Currently, MACPAC is analyzing and considering four potential reforms to Medicaid's estate recovery policy.

- First, Congress could eliminate or limit assets subject to estate recovery; this could address the "chilling effect" at the cost of forgone revenue.
- Second, Congress could eliminate the mandate for states to pursue estate recovery and replace the mandate with a state option; this could grant states additional flexibility and address the "chilling effect", but also could cost some states revenue. Such a policy would also lead to increased variation in estate recovery policies among states.
- Third, through regulatory or subregulatory action, CMS could allow managed LTSS states to pursue estate recovery to reimburse costs of care; this could allow states to pursue recovery based on the actual cost of care rather than all (or a portion of) the capitation payment, but would require additional cost information from plans.
- Fourth, CMS could establish federal standards for hardship waivers. This could also be done through regulatory or subregulatory action, and could potentially address the "chilling effect" as well as some equity concerns.

MACPAC will continue to discuss these potential policy recommendations and follow up on the work presented in the December Public Meeting by pursuing additional survey results and stakeholder views.

Commissioners Comments
Commissioners agreed that gathering additional data, including more stakeholder input, would be beneficial before making a policy recommendation. Commissioners debated the four policy options, and ultimately emphasized caution in considering the fiscal and equity impacts of recommending a particular policy option.

Session 5: Medicaid Drug Rebates and Medications Used for Opioid Use Disorder

MACPAC Staffers Erin McMullen and Chris Park presented on how drugs used to treat Opioid Use Disorder (OUD) are handled by the Medicaid Drug Rebate Program (MDRP), highlighting a new technical problem with the program and proposing a potential solution.

Background
Under the SUPPORT for Patients and Communities Act, all state Medicaid programs must cover all medications used for Opioid Use Disorder (OUD) for a five-year period beginning October 1, 2020. Covered drugs under this policy include methadone, buprenorphine, and naltrexone. While prescription drugs are an optional benefit under the Medicaid statute, all states offer a prescription drug benefit, and those drugs are included in the MDRP. If a drug is eligible for the MDRP, Medicaid receives a rebate in exchange for covering all of a participating manufacturer's drugs. Outpatient prescription drugs are typically covered by the MDRP, unless provided as part of another service and paid under a bundled payment.

Definitional Issue, and Potential Solution
A key definitional issue arose with how the MDRP is applied to drugs for treating OUDs. While the definition of "covered outpatient drug" used by the MDRP specifically references drugs covered under Section 1905(a)(12) of the SUPPORT Act, as of October 1, 2020, coverage under the new mandatory benefit will exclude drugs used

to treat OUDs from the MDRP. This change was unintended. As a result, OUD drugs will not be eligible for statutory rebates, drug utilization review will not be required for OUD drugs, and OUD drugs will no longer be covered by the 340B program.

To rectify this unintended problem the Commission could recommend a change in the definition of "covered outpatient drug" under the MDRP to cross reference coverage of OUD drugs in 1905(a)(29) of the SUPPORT Act. In doing so, OUD drugs would once again be eligible for rebates. The Commission could also recommend the change be retroactive and therefore applied to any OUD drugs used after October 1.

Commissioners' Comments

Commissioners agreed it was important for the Commission to ensure individuals recovering from OUDs face as few barriers as possible to getting their medications, especially if they are Medicaid beneficiaries beginning to transfer off the program. While Commissioners agreed that writing such a recommendation as suggested by Ms. McMullen and Mr. Park would likely fix the problem, one Commissioner noted that the Senate was working on a bill to address the issue, and suggested that the Commission wait on making a recommendation until it was clearly necessary.

Session 6: Behavioral Health in Medicaid

MACPAC staffers Melinda Becker Roach and Erin McMullen presented on MACPAC's policy questions related to behavioral health policy challenges in Medicaid and the Commission's current analytic plan for addressing them. Ms. Roach and Ms. Mc Mullen also presented findings from the State Health Access Data Assistance Center's (SHADAC) 2020 study of non-institutionalized adults with mental illness to help inform MACPAC's future work on behavioral health.

Background

MACPAC currently has four upcoming projects related to analyzing mental health in Medicaid. The projects will examine access to mental health services for adults, access to behavioral health services for children, electronic health record (EHR) use among behavioral health providers, and mental health parity implementation. Each of these four projects is framed by key policy questions and accompanied with an analytic plan to address them.

