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Event Summary *October 31, 2022*

MACPAC October 2022 Meeting

Executive Summary

On October 27 and 28, the Medicaid Access and Payment Advisory Commission (MACPAC) convened for its monthly public meeting. MACPAC's slide presentations from the meeting are available here. Among the highlights of the respective sessions:

- **Medicaid Race and Ethnicity Data Collection and Reporting** — Commissioners were generally interested in improving the quality of race and ethnicity data through T-MSIS. Additionally, other commissioners suggested that data collection can be improved by increasing trust between states and Medicaid applicants.
- **Improving Access to Medicaid Coverage and Care for Adults Leaving Incarceration** — Commissioners were generally interested in further evaluation of the inmate exclusion waivers to determine the policy implications for their continuation.
- **Monitoring the Unwinding of the Public Health Emergency** — Several commissioners expressed concern about the lack of data reporting requirements for states during the Medicaid redeterminations and renewals process for unwinding the public health emergency. Commissioners agreed that data transparency is necessary to ensure that unwinding efforts are not negatively impacting Medicaid beneficiaries.
- **Proposed Eligibility, Enrollment, and Renewal Rule** — Commissioners were overwhelmingly supportive of including previous MACPAC recommendations on eligibility and enrollment in upcoming comments to CMS, due by November 7.
- **Proposed Changes to the Consideration of Access in Actuarial Soundness** — Commissioners discussed measuring access in Medicaid managed care and its relationship to actuarial soundness and rate setting. Several commissioners argued that rate setting in Medicaid has led to less access, advocating for an expert panel to examine this. Other commissioners suggested that there should be consideration of the social determinants of health (SDOH) within actuarial soundness determinations.
- **Trends in Medicaid Drug Spending and Rebates** — Commissioners provided suggestions for further data analysis of Medicaid drug spending data, including a further examination of rebates and generic dispensing rates by delivery system.
- **Panel on Streamlining Delivering of HCBS** — While Commissioners raised concerns about issues plaguing the direct care workforce, many seemed supportive of redesigning the HCBS benefit. Notably, several commissioners were still seeking general recommendations and ideas from the panelists.
- **Maintenance Needs Allowances for Beneficiaries Receiving HCBS** — Generally, commissioners agreed that more research in HCBS beneficiaries' financial obligations to live in the community relative to their states' maintenance needs limits would be useful —

especially regarding trends in health care disparities and the concept of tying spending limits to inflation.

- **Potential Recommendations for Structuring DSH Allotments During Economic Crises** — In general, and as a way to provide states and hospitals with greater certainty about available disproportionate share hospital allotments, Commissioners agreed with a draft recommendation that Congress should amend section 1923 of the Social Security Act to remove the requirement that the CMS compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.
- **MACPAC Response to CMS "Make Your Voices Heard" RFI** — Commissioners reviewed their comment letter to the CMS "Make your Voices Heard" request for information. Generally, their comments discuss strategies related to access to health care, advancement of health equity, and improvements to providers' experiences within the health care workforce and will be available for review on November 4th.

Detailed summaries of these sessions are included below. Due to the coronavirus pandemic, the next MACPAC meeting will take place virtually on December 8-9, 2022.

MEDICAID RACE AND ETHNICITY DATA COLLECTION AND REPORTING: INTERVIEW FINDINGS

In the first session of MACPAC's October meeting, the Commission focused on efforts to improve Medicaid race and ethnicity data collection and reporting. During this meeting, staff presented federal and state considerations for collecting and analyzing race and ethnicity data based on findings from a literature review and key stakeholder interviews. Staff also shared possible approaches for improving the state collection and processing of these data. Commissioners were interested in improving the quality of race and ethnicity through the state Transformed Medicaid Statistical Information System (T-MSIS) by increasing the number of values for reporting the race and ethnicity of Medicaid applicants. Additionally, some Commissioners suggested focusing more on assisting states to improve trust between Medicaid data collection efforts and applicants so that data collection increases and becomes more accurate. Lastly, he noted that the staff will present draft recommendations on ways to improve the race and ethnicity data collection and reporting processes in Medicaid during the December 2022 meeting.

Staff Presentation

Analyst Linn Jennings outlined federal and state priorities for improving race and ethnicity data. She explained that federal priorities include: (1) identifying data inadequacies and strategies for improvement; and (2) supporting agency efforts to expand the collection and improve the quality of these data. She noted that state priorities include efforts to support state health equity plans, and disaggregate the data to assess health disparities, support outreach, and develop targeted state policies. Additionally, states are working on developing processes to leverage additional data sources to supplement eligibility data for state-level analyses, she informed the Commission.

Regarding the data collection process, Ms. Jennings noted that race and ethnicity data are collected on Medicaid applications, however, states cannot require applicants to provide such data. She also explained that CMS has provided states with guidance for developing their application to improve data collection, including a model application, and states are given the choice to use the model, modify it, or develop their own. Looking at data quality, she noted that CMS combines two primary criteria for assessing the quality of state T-MSIS Analytical Files (TAF) race and ethnicity data but underscored the challenges with data collection causing issues with the quality. She said that such challenges include an individual's comfort with providing sensitive information, inability to answer accurately, or confusion about how to respond. Finally, she spoke on the reporting process, explaining that states process and submit race and ethnicity information from the state's Medicaid Management Information System (MMIS) to T-MSIS and shared that most interviewed states did not report data processing challenges. Additionally, CMS has provided states with technical assistance to ensure data quality issues are resolved through tools for evaluation, and over half of the interviewed states regularly communicated with CMS. Ms. Jennings pointed out that race and ethnicity data were not identified by CMS as areas for improvement in these states.

