Highlights from MACPAC October 2021 Public Virtual Meeting

Overview

On October 28th and October 29th, 2021, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its October 2021 public virtual meeting. This summary includes highlights from all seven meeting sessions. Presentation slides and the agenda for this meeting can be found on the MACPAC website.

Session 1: Panel Discussion: Data Issues in Monitoring Access to care for Medicaid Beneficiaries

MACPAC staffer Ashley Semanskee gave a brief overview of available data used to monitor access to care for Medicaid beneficiaries across three domains: provider availability and accessibility, beneficiary utilization, and beneficiary perceptions and experiences. She reviewed common sources for data in each domain, common issues, and themes from stakeholder interviews conducted by MACPAC on the topic of how to improve data availability for each domain. She then introduced three expert panelists to continue the discussion: Dr. Genevieve Kenney, Co-Director and Senior Fellow in the Health Policy Center at the Urban Institute, Dr. Joseph Caldwell, Director of the Community Living Policy Center at Brandeis University, and Barry Cambron, Deputy Commissioner, Health Systems at the Alabama Medicaid Agency.

Ms. Semanskee explained that provider availability and accessibility data is usually gathered from licensure data, directories, claims, secret shopper audits, and provider surveys. Gaps in this data often arise from the difficulty of measuring other factors, like whether providers are taking new patients, providers' caseloads, wait times, and issues with language and disability accessibility. To improve provider availability and accessibility data, interviewees suggested introducing federal guidance for accessibility standardization, further surveying providers, and additional secret shopper audits.

Ms. Semanskee noted that the Transformed Medicaid Statistical Information System (T-MSIS) is the primary source for beneficiary utilization data. A significant limitation of current beneficiary utilization data is difficulty measuring the appropriateness of care received and health outcomes. To improve beneficiary utilization data, MACPAC interviewees suggested improving T-MSIS data, conducting chart reviews, and utilizing other data sources including Healthcare Effectiveness Data and Information Set (HEDIS) and all-payer claims databases.

Ms. Semanskee also noted that most data on beneficiary perceptions and experiences comes from submitted complaints and grievances, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and qualitative data derived from focus groups and interviews. One limitation of this data is that it can sometimes not be representative of the quality of care or of beneficiary perceptions since it is often anecdotal. To improve data on beneficiary perceptions and experiences, MACPAC interviewees suggested introducing a federal Medicaid survey, identifying key measures, and collecting additional qualitative data.

Panel Discussion

Panelists discussed ways to improve data issues in each domain.

Provider Availability and Accessibility

Dr. Kenney suggested that provider availability and accessibility data could be improved by introducing a mechanism for data contributions from private insurers and by building more transparency and accountability in data collection practices. Dr. Caldwell noted that data has already identified the shortage of direct care workers as a major barrier to provider availability and accessibility, so the Commission should focus on addressing that shortage. He also suggested the Commission revisit the way the U.S. Department of Labor collects HCBS data since it often fails to adequately capture the availability of HCBS providers. Mr. Cambron described provider availability and accessibility data practices in his state, Alabama, and how it could be used as a model for other states should they receive adequate assistance in building data processing capacity. He also suggested revisiting providers' self-reporting processes since they often limit the data that can be collected.

Beneficiary Utilization

Dr. Kenney argued that the federal government should prioritize continued investment in T-MSIS and standardization of coding for services. She also argued that data collectors should prioritize measures that can

be collected through claims and Medicaid services and supplement that data with hospital discharge data. Dr. Caldwell noted that beneficiary utilization data often leaves out service gaps, where beneficiaries are covered for services but not receiving them, and argued that additional data on service gaps could help address key issues for beneficiaries. Mr. Cambron stressed the importance of utilizing data sources other than T-MSIS to target geographic hotspots for specific issues, like childhood obesity, substance abuse, and maternal mortality. He also suggested developing methods to incorporate data gathering into the operations of managed care organizations (MCOs).