Policy Questions and Analytic Plans

In examining mental health services for adults, the Commission hopes to address three key benefit coverage questions. First, what services do states cover? Second, what Medicaid authorities are states using to cover mental health services? And finally, are any federal policy changes needed? To address these three questions, MACPAC will conduct a study examining the prevalence of mental illness among adults and treatment rates for these illnesses, develop a 50-state coverage inventory, assess provider participation in providing mental health services for adults, and engage stakeholders in a panel discussion.

Three critical policy questions will also frame MACPAC's analysis of children's behavioral health services. First, are behavioral health services for children accessible? Second, in addition to the Early and Periodic Screening, Diagnostic, and Treatment benefit, what Medicaid authorities are states using? And third, are federal policy changes needed? To explore these questions the Commission will pursue a plan that is similar in approach to its examination of adult mental health. The Commission intends to examine prevalence and treatment rates, assess provider availability and convene a stakeholder panel.

Two policy questions loom large in MACPAC's analysis of behavioral health and EHRs. First, how did the Health Information Technology for Economic and Clinical Health (HITECH) Act increase the use of certified EHR technology? Second, what federal mechanisms can behavioral health facilities use to promote EHR interoperability? To answer these questions, the Commission will examine federal policies intended to strengthen EHR adoption, analyze trends in adoption, and identify new policy options to expand adoption.

MACPAC aims to explore four policy questions related to Mental Health Parity. First, what barriers exist to implementation of mental health parity? Second, how is compliance assessed? Third, how has parity affected

access? Fourth, are federal policy changes needed? To analyze these questions, MACPAC will conduct stakeholder interviews in three states and with CMS officials and national organizations.

Findings: Non-Institutionalized Adults with Mental Illness
SHADAC's study of non-institutionalized adults provides needed context for MACPAC's future work on behavioral health. Key statistics highlight ongoing issues and will guide the Commission's work. Some findings also help answer MACPAC's current policy questions. The study uses self-reported data from the National Survey on Drug Use and Health.

SHADAC's study found that on average, 21% of adults ages 18-64 suffered from some form of mental illness. Notably, adults with private insurance coverage were found to be slightly below this average, with only 18.7% of individuals suffering from some mental illness while individuals on Medicaid were found to be above the average, with 27.6% of individuals suffering from some mental illness. Exploring this disparity will be a central focus of MACPAC's work on adult mental health.

SHADAC's study also found that, when compared to those with private insurance, adult Medicaid beneficiaries with mental illness were almost twice as likely to report that they had ever been arrested or "booked" for breaking the law, and more than three times as likely to report that they were on probation or parole in the past year. Rates were higher still for individuals reporting serious mental illness. This disparity will be a focus of MACPAC's future analysis.

Commissioners' Comments
Commissioners noted that data from the SHADAC study suggests a need for future analysis of coverage gaps and other barriers to access of mental health treatment. They also noted it should be a central focus of the Commission to further explore how disparities among racial and ethnic groups factor into the discussion. Commissioners also agreed that ongoing policy questions and SHADAC data suggest a need for greater coordination of care, especially among adult beneficiaries.

Session 7: Federal Data Sources for Analyzing Racial and Ethnic Disparities in Medicaid and CHIP
As a part of MACPAC's commitment to addressing institutional racism and racial disparities in health care, MACPAC's Executive Director Anne Schwartz presented on the availability of information on race and ethnicity of Medicaid beneficiaries in federal administrative data and household surveys, and suggested options for improving federal data.

Background
Currently, two policies govern federal standards for data pertaining to race and ethnicity. Federal standards set by the Office of Management and Budget (OMB) in 1997 specify that data on race and ethnicity must be collected via self-identification, that when collecting data, race and ethnicity must be separated into two unique categories, and that respondents must be able to select more than one option in each category when responding to surveys. OMB standards also establish a minimum five categories for race, and two minimum categories for ethnicity (Hispanic or Latino vs. not Hispanic or Latino). The Affordable Care Act (ACA) set additional requirements for federal data, requiring collection of data on sex, primary language and disability status for continuing evaluation and reports to Congress.