Research Assistant Jerry Mi presented the staff's findings for potential approaches to improve usability of the data. He explained that in terms of states' data collection efforts, states can: (1) update model application race and ethnicity question format categories; (2) provide additional guidance on state-designed applications; and (3) update training to include information on how to ask race and ethnicity questions and explain why they are included. In terms of data processing, he suggested: (1) increasing reporting options, such as allowing states to report multiple race and ethnicity values; and (2) providing additional mapping guidance, specifically for states that collect values that are not supported by T-MSIS, such as multiple race and ethnicity selection.

Commissioner Discussion

- **Commissioner Laura Herrera Scott, M.D.,** of Summit Health, recommended exploring data collection methods for the states where there are T-MSIS data quality concerns to understand the future policy implications for improving usability.
- **Commissioner Fred Cerise, M.D.,** of the Parkland Health Hospital System, suggested that methods on how to collect data are worth exploring and commenting on to improve data reporting. He expressed interest in assisting states to improve the level of trust between applicants and application assisters — individuals who help potential beneficiaries enroll in Medicaid — such as improving training for assisters.
- **Commissioner Heidi Allen, Ph.D.,** of the Columbia University School of Social Work, inquired about the non-inclusion of gender identity and sexual orientation data and the limitations that might play into analyzing intersectionality with race and ethnicity data. She also suggested that there should be a forced choice component in the applications and recommended including information on the application that explains to applicants why this data is being requested.
- Additionally, Commissioner Allen suggested that in the state reporting process, states must submit one race value and one ethnicity value for each individual to T-MSIS, but she cautioned that T-MSIS needs to allow for the ability to submit more than one of each value.

- **Commissioner Dennis Heaphy,** of the Massachusetts Disability Policy Consortium, argued that the Commission must focus on ensuring the accuracy of racial and ethnicity data collection and reporting before including gender identity and sexual orientation data. He recommended including MACPAC sessions on the application of disability data and gender identity data later, which he agreed with Commissioner Allen that it will be useful.
- **Commissioner Darin Gordon,** of Gordon and Associates, asked the staff to dig into data on applicants who have completed applications with assisters.
- Commissioner Allen wanted to learn more about states receiving data from numerous sources and how they determine whether to use the information, where they use it, and how they use it.

IMPROVING ACCESS TO MEDICAID COVERAGE AND CARE FOR ADULTS LEAVING INCARCERATION

In the second session of MACPAC's October meeting, the Commission discussed strategies to improve access to Medicaid coverage and care for adults leaving incarceration. The staff presented demographic characteristics, health status, and access to care among adults who have been incarcerated. Additionally, staff highlighted approaches that states can take to facilitate Medicaid coverage and access to care for adults upon release based on interviews with state Medicaid and corrections agency officials in 16 states. Commissioners were generally interested in further evaluation of the inmate exclusion waivers to determine the policy implications for their continuation. Some of the commissioners expressed support for continuous coverage of care models to improve mental health and SUD outcomes while justice-involved Medicaid beneficiaries' cycle in and out of incarceration.

Staff Presentation

Ms. Lesley Baseman provided background information, including demographic data, on justice-involved adults and the role of Medicaid when individuals are released back into the community. She explained the Medicaid inmate exclusion policy which prohibits the use of federal Medicaid funds for health care services during incarceration, with an exception for inpatient care lasting 24 hours or more. She also described the health status of justice-involved adults, noting that they report high rates of physical and behavioral health conditions and disabilities. Ms. Bateman explained that Medicaid-eligible adults leaving incarceration can face gaps in coverage and care and that many behavioral health needs of such individuals often go unmet, as there is limited access to medication-assisted treatment (MAT) during incarcerations.

Ms. Melinda Becker Roach highlighted the state strategies for improving access to Medicaid coverage and care. First, she said the staff found that states are facilitating Medicaid enrollment by suspending, rather than terminating, Medicaid coverage for adults during incarceration, as well as providing pre-release enrollment assistance. In the interviews, Ms. Roach noted, states commonly cited the cost of data infrastructure improvements, data quality, and difficulty anticipating jail release dates as barriers to timely Medicaid coverage on release. Also, states are providing state-funded in-reach or pre-release programs, often including enrollment assistance and discharge planning, she said. In addition, Ms. Roach explained that states offer post-release services often

including a supply of needed medication and care coordination. She presented a graph showing 12 states with pending Medicaid section 1115 demonstrations to waive the inmate exclusion and noted that the eligibility, benefits, and duration of pre-release coverage varied between those states. While CMS has not yet approved any demonstration to waive the inmate exclusion, the Department of Health and Human Services (HHS) is required to release new guidance, including a best practices report on improving care transitions. Ms. Roach anticipated that the report will be released "soon" but did not offer a specific timeline. Additionally, HHS is required to release section 1115 guidance with opportunities to provide pre-release Medicaid coverage, but she did not opine on when that would be released.