Beneficiary Perceptions and Experiences
Dr. Kenney argued that policymakers have underinvested in data collection on beneficiary perceptions and experiences more than other data collection categories. She highlighted issues in beneficiary perception and experience data including incomplete information and a lack of data on beneficiary issues like out-of-pocket spending burdens and discrimination in healthcare. She said that lack of data in these areas often affects healthcare outcomes. Mr. Cambron agreed on the need for additional investment, and argued for greater standardization of data collection practices for qualitative data (he suggested the federal government could issue some guidance in this area). Dr. Caldwell added that collecting additional survey data from beneficiaries on healthcare experiences could improve available data.

Commissioners' Comments
Commissioners identified key takeaways from panelists' remarks in their commentary. They considered recommending additional investment in beneficiary experience data collection and noted the importance of ensuring researchers' access to high-quality data. Multiple Commissioners commented that the healthcare sector needs to modernize its data collection processes given the importance of healthcare data and the inadequacy of healthcare data processing compared to data processing practices in other sectors. Commissioners thanked the panelists and moderator and noted that they will continue to explore this issue in future meetings.

Session 2: Analyses for Mandated Study on Money Follows the Person
MACPAC Staffers Kristal Vardaman and Tamara Huson presented on the Commission's congressionally-mandated analysis of the Money Follows the Person (MFP) demonstration. They gave a brief overview of the program, reviewed results from a survey conducted by the Commission, discussed key themes from stakeholder interviews, and detailed policy options for improving the MFP program.

Ms. Vardaman and Ms. Huson began their presentation with background on the MFP program. The MFP demonstration program assists Medicaid beneficiaries who have been institutionalized for at least 60 days to return to a qualified residence in their community. Qualified residences include homes owned or leased by the beneficiary or their family member, an apartment leased by the beneficiary, or a community-based setting in which no more than four unrelated individuals reside. These MFP rules differ from Medicaid's home- and community-based services (HCBS) settings rule, which generally allows for more settings and focuses more on beneficiary experience rather than specific acceptable physical locations.

In the Consolidated Appropriations Act of 2021, Congress directed MACPAC to identify settings that comply with both the MFP's qualified residence criteria and the HCBS settings rule. Congress also directed the Commission to explore if it would be appropriate to align the qualified residence criteria and the HCBS settings rule. MACPAC's analysis covers these topics.

For context, the Commission's analysis collected data on MFP transitions. Data showed the MFP demonstration program mostly transitioned people aged 65 and older and those with physical disabilities. The number of transitions declined from 2016 to 2019, with a small increase in 2020. About 64 percent of MFP participants transitioned to an apartment or home, and about 20 percent transitioned to congregate settings like group homes or assisted living.

Twenty eight MFP program directors responded to MACPAC's survey. Just over half of the directors reported that the qualified residence criteria were a barrier to transitions and a large majority (71.4 percent) of them supported aligning the qualified residence criteria with the HCBS settings rule.

Stakeholders interviewed by MACPAC, including state and federal officials, intellectual and developmental disability advocates, providers, and researchers, did not reach a consensus on whether the two sets of rules should be aligned. Stakeholders in favor of alignment argued that having a single set of standards avoids confusion, streamlines operations, maximizes MFP transitions, and enables more choices for individuals with disabilities. Stakeholders against alignment argued that the MFP qualified settings criteria should not change because it is clear and enforceable and because it creates protections that preserve a higher quality of life for MFP participants. Generally, survey respondents welcomed additional oversight from the Center for Medicare and Medicaid Services (CMS).

Stakeholders also highlighted other concerns about the MFP demonstration program, including barriers to transitions caused by shortages of affordable housing and shortages in the direct care workforce. They also questioned the necessity of some of the MFP qualified residence criteria, like the limit of four unrelated people in a residence and the requirement for full kitchens and individual leases.

Following their review of MACPAC's analysis, Ms. Vardaman and Ms. Huson listed potential policy options for the Commission, including:

- Expressing support for maintaining the existing MFP qualified residence criteria without making recommendations;
- Aligning the MFP qualified residence criteria with the HCBS settings rule, and;
- Loosening the MFP qualified residence criteria to include some HCBS settings that do not currently qualify.

Commissioners discussed these policy options and their implications in their commentary.