Issues with Administrative and Survey Data
One source of federal data on race and ethnicity is from Medicaid applications that are compliant with federal standards. Analysis of 2018 Transformed Medicaid Statistical Information System (T-MSIS) data shows high rates of missing or unknown data, and clear data discrepancies (i.e. some states reported 0% of their population identified as Hispanic). MACPAC also uses data from the National Health Interview Survey, the National Survey of Drug Use and Health, the National Survey of Children's Health, and other surveys to collect data on race and ethnicity. However, in many cases, sample sizes are insufficient for specific subgroup and state-level analyses.

Commissioners' Comments
One Commissioner noted that one reason for low rates of self-reporting of racial and ethnic information in Medicaid applications may be that enrollees have doubts about how the data will be used. He suggested that

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building trust in communities of color and addressing privacy concerns could be a way to help improve federal data from applications. Commissioners expressed their interest in continuing to pursue ways to address structural inequities and institutional racism in health care. One Commissioner also expressed his interest in recruiting more diverse voices to the Commission.

Session 8: Integrating Care for Dually Eligible Beneficiaries through Medicare-Medicaid Plans: Panel Discussion

Following up on policy discussions surrounding integrated care that MACPAC conducted in their April 2020, February 2020, January 2020, and December 2019 public meetings (see the Healthcare section of the Viohl & Associates website for summaries), MACPAC staffer Kirstin Blom moderated a panel discussion on the topic of integrating care for dually eligible beneficiaries through Medicare-Medicaid plans. After giving a brief background, Ms. Blom introduced MACPAC's guest panelists, including Tim Engelhardt, Director of the Medicare-Medicaid Coordination Office at CMS, Laura Phelan, Director of Policy for the Illinois Department of Healthcare and Family Services (IDHFS), and Karla Warren, Integrated Care Manager for the Ohio Department of Medicaid.

Background

Medicare-Medicaid Plans (MMPs) are capitated plans under the Financial Alignment Initiative that integrate care for dually eligible beneficiaries. MMPs are not widely available, and participation rates in MMPs are relatively low, with only about 30% of dually eligible beneficiaries enrolling. MACPAC is currently preparing to make a recommendation on integrating care in their March or June report.

Panel Discussion

Mr. Engelhardt highlighted findings from an earlier CMS report that dually eligible beneficiaries are four times more likely to be hospitalized for COVID-19, which he explained underscored the continued importance of focusing on this population.

Mr. Engelhardt noted that CMS has been taking action to improve uptake of, and quality of care in MMPs. He highlighted specific CMS initiatives, including CMS's new proposed rule aiming to eliminate D-SNP "lookalike" plans, a recent Dear State Medicaid Director letter offering states the opportunity to extend their integrated care demonstrations and make programmatic improvements, and added efforts to collect more T-MSIS data to conduct more Medicaid-focused analysis. Although Mr. Engelhardt noted these measures were useful for promoting further integration of care for duals, he explained that enrollment in integrated plans is still "not ultimately where we want it to be", and he invited the Commission to provide further support and guidance for increasing enrollment and improving quality of care.

Ms. Phelan discussed Illinois' decision to extend the Medicare-Medicaid Alignment Initiative (MMAI) demonstration. She explained that dual-eligible special needs plans (D-SNPs) were originally eliminated under Governor Rauner's administration, but that the DHFS ultimately decided not to reintroduce D-SNPs and instead expand the MMAI statewide for two key reasons. First, administrators in the IDHFS felt they had more experience operating under the MMAI, and because of this experience felt that they would be able to provide more opportunities for plans to assist with care coordination and thus successfully expand integrated care. Second, IDHFS-hired actuaries determined the state would save money if it continued the MMAI program, which would allow for lower Medicaid rates than if the state continued with D-SNP plans. Ms. Phelan also explained some operational challenges that impeded DHFS from switching back to D-SNP contracting.