Commissioner Discussion

- **Commissioner Tricia Brooks,** of the Georgetown University Center for Children and Families, emphasized that the Commission cannot leave states behind that do not have good behavioral health treatment for substance use disorders (SUD).
- **Commissioner Martha Carter** asked the staff to provide a report on when the inmate exclusion was put in place and what has been put in place since to further evaluate the continuation of the waivers, considering the Commission's new understanding of SUD and behavioral health.
- **Commissioner Heidi Allen, Ph.D.,** of the Columbia University School of Social Work, suggested disaggregating jail versus prison issues because the typical jail time is only 28 days. Additionally, she noted that since the rise in telehealth, there can be continuity of care in jail.
- **Commissioner Rhonda Medows, M.D.,** of Providence Population Health Management, underscored the difference in budgetary implications and other factors between states and correction agencies. She also questioned the willingness of corrections agencies with respect to incorporating the proposed changes.
- **Commissioner Angelo Giardino, M.D., Ph.D.,** of the University of Utah, was interested in directing attention toward adolescents who are incarcerated, raising concerns about those individuals having fragmented care from an early age and then leaving incarceration**.**
- **Commissioner Laura Herrera Scott, M.D.,** of Summit Health inquired about more information regarding the delays and gaps in getting individuals re-engaged in care after incarceration. She expressed interest in additional data on the costs of not improving this process and providing coverage continually throughout incarceration.
- **Commissioners Fred Cerise, M.D.,** of the Parkland Health and Hospital System, and **Dennis Heaphy,** of the Massachusetts Disability Policy Consortium, both supported a continuous coverage model while individuals are incarcerated or an assurance of coverage on the day that they leave incarceration.
- Commissioner Brooks explained that some corrections facilities cannot go through the application process with the individual, but utilizing presumptive eligibility is a "very simple" solution to get the application process started.
- **Commissioner Jennifer Gerstorff**, of Milliman, asked for information on housing stability before and after incarceration.

MONITORING THE UNWINDING OF THE PUBLIC HEALTH EMERGENCY

In the third session of MACPAC's October meeting, commissioners discussed the preparations underway by the Centers for Medicare and Medicaid Services (CMS) and individual states to unwind flexibilities afforded under the COVID-19 public health emergency (PHE), particularly as it pertains to data collection and monitoring to identify potential challenges during this process.

Of interest to the Commission was the need for transparency of this data, as both commissioners and MACPAC staff agreed that concern is mounting that states will be unable to adequately process renewals and disenrollments as the continuous coverage requirement unwinds. Commissioners agreed that data transparency is necessary to ensure that unwinding efforts are not negatively impacting Medicaid beneficiaries.

Looking ahead, MACPAC staff noted that the Commission's December meeting will focus on easing transitions in coverage post-PHE, followed by future meetings to consider efforts to unwind other state flexibilities.

Staff Presentation

Principal Analyst and Research Advisor Martha Heberlein discussed the Commission's prior work related to COVID-19 PHE unwinding, pointing toward panel discussions held with state officials and beneficiary advocates to review unwinding efforts as well as a special session held by the Commission in July. Ms. Heberlein noted that, while states and CMS have been collectively engaged in planning for the resumption of Medicaid redeterminations for some time, concerns remain surrounding the potential loss of beneficiary coverage post-PHE.

To help assuage these concerns, other data sources exist that CMS, states, the Commission, and stakeholders can monitor to assess state progress beyond the required reporting specifically related to the unwinding required by CMS, Ms. Heberlein explained. However, she noted that quality concerns, public availability, and the timeliness of their release may limit their utility for real-time assessments. Ms. Heberlein walked through other data sources, including federal, state, and qualitative data, as well as their roles in better understanding the effects of unwinding post-PHE.

Ms. Heberlein articulated the Commission's next steps surrounding this topic, explaining that MACPAC's December meeting will place focus on easing transitions in coverage post-PHE. Future meetings during this work cycle will examine efforts to unwind other state flexibilities, she said.

Commissioner Discussion

- **Commissioner Tricia Brooks,** of Georgetown University Center for Children and Families, expressed concern over CMS' lack of commitment to data transparency. She added that, while some states have agreed to release this data, there is no requirement to do so under current law. Commissioner Brooks specifically called for a Congressional requirement that CMS release call center statistics and the share of procedural disenrollment data at

minimum. **Commissioner Angelo Giardino, MD, Ph.D.**, of the University of Utah, called for greater data transparency as well.

- Echoing these comments, **Commissioner Robert Duncan,** of Connecticut Children's – Hartford, stated that children are at risk of being negatively affected by unwinding efforts. He suggested that, when assessing data, commissioners place a particular focus on data by age group and make timely recommendations to alleviate any issues revealed from such data.
- Ms. Heberlein clarified for **Commissioner Dennis Heaphy**, of the Massachusetts Disability Policy Consortium, that CMS intends to use the data it is collecting to provide states with technical assistance to mitigate any issues that may arise.
- **Commissioner Martha Carter** stressed the need to ensure that data is utilized in real-time to improve outcomes.

PROPOSED ELIGIBILITY, ENROLLMENT, AND RENEWAL RULE

In the fourth session of MACPAC's October meeting, Commission staff reviewed the Center for Medicare and Medicaid Services' (CMS) proposed rule related to the Medicaid enrollment and renewal process. Staff reviewed all of the relevant policy areas on which MACPAC could provide comment, and the Commission was overwhelmingly supportive of including each issue in a comment to CMS. Notably, each policy suggestion aligns with the Commission's previous work on these topics.

Staff Presentation

Principal Analyst and Research Advisor Martha Heberlein provided background on CMS's proposed rule, noting that it would provide the first substantial changes to the enrollment and renewal process since the inception of the Affordable Care Act (ACA). While comments on the rule are due November 7, she said that the rule's finalization is unknown and is unlikely to be implemented before the redetermination process beings at the end of the COVID-19 public health emergency (PHE). Ultimately, Ms. Heberlein explained that — if finalized — the rule would ease administrative burdens for states, reduce barriers to enrollment and coverage retention, and improve program integrity.