Commissioners' Comments

Commissioners generally supported aligning the MFP qualified residence criteria with the HCBS settings rule, and the Commission intends to do more analysis on the implications of this recommendation before formalizing it. Commissioners said additional analysis should be conducted to find a recommendation that will transition more individuals out of institutions while still protecting their rights and quality of life. The Commission stated it intends to conduct additional analysis and gather additional beneficiary perspectives before making a recommendation.

Session 3: Vaccines for Adults Enrolled in Medicaid: Interview Findings

Continuing work from previous MACPAC meetings on vaccine coverage and access for adults enrolled in Medicaid, MACPAC staffers Amy Zettle and Chris Park discussed findings from interviews with state and federal officials, Medicaid managed care plans, providers, vaccine manufacturers, immunization experts, and a consumer group. Interviews from MACPAC's survey focused on state vaccine policies, barriers to vaccine access, and the relative effectiveness and challenges of different federal policy options. For a recap of the Commission's past work on adult vaccine coverage, see Viohl & Associates' past MACPAC meeting summaries.

Generally, interviewees identified limited coverage, bad payment policies, and beneficiary-specific barriers (i.e. transportation issues or physical disabilities) as key obstacles to vaccine access. Interviewees mostly agreed that a vaccine benefit should be universal and that low provider payment rates for vaccinations could create a barrier to access if low rates hinder providers' willingness to administer vaccines. Interviewees also agreed that beneficiaries should have multiple points of access to receive vaccinations to maximize vaccine uptake.

Interpreting the results of the interviews, MACPAC staffers concluded that increasing vaccination rates will require a multi-faceted approach that ensures all Medicaid beneficiaries have vaccine coverage. Staff then identified policy options for expanding vaccine coverage, including:

- Introducing a financial incentive for Medicaid coverage of vaccinations, such as a targeted Federal Medical Assistance Percentage (FMAP) increase for vaccine coverage;
- A federal purchasing program for vaccines;
- Making vaccination coverage a mandatory Medicaid benefit, and;
- Adding vaccines to the Medicaid Drug Rebate Program (MDRP).

Among interviewees, there was generally strong support for improving provider payments by increasing the FMAP for vaccine administration and for broadening the types of providers administering vaccines. Interviewees also agreed that beneficiaries need greater support and education to ensure that they receive recommended vaccines, which could be boosted by vaccine counseling payments or general support for Medicaid resources being used to address vaccine hesitancy.

After compiling interviewee answers, MACPAC staffers assessed the discussed policy options and compiled their findings in the chart below:

Policy Options Assessment

Policy option	Improve vaccination rates	State spending	Federal spending	Operational complexity	Reduce racial disparities
Mandatory coverage of vaccines	Medium	Increase	Increase	Low	Medium
Coverage of vaccines through the Medicaid Drug Rebate Program	Medium	Medium decrease[1]	Medium decrease[1]	Medium	Medium
Additional federal funding for vaccines	Low	Decrease[2]	Increase[2]	Low-medium	Low-medium
Federal purchasing program	High	High decrease	High increase	High	High
Federal contract price	Low	Low decrease	Low decrease	Medium	Low

Notes:
[1] The MDRP rebates would decrease the acquisition cost of the vaccine, but overall spending on vaccines could increase if utilization also increases.
[2] The amount of decrease in state spending and increase in federal spending depends on the amount of additional federal funding and to what extent utilization increases.

Commissioners further discussed these policy options and their implications following the presentation.

Commissioners' Comments
Several Commissioners supported mandating Medicaid coverage of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), although they noted that vaccine manufacturers typically oppose this policy change, arguing that it can stifle vaccine innovation. Commissioners also agreed that MACPAC should continue to explore provider vaccine incentives. Commissioners also expressed interest in establishing a federal vaccine purchasing program. The Commission instructed staff to conduct additional research and present the potentially most effective policy suggestions as recommendations at the next MACPAC public meeting.