Ms. Warren discussed Ohio's integrated care program, called MyCare Ohio, which has been running for seven years, and it operates in 29 Ohio counties (which include all of Ohio's major cities). About 83,000 beneficiaries are part of the program. One reason for the program's success, according to Ms. Warren, is strong community participation with local area agencies on aging. These partnerships have helped MyCare Ohio connect with individuals receiving LTSS, enabling better coordination of care for individuals who are dually eligible. Ms. Warren said she also believed care coordination was strong in Ohio because of MyCare Ohio's required Medicaid component; under this system, an individual eligible for Medicaid in a MyCare county that meets all eligibility requirements must participate in the MyCare demonstration. So far, MyCare Ohio has showed good results in

independent analyses of their program. Currently, MyCare Ohio is awaiting additional independent analysis from RTI international, a data collection and analysis contractor, so they can determine next steps for the program.

Commissioners' Comments
Commissioners noted that MACPAC was still especially sympathetic to state budgetary and capacity concerns when trying to promote integrated models of care. A key theme from Commissioners' comments was that in order to increase enrollment in integrated products, MACPAC must first identify factors restraining growth in enrollment in integrated models, such as lack of education, fear of leaving fee-for-service, and so on. Another key theme was that lack of data was still a major obstacle to successfully identifying restraining factors. Commissioners suggested that better integration of Medicare and Medicaid data could help. Finally, MACPAC Chair Melanie Bella suggested that the Commission should consider if MMPs should be made permanent. She noted that in some states, like Ohio, demonstrations for MMPs had been extended for several years, so making MMPs permanent could give states additional stability and reason to invest in these plans and programs.

Session 9: State Management of Waiting Lists for Home- and Community-Based Services

MACPAC staffers Tamara Huson and Kristal Vardaman presented information from MACPAC's August 2020 issue brief on how states manage waiting lists for HCBS.

Background
HCBS is not a mandatory benefit, but currently all Medicaid programs provide some HCBS benefit. States cover the HCBS benefit through waivers under Section 1915(c) and Section 1115 of the Social Security Act. These waivers are permitted to have waiting lists. Most states covered HCBS benefits under Section 1915(c) waivers. Only Arizona, Rhode Island, and Vermont use 1115 waivers as their only HCBS authority.

According to a 2018 Kaiser Family Foundation survey, 41 states reported having an HCBS waiting list for at least one population group. Across all states, Kaiser found total waiting list enrollment was 819,886 with an average wait time of 39 months. States each had different methods of managing these waiting lists, including "first come, first served", priority, and so on. A table on slide 7 of MACPAC's presentation gives a detailed breakdown of how waiting lists are managed for Section 1915(c) and 1115 waivers.

Generally, unmet needs of individuals on HCBS waiting lists vary widely. While some individuals are lacking crucial care, some have other supports like family caregivers. Others may also instead choose to receive institutional care. Many individuals on waiting lists receive some other Medicaid services while waiting for HCBS waiver services.

Policy Changes to Reduce or Eliminate Wait Lists
MACPAC's issue brief found that state funding and prioritization of HCBS and support from the Governor or legislature largely influences state waiting list size. Stakeholder surveys from MACPAC's issue brief showed varying stakeholder views on whether state adoption of managed LTSS affects waiting lists.

The need for HCBS continues to grow across many states, leading to ongoing concerns about state capacity and the overall demand for HCBS waiver services. In some cases, provider capacity is a limiting factor. Growing wait lists and demand for HCBS can, in some cases, affect states' ability to meet the needs of individuals with intellectual and developmental disabilities.

To address these challenges, MACPAC will consider how states can rebalance the need for HCBS more effectively. The Commission will also explore potential fundamental changes to LTSS policies; two possible policy avenues include making HCBS a mandatory Medicaid benefit, or creating unique policies for each subpopulation of LTSS users.

Commissioners' Comments
Commissioners generally seemed apprehensive about making HCBS a mandatory Medicaid service. One Commissioner noted the importance of maintaining state flexibility for LTSS management, noting how expensive

HCBS can be for states to provide. Another Commissioner suggested revisiting eligibility criteria for LTSS as a way to reduce waiting lists.

Session 10: Medicaid Coverage of Vaccines

MACPAC staffer Chris Park gave a presentation covering past Medicaid coverage of vaccines, and how the Commission might address current barriers to vaccine access.

Background

The Vaccines for Children (VFC) program initially established Medicaid coverage of vaccinations for children. Under the program, children under 19 years old who are Medicaid-eligible, uninsured, underinsured, or an American Indian or Alaskan Native can receive all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) without cost sharing.