As the Commission considered potential areas of comment on the rule, **Principal Analyst and Contracting Officer Kirstin Blom** reviewed MACPAC's previous work relevant to the topic. Specific policy recommendations she highlighted include:

- Aligning Medicare Savings Program (MSP) rules with the Medicare Part D Low-Income Subsidy (LIS) program;
- Requiring states to use electronic data to verify resources prior to requesting additional beneficiary information and applying reasonable compatibility standards for income;
- Aligning non-modified adjusted gross income (MAGI) and MAGI rules;
- Providing beneficiaries with adequate time to respond to additional requests for information;

- Addressing concerns related to missing contact information for beneficiaries, such as returned mail, which has coverage implications for beneficiaries;
- Easing transitions between Medicaid and Children's Health Insurance Program (CHIP) to address coverage gaps;
- Prohibiting premium lock-out periods in separate CHIP programs following 90 days of non-payment; and
- Disallowing waiting periods in between transferring from private to public coverage in CHIP.

Ms. Heberlein concluded the discussion by noting that MACPAC staff is prepared to draft comments promoting the areas that Ms. Blom discussed, and she asked for commissioner feedback related to the inclusion of these policy suggestions.

Commissioner Discussion

- **Chair Melanie Bella**, of Cityblock Health, advocated for each policy that Ms. Blom reviewed and supported the Commission's decision to draft a comment to submit to CMS.
- **Commissioner Tricia Brooks** echoed Chair Bella's sentiments, though she added that she would like to eliminate CHIP premiums for those under 150 percent of the federal poverty line (FPL). Commissioner Brooks then advocated for premium prepayments to be collected post-enrollment with a 30-day grace period for payment of the first premium in CHIP. She also pointed out that states have a great deal of flexibility to decide which redetermination information is reliable, arguing that CMS should play a larger role in regulating this area.
- **Commissioner Heidi Allen, Ph.D.,** of the Columbia University School of Social Work, and other commissioners agreed with Commissioner Brooks that CHIP beneficiaries should have a grace period and be allowed to pay prepayments post-enrollment.
- **Commissioner Martha Carter** reiterated Ms. Blom's discussion of providing beneficiaries adequate time to respond to a request for additional information to make a redetermination decision. Staff and commissioners agreed that ten days is not enough time. Commissioner Brooks noted that many states try to align the Medicaid redetermination process with SNAP redetermination, and the Supplemental Nutrition Assistance Program (SNAP) provides ten days to respond to a request for additional information. In general, Commissioner Brooks emphasized the need for CMS to better align SNAP and Medicaid.

POTENTIAL CHANGES TO THE CONSIDERATION OF ACCESS IN ACTUARIAL SOUNDNESS

In the fifth session of MACPAC's October meeting, commissioners discussed key considerations related to access and rate setting. Recently, the Commission previewed anticipated federal rulemaking from the Centers for Medicare and Medicaid Services (CMS) related to rate-setting, to which commissioners discussed priority areas for comments and additional areas for examination in advance of this forthcoming proposed rule during this session. Of interest to the Commission was access in this regard, where commissioners provided suggestions to make updates to rate setting, actuarial soundness, and directed payments to better consider — and improve — access.

Staff Presentation

Principal Analyst Sean Dunbar noted that the Commission reviewed findings from recent work on rate setting and risk mitigation in September, where interest in further analysis on access and state-directed payments, among other items, was expressed. Building off this request, Mr. Dunbar explained that no specific requirements exist as to how states must account for access or document standard compliance, though other components of rate setting contain specific definitions and requirements under regulation or guidance. Specifically, he said that access to care, continuity of care, and network adequacy requirements are not contained within CMS' annual rate guide, which describes the details needed for rate certification and CMS standards for determining compliance.

Additionally, regarding access improvement efforts and their inclusion in rates, Mr. Dunbar articulated that the lack of professional actuarial guidance in this regard results in challenges when actuaries are developing adjustments to address access concerns. Moreover, he explained, directed payments complicate the consideration of access in rates as actuaries play no role in reviewing the appropriateness of directed payments.

Commissioner Discussion

- **Commissioner Jennifer Gerstorff**, of Milliman, suggested that the Commission propose that CMS update its guidance to have a dedicated section detailing how rates might be adjusted for access.
- Echoing Commissioner Gerstorff, **Commissioner Darin Gordon**, of Gordon & Associates, stated that information surrounding compliance with network adequacy and deficiencies should be provided to actuaries by CMS as a portion of their review.
- Commissioner Gordon noted that directed payments exist to increase health care access. He encouraged CMS to provide information on these payments to actuaries as a part of the rate setting process for consideration.
- **Commissioner Angelo Giardino, M.D., Ph.D.**, of the University of Utah, explained that an actuarily sound plan can have poor network adequacy, adding that issues with access are much broader than rate setting alone. **Chair Melanie Bella**, of Cityblock Health, agreed that access challenges stem far beyond actuarial soundness and rate setting.
- **Commissioner Heidi Allen, Ph.D.**, of Columbia University School of Social Work, articulated that a fundamental source of disparities stems from Medicaid paying less than other payers. She called for an expert panel to discuss ways to benchmark access under the Medicaid program. **Commissioner Frederick Cerise, M.D.**, of Parkland Health and Hospital System, echoed these comments, noting that Medicaid beneficiaries are "severely disadvantaged" because of this.
- **Commissioner Tricia Brooks**, of Georgetown University Center for Children and Families, agreed that rates are important but suggested that a "cultural aspect" exists, particularly regarding provider types, that may not be present outside of Medicaid.
- Commissioner Brooks disagreed with the argument that all Medicaid beneficiaries experience issues with access. Commissioner Allen countered that, while primary care access is largely high, specialty access is not.

- Commissioner Allen suggested that actuaries participate in the setting of directed payments rather than receiving that information after those rates have been determined.
- **Commissioner Laura Herrera Scott, M.D.**, of Summit Health, stressed the need for the ability to leverage information and data from one federal agency to another for streamlining purposes — particularly to provide actuaries with the information needed to determine whether access is met.
- **Commissioner Sonja Bjork**, of Partnership HealthPlan of California, advocated for consideration of the social determinants of health (SDOH) within actuarial soundness determinations.