Session 4: Required Annual Analysis of Disproportionate Share Hospital Allotments to States
MACPAC staffers Aaron Pervin and Jerry Mi provided updated analysis of data from MACPAC's statutorily required annual analysis of Disproportionate Share Hospital (DSH) allotments that will be published in the Commission's upcoming March 2022 report to Congress. Mr. Pervin and Mr. Mi discussed new data on the uninsured rate during the COVID-19 pandemic, DSH allotment changes during the public health emergency (PHE), and the treatment of third-party payments in Medicaid shortfall. Mr. Pervin and Mr. Mi noted that the data

this year was similar to data from previous years, likely because of no substantive policy changes occurring for DSH payments.

According to the Current Population Survey, 28 million individuals were uninsured in 2020, with the uninsured rate being the highest for non-elderly adults, Hispanic individuals, and individuals with incomes below the federal poverty level. Data from the Census Household Pulse Survey found that the uninsured rate increased during the early stages of the pandemic due to economic challenges but then later decreased from August 2020 through July 2021 as Medicaid coverage increased.

In Fiscal Year 2019 (FY 2019) hospitals reported $42 billion in charity care and bed debt. Recent research highlighted that states that chose to expand Medicaid under the Affordable Care Act (ACA) had lower unpaid costs of care for the uninsured than states that did not; hospitals in ACA expansion states on average had 50 percent less charity care costs and bad debt than non-expansion states in FY 2019.

According to the American Hospital Association annual survey, the Medicaid shortfall in FY 2019 totaled $19 billion. Incorporating MACPAC recommendations, a new definition of third party payments established under the Consolidated Appropriations Act of 2021 changed how third-party payments are treated. Under the new definition, the DSH payment limit for hospitals that serve a high share of Medicaid patients with private coverage increased, the DSH payment limit for hospitals that serve a high share of patients dually eligible for Medicare and Medicaid decreased, and FY 2022 DSH payments were implemented.

In addition to these updates, MACPAC staff also noted that the number of providers administering services meeting MACPAC's definition of "essential community services" remained largely unchanged.

Under the American Rescue Plan Act of 2021, Congress temporarily increased federal DSH allotments by increasing the share of DSH payments paid by the federal government and thereby decreasing the states' share. Increased allotments are in effect until the fiscal year after the end of the PHE, at which time the states' share of DSH payments will increase back to normal levels.

In a summary of their findings, MACPAC staffers noted that the Commission continues to find that DSH allotments do not correlate with the number of uninsured individuals in each state, the amount of state-level uncompensated care, or the number of hospitals with high levels of uncompensated care that also provide essential community services. The upcoming chapter to be released in the Commission's March 2022 report will publish the above data and describe congressional changes to DSH payments, including modifying the hospital payment limit and temporarily increasing federal allotments during the PHE.

Commissioners' Comments
Commissioners' comments were brief since staff's analysis of DSH payments mostly reiterated findings from past years. Commissioners thanked staff for their analysis.

Session 5: Raising the Bar and Supporting State Efforts to Integrate Care for Dually-Eligible Beneficiaries
MACPAC staffers Kristin Blom and Ashley Semanskee presented on improving care for dually-eligible beneficiaries and supporting state efforts to integrate care. Their presentation covered themes from MACPAC's roundtable with selected states and key stakeholders. For more information on the Commission's past work on integrating care for dually-eligible beneficiaries, see Viohl & Associates' past MACPAC meeting summaries.

MACPAC convened a roundtable discussion to better understand the factors affecting state decisions on integrated care and how the federal government can better support states' efforts to integrate care. Participants at the roundtable discussion included state staff from Delaware, Kansas, Louisiana, Maine, Mississippi, Missouri, North Carolina, and Washington, as well as policy experts from ADvancing States, the CMS Medicare-Medicaid Coordination Office, Speire Healthcare Strategies, and MACPAC Commissioners Melanie Bella and Dennis Heaphy.

MACPAC staff identified a number of key takeaways from stakeholders' comments during the roundtable discussion:

- Stakeholders reported that states could benefit from increased federal support of states' integration efforts in the form of technical assistance or financial support;
- Participants in the roundtable agreed that discussions about integrating care should center around beneficiaries' experiences;
- Integrated care where all benefits are covered by a single managed care plan does not necessarily mean more coordination of care or improved beneficiary experience, and;
- Exploring integrated care options outside of managed care could enable states to reach beneficiaries still in fee-for-service models.