Adult Medicaid beneficiaries in the ACA-expansion population receive essential health benefits (EHB) under Medicaid, which includes mandatory coverage of vaccinations without cost sharing. However, vaccine coverage is not required for other adults who do not receive EHB. States can cover some vaccines in their Medicaid program, but ultimately they do not have to cover all ACIP-recommended vaccinations. This means beneficiaries may experience cost sharing when they get a vaccination. While all states offered some vaccine coverage for Medicaid-enrolled adults in 2018-19, vaccine coverage varied widely by state, with 24 out of 49 states covering all ACIP-recommended vaccines.

States looking to expand Medicaid coverage of vaccines were provided an incentive in the ACA; under the ACA program, the federal government provides a 1% increase in the FMAP on vaccine-related spending if states agree to cover all ACIP-recommended vaccines without cost sharing. Twelve states have implemented this option.

Barriers to Access and Potential Solutions

According to a CDC study, individuals with public insurance generally have lower rates of vaccination than those with private insurance, which may be partially caused by lack of mandatory vaccine coverage. Another contributing factor may be lower provider payment rates in Medicaid, since lower payments may not cover providers' costs.

To improve access to vaccines, MACPAC could pursue several policy options. First, MACPAC could recommend mandatory coverage of all ACIP-recommended vaccines. This would equalize coverage for Medicaid-covered adults and likely improve vaccination rates. Second, MACPAC could recommend additional federal funding for vaccinations; this could take the form of an FMAP increase like the incentive program from the ACA. Third, MACPAC could recommend vaccines be included in the MDRP. Currently, vaccines are excluded as they do not meet the definition of an outpatient drug. Finally, MACPAC could recommend a new federal purchasing program. Already, the federal government is pursing such an option for a potential COVID-19 vaccine with their program "Operation Warp Speed."

Commissioners' Comments

MACPAC Commissioners discussed the policy options suggested in Mr. Park's presentation. MACPAC Chair Melanie Bella noted interest among Commissioners regarding Medicaid coverage of all ACIP-recommended vaccines was "very high", but that the Commission does not yet have enough information to know what recommendation to make. She suggested the Commission could work to have a recommendation for Congress in MACPAC's next June report if interest was still high.

Section 11: Oversight and Accountability for Pediatric Oral Health Services in Medicaid Managed Care

MACPAC staffer Joanne Jee presented findings from work conducted by the National Academy for State Health Policy (NASHP) for MACPAC on oversight and accountability of Medicaid managed care for pediatric oral health services.

Background
The percentage of children (aged 1-20 years old) receiving preventive oral health services drastically increased from 2000 to 2018 from 23% to 48%, respectively. CMS, aiming to further increase the number of children accessing preventive oral health services, established the CMS Oral Health Initiative. The goal of this program was to increase by 10% the percentage of children receiving preventive dental services. The program worked by encouraging states to develop oral health action plans and providing technical assistance to states attempting to achieve quality improvements, introduce VBP, or make other reforms.

NASHP, under the instruction of MACPAC, reviewed contracts, procurement documents, state rules and regulations, and state policy guidance pertaining to pediatric oral health services in Medicaid managed care. They also interviewed state officials, managed care organization (MCO) representatives, and other stakeholders. The study focused on 11 states, four of which had a carved-in pediatric oral health benefit (Arizona, Kentucky, New Mexico, and Pennsylvania) and six of which had carved out the benefit (California, Massachusetts, Nebraska, Tennessee, Texas, and Virginia). One state, New Hampshire, provides services with a fee-for-service model.

Findings
Through their review, NASHP identified several monitoring and oversight approaches utilized by states to improve children's oral health. For example, some states utilize network adequacy standards and provider monitoring, some states require preventive and follow-up visits for certain Medicaid-covered children, and some states have in place beneficiary grievance and appeals processes.

However, MACPAC analysis of NASHP's findings ultimately raised questions about the effectiveness of these monitoring and oversight approaches, highlighting concerns about effective use of state resources, cultural competence, lack of necessary data, and other challenges. MACPAC is interested in exploring new policy "levers" for improvement, including provider incentives, "pay for performance" programs, and beneficiary incentives.

Commissioners' Comments
Commissioners' comments were brief, but Commissioners generally wanted to further examine existing oversight and accountability structures. More research will be done before the Commission makes a recommendation.