TRENDS IN MEDICAID DRUG SPENDING AND REBATES

In the sixth session of MACPAC's October meeting, Commission staff provided an overview of drug spending in Medicaid. Specifically, the presentation included a discussion of the pharmaceutical supply chain, the Medicaid Drug Rebate Program (MDRP), and spending trends for generic and branded drugs. In general, drug spending has increased since 2018 despite a steady upward trend in the utilization of generic drugs. This new data will be included in an update to MACPAC's fact sheets. The Commissioner discussion centered around clarification questions and suggestions for further data analysis.

Staff Presentation

Principal Analyst and Data Analytics Advisor Chris Park presented background information on drug rebates and payments in Medicaid. This refresher included Medicaid outpatient prescription drugs, various transactional relationships in the pharmaceutical supply chain, and mechanisms surrounding payments to pharmacies. After providing a slightly more in-depth review of the MDRP, he analyzed spending trends in Medicaid drug spending. Mr. Park began by explaining that from 2018 through 2021, Medicaid drug rebates reduced gross drug spending (before rebates) by over 50 percent compared to net spending (after rebates).

Additionally, he explained net spending on drugs has increased each year since 2018, while beneficiaries are taking a higher proportion of generic drugs than branded drugs. Despite an influx in generic drug use, the proportion of spending on branded drugs has increased. Coinciding with this data, Mr. Park noted that average spending on brand drug claims rose sharply, with each claim rising from about $84 to $111 from 2018 to 2021. He deduced that increased spending on brand drug claims reflects spending on high-cost drugs.

Shifting focus to the composition of drug rebates, Mr. Park noted that most rebates are statutory, and these rebates reduced gross spending on brand drugs much more than on generic drugs in 2020. He explained that most brand drug rebates are based on best price calculations, as opposed to the minimum basic rebate. Most brand drugs also received inflationary rebates in 2020, compared to only about 25 percent of generic drugs. Regardless of a product being branded or genericized, inflationary rebates increased significantly in 2020, and only a small portion of drugs reached the rebate cap. Notably, he pointed out that high-cost drugs generally have lower rebate

rates than other drugs. Upon conclusion of the presentation, Mr. Park said that this data will inform updates to MACPAC's fact sheets. He also welcomed feedback on the analysis.

Commissioner Discussion

- **Commissioner Laura Herrera Scott, M.D.**, of Summit Health, was curious as to why newer drugs generally received lower rebates, to which Mr. Park explained that first-in-class drugs generally experience less competition and are subject to fewer rebates. He drew her attention to CMS's rule allowing for value-based contracts relating to supplemental rebates for new drugs.
- **Commissioner Heidi Allen, Ph.D.,** of the Columbia University School of Social Work, expressed confusion regarding rebate caps and inquired about the reasoning behind rebate caps being higher than AMP. Mr. Park explained that the ACA initially limited rebates to 100 percent of AMP, under which manufacturers did not make money off Medicaid beneficiaries. Now, caps will allow rebates to exceed this 100 percent threshold, though manufacturers raise prices and still make very little money on the Medicaid population, he said.
- **Commissioner Jennifer Gerstorff,** of Milliman, suggested that staff further examine rebates and generic dispensing rates by delivery system, including pharmacy benefit manager (PBM) contracts, risk-based pharmacy rates, and uniformed preferred drug list (PDL). While Mr. Park agreed, he expressed caution that such an analysis could lead to false assumptions of causation.
- **Commissioner Dennis Heaphy**, of the Massachusetts Disability Policy Consortium, inquired about an analysis through an acuity lens, though Mr. Park notes that while staff could use a common risk adjustment model to parse out this information, the data is generally unreliable. Instead, Mr. Park suggested disaggregating data by drug class, drug mix, and spending.

PANEL DISCUSSION ON STREAMLINING DELIVERY OF HOME- AND COMMUNITY-BASED SERVICES (HCBS)

In the seventh session of MACPAC's October meeting, an expert panel described some of the issues facing the current design of the HCBS benefit. The panelists raised a series of concerns related to the complexity of the HCBS waivers, the difficulties that beneficiaries face in the enrollment process, the "artificial barriers" created by federal statute that prevent access, among other issues. Notably, both the panelists and commissioners were concerned about issues plaguing the direct care workforce, and the panelists recommended that the Commission examine rate setting as a potential solution to the workforce's low wages. Commissioners seemed supportive of redesigning the HCBS benefit, although they were still seeking general recommendations and ideas from the panelists.

Panelists

- Henry Claypool, Policy Director, Community Living Policy Center, University of California, San Francisco
- Katie Evans Moss, Chief, TennCare Long Term Services and Supports (LTSS) Division

Panel Discussion

Senior Analyst Esmaa Albaroudi explained that the purpose of the panel was to examine ways to simplify the administrative complexity, increase access, and change the design of the Medicaid HCBS benefit. She observed that beneficiaries have difficulty accessing the HCBS benefit because of a patchwork of requirements and enrollment processes across states. Analyst Albaroudi then asked the panelists several questions related to these topics.

Do barriers to access exist for beneficiaries?