MACPAC staff also identified additional themes from the roundtable discussion, including key factors for state adoption of integrated care such as:

- Availability of experience enrolling dually-eligible beneficiaries in Medicaid Managed Care;
- Options to integrate care through fee-for-service, and;
- Access to integrated plans for beneficiaries exempt from mandatory Medicaid managed care.

They noted other factors inhibiting states' progress integrating care including:

- Lack of state capacity;
- Limited beneficiary knowledge of integrated care and their preference for existing coverage, and;
- Lack of data,

Stakeholders also discussed potential state actions that could help to address barriers to integration including:

- Identifying state staff leads;
- Enhancing state contracts with D-SNPs, and;
- Establishing a beneficiary advisory mechanism,

Additionally, they discussed federal supports to help states improve integrated care including:

- Technical assistance;
- Enhanced short-term funding, and;
- Enhanced long-term funding.

For a full list of the Commission's takeaways, see MACPAC's presentation. Following Ms. Blom and Ms. Semanskee's review of themes from stakeholder interviews, Commissioners discussed policy options based on roundtable participants' feedback, including:

- Making additional federal financing available;
- Requiring states to develop a strategy to integrate care;
- Requiring states establish an ombudsman for integrated care programs;
- Requiring that states contracting with D-SNPs select at least one Medicare Improvements for Patients and Providers (MIPPA) contracting strategy and include it at the next contract renewal;
- Requiring that states only contract with D-SNPs designated as highly-integrated or financially aligned, and;
- Requiring that every state fully integrate care for full-benefit dually eligible beneficiaries.

Commissioners' Comments

MACPAC Chair Melanie Bella noted that the Commission is moving closer to making a recommendation. Generally, Commissioners were supportive of recommending the federal government make additional financing available to states that want to advance integrated care and requiring that every state develop a strategy for integrating care. Commissioners also considered requiring states to establish an ombudsman for integrated care programs as a part of the requirement that states develop a strategy for integrating care. Commissioners directed staff to conduct additional analysis on the remaining policy options, and to finalize language for the policy options with strong support.

Session 6: Response to Senate Finance Committee Request for Information on Behavioral Health Priorities

MACPAC staffer Joanne Jee reviewed the Commission's draft response to a Request for Information issued by the Senate Committee on Finance in September 2021 requesting input on policy approaches to enhance behavioral health care. The draft draws on the Commission's previous work on behavioral health and explores topics including strengthening the behavioral health workforce, increasing integration of care, ensuring parity between behavioral and physical healthcare, expanding the use of telehealth, and improving access to behavioral care for children and young people. For more information on the Commission's previous work on behavioral healthcare, see Viohl & Associates' summaries of past MACPAC meetings.

In their draft response to the Senate Committee on Finance, MACPAC notes that provider shortages and maldistribution of available providers contribute to an inadequate behavioral health workforce. The Commission also identified selective provider acceptance of Medicaid as another barrier to accessing behavioral health services. The draft also urges policymakers to address these issues and suggests policy changes, like improving payment rates for behavioral health providers accepting Medicaid patients, to address them.

Additionally, MACPAC's letter currently includes recommendations for improving integration of, coordination of, and access to behavioral health services. The Commission recommends better integrating clinical care by addressing barriers to adoption of certified electronic health record (EHR) technology, aligning federal privacy rules, and improving access to institutions for mental diseases, crisis services, Substance Use Disorder, opioid treatment services, and services for individuals in the criminal justice system.

MACPAC's draft response notes that federal parity law does not "appear to have substantially improved access to behavioral health care for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries." The Commission's response also further explores discrete barriers that may limit access, lack of requirements mandating coverage of behavioral health services, and difficulty operationalizing policies to improve parity.