- Mr. Claypool highlighted the "crisis" in the HCBS workforce as one barrier, and he recommended that the Commission make recommendations to address this "systemic failure" in the program. He pointed to housing as another barrier to services since, he explained, someone lacking housing prevents access to HCBS. Financing, he continued, is another barrier because some states are less generous when it comes to making HCBS available to beneficiaries.
- Mr. Claypool also noted some other smaller barriers, including: (1) the HCBS enrollment process being difficult for beneficiaries to navigate; (2) asset limits not allowing beneficiaries to maintain housing; (3) functional eligibility varying across the different groups and programs in a way that siloes the populations instead of taking a needs-based approach; and (4) access to information about enrollment in HCBS being fragmented.
- When concluding, Mr. Claypool explained that three major populations constitute the core of the HCBS population: (1) people with behavioral health issues, where financing is the largest issue; (2) older adults, where people go without needs met until reaching the necessary level of care; and (3) people with physical and intellectual disabilities, where the program is more well-organized than the other groups, although it is oversubscribed in some states.
- Ms. Evans Moss agreed with Mr. Claypool's remarks, describing how Tennessee has structured benefits to ensure a continuum of care so that individuals can access services before crises. However, she noted difficulties with workforce challenges.

How can states and the federal government address access barriers?

- Mr. Claypool again argued that the workforce issue is pressing, and he contended that the rates for the direct care workforce is an underdeveloped policy area that should be examined. Immigration is also a related issue and could help address workforce shortages, he said. Mr. Claypool stated that federal financing is key to increasing wages for the HCBS workforce, and he recommended provider taxes for homecare agencies to raise revenue. He added that functional assessments are key to moving toward needs-based care, that better data is also needed, and that wait list management should also be examined.
- Ms. Evans Moss agreed that rates for the direct care workforce are a major issue. Additionally, she argued that "institutional bias" exists in federal HCBS statute that needs to be addressed. She posed an example, explaining that people are unable to access nursing care facilities while keeping their homes because of federal statute. Ms. Evans Moss added that Tennessee is looking to expand its technology-focused approach but has been slowed in its efforts because broadband is not reimbursable.

States often manage several HCBS benefit packages at once. What are the advantages and disadvantages of the range of Medicaid HCBS authorities?

- Ms. Evans Moss responded that Tennessee is working to consolidate waivers so that HCBS is managed by managed care organizations (MCO).
- Mr. Claypool stated that variety in states-offered packages can provide some variety to the beneficiaries. However, he cautioned that the targeted nature of these packages can have disadvantages by limiting the options available to beneficiaries.

What flexibilities could help administration of HCBS services?

- Ms. Evans Moss answered that addressing the complexity around waivers would be helpful. Tennessee has been able to leverage the 'No Wrong Door' policy to streamline the application process for individuals, she said. However, Ms. Evans Moss continued to voice her concern that workforce issues are still a major barrier and will be the focus of her state for the next several years.
- Mr. Claypool advocated for a state plan service where the bulk of services would be offered, on top of which more specialized services could be built that would be triggered if eligibility requirements were met. Since 1915(i) permits enrollment triggers, he argued that this could be done using existing authorities.

MACPAC is working on rethinking the design of the HCBS benefit. What are some key considerations that policymakers should take into account?

- Ms. Evans Moss stated that state-wide MCOs simplify administration and member use. She also observed telehealth as a "key" opportunity, although she recognized that there are disparities in rural areas because broadband is not a reimbursable service.
- Mr. Claypool urged policymakers to take steps to bolster and protect the social supports provided by HCBS as it becomes more integrated with the modern health care delivery system. He purported that there are large clinical interests that will direct how these services are provided, which he believed could threaten the qualitative aspects of HCBS that are focused on the social supports that beneficiaries need. Mr. Claypool recommended that policymakers invest in care support models for people with behavioral health issues. Finally, he argued that "No Wrong Door" should act as a one-stop shop where people can access all the information they need.

Commissioner Discussion

- **Commissioner Dennis Heaphy**, of the Massachusetts Disability Policy Consortium, asked what would happen if policymakers did not address the current state of HCBS. Mr. Claypool argued that emergency services will become more involved and that adult protective services will be forced to play a role. States and the federal government need to invest in preventative care, he concluded. Ms. Evans Moss added that the workforce challenges are contributing to these issues, and she encouraged policymakers to focus on enabling technology — such as telehealth — to help mediate this.
- Commissioner Heaphy asked what getting rid of the waivers would look like. Ms. Evans Moss responded that there are some benefits to the waivers, especially in states such as

Tennessee that are working to streamline them. Mr. Claypool encouraged an examination of how a state plan approach would aid the transition to a needs-based approach.

- Regarding what the Commission can recommend to CMS, **Commissioner Darin Gordon**, of Gordon & Associates asked what else could be done — outside of additional funding — by policymakers to address workforce shortages. Ms. Evans Moss recommended expanding what counts as a reimbursable service to include broadband. Mr. Claypool noted the Federal Trade Commission's (FCC) Affordable Connectivity Program funded by the Bipartisan Infrastructure Law (BIL), saying that interagency cooperation on this could be helpful. Ultimately, Mr. Claypool argued that the workforce is not paid enough, urging policymakers to consider targeted rate setting to address specific areas with shortages.
- **Commissioner Sonja Bjork**, of Partnership HealthPlan of California, supported looking into presumptive eligibility and related options.
- **Vice Chair Kisha Davis**, MD of Aledade, asked if there are specific policies that are getting in the way of providing care. Mr. Claypool argued that there should be a way of streamlining the waiver process so that states can take advantage of the services and so that Centers for Medicare & Medicaid Services (CMS) does not have to divert as many resources when it comes to reviewing waivers.
- **Commissioner Heidi Allen**, Ph.D. of Columbia University, further highlighted the low wages of the HCBS workforce, noting that a large portion of the workforce is on Medicaid.
- Commissioner Gordon reiterated Commissioner Allen's point. He urged the Commission to explore ways to get rid of "artificial barriers" that prevent people from working in this space.

MAINTENANCE NEEDS ALLOWANCES FOR BENEFICIARIES RECEIVING HCBS

In the eighth session of MACPAC's October meeting, Commission staff examined beneficiaries' costs in home- and community-based services (HCBS). Specifically, the Commission previously expressed interest in HCBS beneficiaries' financial obligations to live in the community relative to their states' maintenance needs limits. The data presented during this session includes updates to a 2017 study that the Urban Institute conducted on the subject. Commissioners generally agreed that more research on this issue would be useful — especially regarding trends in health care disparities and the concept of tying spending limits to inflation.

Staff Presentation

Analyst Tamara Huson reviewed functional eligibility criteria for HCBS beneficiaries, noting that eligibility is generally based on an institutional level of care (LOC). Financial eligibility criteria include income and asset limits, and she added that there is a special income level pathway for those who meet LOC requirements and have income up to 300 percent of the Supplemental Security Income (SSI) benefit rate. Regarding maintenance needs allowances, Ms. Huson noted that in 2018, limits ranged from $100 to $2,250 per month.

Relative to household spending, **Senior Analyst Asmaa Albaroudi** explained that maintenance needs limitation research was limited due to the small sample size of Medicaid-only or dually

eligible Health and Retirement Study (HRS) respondents. Additionally, staff could not ascertain HCBS eligibility, as well as other factors affecting beneficiary spending. Instead, staff used parameters that included individuals with income below 400 percent of the federal poverty guideline (FPG) and those with long-term service and support (LTSS) needs.

Ms. Albaroudi found that most households spent about 86 percent of their expenditures on essentials, such as housing, and about half of households spent over 83 percent of their income on essentials. Roughly 40 percent of households spent more than their allowance limit on essential expenditures, she said. Median household expenditures were about $21,300, which is at least 60 percent of household income for all adults. Notably, Ms. Albaroudi explained that expenditures were lower for those with an LTSS need, compared to those without an LTSS need. Ms. Albaroudi concluded that states with more generous income limits still had beneficiaries exceeding these limits, though the portion of spending on "essential" expenditures fell within state limits. She emphasized that there is still ambiguity surrounding the role of allowance limits in meeting the needs of Medicaid HCBS beneficiaries.

Commissioner Discussion

- **Chair Melanie Bella**, of Cityblock Health, advocated for further research on this topic.
- **Commissioner Martha Carter** wanted more information on how states determine eligibility for HCBS, to which Ms. Albaroudi said that staff garnered very little information in this area. However, she said that one state measured eligibility by shelter, utilities, and other costs of living specific to geographic areas. Commissioner Carter found this measure to be inadequate, citing cost differences in rural and urban areas.
- In response to **Commissioner Sonja**, Ms. Albaroudi explained that if the Commission wants to continue research into HCBS maintenance needs allowances, staff will constrict the study population to just Medicaid beneficiaries.
- Compared to institutional monthly allowances, Ms. Albaroudi explained to **Commissioner Laura Herrera Scott, M.D.**, of Summit Health, that HCBS maintenance needs allowances are generally over $2,000, while institutional allowances are subject to a $30 federal minimum. Commissioner Hererra Scott was concerned that HCBS maintenance needs allowances were too low, and Ms. Albaroudi said that she would like to explore the extent to which the allowance covers the cost of food and other necessities.
- Ms. Albaroudi told **Commissioner Heidi Allen, Ph.D.,** of the Columbia University School of Social Work, that staff can dig into the root causes of why people with an LTSS need exceed essential spending allowances at higher rates than beneficiaries without an LTSS need.
- **Commissioners Tricia Brooks** and Allen inquired about state spending maximums being tied to inflation and agreed that staff should look into this area
- **Commissioner Dennis Heaphy**, of the Massachusetts Disability Policy Consortium, asked about ways to view this data through a racial and health equity lens.
- Chair Bella suggested that the Commission consider a recommendation related to tying needs allowances and spending to inflation. She also supported more general qualitative analysis — including presumptive needs analysis and the ability for beneficiaries to enter the community — as to how states are handling this issue.

POTENTIAL RECOMMENDATIONS FOR STRUCTURING DSH ALLOTMENTS DURING ECONOMIC CRISES

In the ninth session of MACPAC's October 2022 meeting, the Commission discussed potential recommendations for structuring disproportionate share hospital (DSH) allotments during economic crises. The Commission staff provided two policy options that would increase federal support to states during future economic recessions by tying DSH allotments to each state's federal medical assistance percentage (FMAP). Additionally, staff presented other policy options to adjust prior countercyclical financing and make a technical correction to streamline annual allotment calculations. The commissioners expressed general support for the third recommendation. Additionally, a majority of the commissioners were supportive of draft recommendation 1B, while a few remained unconvinced of permanently requiring calculations of federal DSH allotments.

Staff Presentation

Senior Analyst Aaron Pervin provided background noting that state DSH funding is limited by federal allotments — a higher FMAP results in lower state and federal DSH funding — and that the need for such funding is countercyclical, whereas during economic recessions hospital uncompensated care tends to increase while state tax revenue decreases. He reminded the Commission that the American Rescue Plan (ARP) addressed these issues during the COVID-19 public health emergency (PHE), as it increased federal DSH allotments so that total DSH funding is the same as it would have been without the increased FMAP that was also made available to states during the PHE. Mr. Pervin suggested that the commissioners may want to consider extending a similar policy to other FMAP changes during periods of normal growth. To inform the discussion of the issue, the staff examined changes in total federal spending and state-by-state effects with and without ARP-like adjustments.

Mr. Pervin reviewed two policy options and explained the implications for stakeholders such as the federal government, states, providers, and enrollees.