To improve access to behavioral health services, MACPAC's draft response discusses continued expansion of telehealth services. The Commission notes that new flexibilities introduced during COVID-19 that catalyzed rapid expansion of telehealth could be useful in continuing to improve access, but that considerations like the availability of broadband networks and the need for better data collection and sharing should be central to policymakers' considerations.

MACPAC's draft response also covered improving access to behavioral health services for children and young people. The Commission notes that despite federal requirements for access to behavioral healthcare under Medicaid and CHIP, the need for services remains largely unmet. The response also discusses the needs of youth in the juvenile justice and child welfare systems. To better meet youths' behavioral health needs, the Commission recommends issuing guidance on the design and implementation of benefits for children and youth with significant mental health needs, and additional education and technical assistance for states to improve access to behavioral health-related HCBS.

For next steps, the MACPAC staff will edit their letter based on feedback from Commissioners and submit it to the Senate Committee on Finance by November 1.

Commissioners' Comments

Commissioners agreed that content of the letter was sufficient and offered little feedback. However, they noted that the final draft of the letter should emphasize the importance of early behavioral health intervention for youths and the importance of access to behavioral health services for children and communities of color.

Session 7: Panel Discussion: The Workforce for Home- and Community-based Services

MACPAC's October public meeting concluded with a panel discussion on the workforce for HCBS moderated by MACPAC staffer Tamara Huson. The Commission heard commentary from expert panelists including Robert Espinoza, Vice President of Policy at PHI International, Bill Kennard, an Administrator at the Arizona Department of Health Services' Office of Workforce Development, and Bea Rector, Director of the Home and Community

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Services Division within the Aging and Long-Term Support Administration in Washington State's Department of Social and Health Services.

Mr. Espinoza noted that the shortage of direct care workers remains a major barrier to expanding access to HCBS and gave his perspective on addressing this shortage. He noted that the term "direct care worker" is so broad that it encompasses many different kinds of workers, and that lack of a standard definition of direct care workers can often contribute to difficulties identifying the issues that direct care workers face. However, Mr. Espinoza argued that workers in this broad field share common issues that should be addressed, including:

- Low wages (Mr. Espinoza noted that the median wage for direct care workers is just $12 per hour);
- Lack of support for workers displaced by the COVID-19 pandemic, and;
- Lack of advancement and professional learning opportunities.

Mr. Espionza argued that funds from the American Rescue Plan Act could be used by state policymakers to address the needs of the direct care workforce by making investments in higher wages, employer transparency, equity, underserved rural areas, technology, training infrastructure, and data collection. While Mr. Espinoza said there was a need for more "transformative changes" for the direct care workforce, he also noted that targeted short-term investments can have long-term payoffs.

Mr. Kennard described the licensing and contracting procedures for direct care workers in the State of Arizona and identified solutions for addressing issues among the direct care workforce. To improve conditions within the direct care workforce and address the direct care worker shortage, Mr. Kennard suggested:

- Providing increased services for direct care workers addressing burnout;
- Increasing efforts to promote diversity, equity, and inclusion;
- Promoting access to additional hours and full-time schedules;
- Expanding training and advancement opportunities, and;
- Including the voices of direct care workers when evaluating policy options.

Ms. Rector discussed the direct care workforce in Washington State. She noted that like in most states, the direct care workforce in Washington is diverse, largely comprised of women, people of color, and immigrants. She noted that these workers provide highly personal, skilled services that are often transferrable to other kinds of jobs, and that as a result low wages may contribute the workforce shortages as direct care workers pursue more competitive wages in other fields.

Ms. Rector agreed that additional support for direct care workers will be a crucial component of addressing the direct care worker staffing crisis. She suggested the federal government pursue partnerships with states and organizations within states that employ or assist direct care workers to provide this support. She also suggested targeting issues with HCBS data collection and considering new, state-led programs for HCBS workforce development.

Commissioners' Comments

Commissioners noted that given the great diversity of the direct care workforce, ensuring that training for direct care workers is offered in multiple languages could be crucial for addressing worker shortages. Commissioners also noted data collection inadequacies as an area for further exploration. Melanie Bella noted that the Commission will seek out additional state perspectives to develop recommendations going forward.