- Draft Recommendation 1A. Temporary: In order to preserve total DSH funding when the FMAP increases during national economic recessions, Congress should amend Section 1923 of the Social Security Act to temporarily increase federal DSH allotments so that total available state and federal DSH funding is the same as it would have been without an increased FMAP during the period.
- Draft Recommendation 1B. Permanent: In order to preserve total DSH funding when the FMAP changes, Congress should amend Section 1923 of the Social Security Act to permanently calculate federal DSH allotments so that total available state and federal DSH funding does not vary based on changes in a state's FMAP.

Principal Analyst Robert Nelb led a discussion on a recommendation to adjust prior countercyclical financing, explaining that if the Commission adopts an ARPA-like change to DSH allotments — draft recommendations 1A or 1B — the Commission could also revise its prior countercyclical financing recommendation to include DSH. He found that this would benefit states

during economic recessions without negatively affecting providers and would also reaffirm MACPAC's prior recommendation to Congress in 2021 to adopt such a mechanism. He provided the draft language of the second recommendation:

- Draft Recommendation 2: Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis.

Mr. Nelb provided a third recommendation that would make a technical correction in the statutory requirement that CMS compare DSH allotments to total state medical spending to streamline annual allotment calculations. The result of this requirement was increased delays in finalizing DSH allotments which affected states' ability to spend all DSH funds in a timely manner early in the pandemic. The current requirement dictates that federal allotments cannot exceed 12 percent of total medical spending. However, he noted that the 12 percent limit no longer has any effect.

- Draft Recommendation 3: To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare and Medicaid Services (CMS) compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

Commissioner Discussion

- **Commissioner Darin Gordon**, of Gordon Associates, was supportive of the third recommendation in that it would increase states' ability to utilize existing allotments in a timely manner — a two-year limit to spend allotments. **Commissioners Heidi Allen, Ph.D.**, of the Columbia University School of Social Work, and **Verlon Johnson**, of Client Network Services, Inc. (CNSI) also expressed their support for recommendation 3.
- **Commissioner Angelo Giardino, M.D., Ph.D.**, of the University of Utah, said that he saw the "wisdom" of recommendation 1A, and needed more convincing to support recommendation 1B. Commissioners Gordon and **Laura Herrera Scott, M.D.**, of Summit Health, and **Chair Melanie Bella,** of Cityblock Health, leaned toward supporting recommendation 1A over recommendation 1B because the temporary recommendation is more consistent with other policies. The remaining commissioners voiced their support for 1B.
- **Commissioner Bill Scanlon, Ph.D.,** was supportive of ensuring access for those impacted by the business cycle. He raised concerns about reinforcing DSH allotments that are not based on valid measures of the problem that would target money to those most in need.

RESPONSE TO RFI ON PROMOTING EFFICIENCY AND EQUITY WITHIN CMS PROGRAMS

In the tenth session of MACPAC's October meeting, commissioners discussed their planned comments in response to the Centers for Medicare and Medicaid Services' (CMS) request for

information (RFI) surrounding the efficiency and equity of the agency's programs. Focused heavily on actions the Administration can take, the Commission's comment letter discusses strategies related to access to health care, advancement of health equity, and improvements to providers' experiences within the health care workforce. Additionally, the letter details efforts to discern the effects of the COVID-19 public health emergency's (PHE) waivers and flexibilities on beneficiaries and providers alike.

The Commission's comments will be available on its website following the November 4th submission deadline.

Staff Presentation

Policy Director Joanne Jee explained that the Commission's comments draw from its prior work and discussions with relation to topics of interest as indicated by CMS within the RFI, including: (1) access to health care; (2) provider experiences; (3) health equity; and (4) the impact of waivers and flexibilities afforded under the COVID-19 PHE. Ms. Jee noted that the RFI specifically requests stakeholder perspectives on actions that CMS can take and, as such, the Commission's comments are tailored towards administrative actions rather than actions that would require an act of Congress.

With respect to health equity, the Commission's comments include suggestions to better collect and report race and ethnicity data, monitor access to care, and address disparities for dually eligible beneficiaries, she said. Ms. Jee explained that the Commission is additionally suggesting that the agency provide opportunities for streamlining eligibility and enrollment processes, with an increased focus on Medicare Savings Programs. Regarding the COVID-19 PHE waivers and flexibilities, Ms. Jee asserted that the comment letter will express support for the streamlining of the provider enrollment process and program integrity efforts, as well as assessing the implications of telehealth on access, quality, and cost. Notably, the Commission's comments will also include a call for transparency — both with respect to the RFI process as well as data collection, she said.

Commissioner Discussion

- **Commissioner Tricia Brooks**, of Georgetown University Center for Children and Families, spoke in favor of including comments on the three topics proposed by MACPAC staff within the response to CMS' RFI.
- Noting that the RFI calls for strategies to address health equity, **Commissioner Rhonda Medows, M.D.**, of Providence Population Health Management, suggested that staff include references to the Commission's prior work on maternal and behavioral health strategies.
- **Commissioner Heidi Allen, Ph.D.**, of Columbia University School of Social Work, called for emphasis on the lack of beneficiary data transparency overall — with an emphasis on unrealized access — within the letter.
- **Commissioner Verlon Johnson**, of Client Network Services, Inc., echoed Commissioner Meadows' comments that, because states are unable to choose more than one race and ethnicity under the Transformed Medicaid Statistical Information System (T-MSIS), the

availability and accuracy of such data is severely lacking, causing challenges when seeking to monitor disparities and access.

- **Commissioner Jennifer Gerstorff**, of Milliman, suggested the inclusion of strategies related to the direct care workforce within the letter.