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Event Summary

February 1, 2021

MACPAC January 2021 Meeting

EXECUTIVE SUMMARY

On January 28-29, the Medicaid and CHIP Payment and Access Commission (MACPAC) convened for its monthly public meeting. The slide presentations from the meeting are available here.

Among the highlights of the respective sessions:

- **Postpartum Coverage** — Commissioners approved a recommendation to increase FMAP to 100 percent for postpartum coverage.
- **Medicaid Estate Recovery** — Commissioners approved three recommendations relating to the Medicaid estate recovery program in spite of some worry that the recommendations are not ambitious enough.
- **Automatic Countercyclical Financing Adjustment** — Commissioners approved a recommendation to create an automatic countercyclical financing adjustment in Medicaid.
- **New Unified Program for Dually Eligible Beneficiaries** — Commissioners discussed options for a new program focusing on duals.
- **Report on Housing Supports for Individuals with SUD** — Commissioners will send a letter to HHS and leadership of relevant congressional committees addressing a potential Medicaid roadmap to work towards a coordinated solution on housing supports.
- **State Budget Outlook and Implications for Medicaid** — Members of a panel noted that the pandemic has impacted state budgets and fiscal outlooks, while also increasing demand for public assistance programs.
- **Value-Based Payment for Maternity Care in Medicaid** — Commissioners were underwhelmed with VBP performance for maternity care so far.
- **The Role of Medicaid for People with Intellectual and Developmental Disabilities** — Commissioners and panelists emphasized the need to address discrimination against individuals with disabilities and to provide individualized, supportive care to individuals with ID/DD.
- **MACPAC Study on Non-Emergency Medical Transportation** — Analysts overviewed an in-progress MACPAC study on NEMT.
- **Integration of Care for Dually Eligible Beneficiaries** — Commission staff will look into ways that states can receive support for utilizing mechanisms to attract and integrate duals, supplement the broker and agent pool with impartial advisors for beneficiaries, and encourage states to better integrate the dual-eligible population.
- **Implementation of the Mental Health Parity and Addiction Equity Act** — The Commission will discuss options to improve mental health access during its next meeting.

- **Payment and Coverage of High-Cost Specialty Drugs** — There is Commission interest in fleshing out recommendations on differential rebates for accelerated approval drugs and a national benefit on cell and gene therapies.

Detailed summaries of the sessions are included below. The next public meeting will be held virtually on March 4-5, 2021.

POSTPARTUM COVERAGE: REVIEW OF DRAFT CHAPTER AND RECOMMENDATIONS

In the first session of MACPAC's January meeting, Commissioners discussed increasing the Federal Medical Assistance Percentage (FMAP) to either 90 percent or 100 percent for postpartum coverage. Despite some disagreement between a ten percent state match or 100 percent federal coverage, the Commission decided to move ahead with the 100 percent draft recommendation, with a fallback plan based on an Affordable Care Act (ACA) model, which would create a 100 percent match for two to three years, then phase in a 90 percent matching requirement. Commissioners found this idea appealing, as it encourages long-term participation and eases state financial burdens while experiencing and recovering from the COVID-19 pandemic. Ultimately, the Commission approved three recommendations on postpartum coverage.

Staff Presentation

Principal Analyst and Research Advisor Martha Heberlein elaborated upon two outstanding issues that the draft recommendations will address. She explained that the first issue is whether the mandatory extension should apply to all postpartum individuals, or if the coverage extension should be mandatory up to 133 percent of the federal poverty level (FPL). Ms. Heberlein suggested a tiered approach to work out this issue. The other outstanding issue was whether a 90 percent of 100 percent level of enhanced federal funding should be provided to states.

The draft recommendations are as follows:

- **Draft Recommendation 1** — Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced [insert 90 or 100 percent] federal matching rate.
- **Draft Recommendation 2** — Congress should extend the postpartum coverage period for individuals who were eligible and enrolled in the State Children's Health Insurance Program while pregnant (if the state provides such coverage) to a full year of coverage, regardless of changes in income.
- **Draft Recommendation 3** — Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways.

Commissioner Discussion and Votes

Commission Chair Melanie Bella immediately centered the discussion on the 90 percent versus 100 percent issue, noting that the Commission takes issue with tiering. **Commissioner Toby Douglas**, of Kaiser Permanente, reiterated that tiering for non-expansion states would not solve the problems at hand, and he leaned towards a 90 percent match along with **Commissioners Fred Cerise, M.D.**, of Parkland Health and Hospital System, **Thomas Barker**, of Foley Hoag, LLP, **Christopher Gorton, M.D.**, and **Vice Chair Charles Milligan**.

Commissioner Sheldon Retchin, M.D., of The Ohio State University, agreed with 90 percent, but he also offered an alternative. Inspired by the ACA model, he suggested that states received 100 percent for the first three years, then drop down to 90 percent going forward. While **Commissioner Peter Szilagyi, M.D.**, of UCLA, leaned more towards the 90 percent recommendation, he strongly agreed with Commissioner Retchin's ACA-inspired plan. **Commissioners Darin Gordon**, of Gordon & Associates, **Katherine Weno**, **Kisha Davis**, of Aledade, **Stacey Lampkin**, of Mercer Government Human Services Consulting, and **Tricia Brooks**, of Georgetown University Center for Children and Families, preferred a 100 percent match.

After the Commission voted on whether to include a 90 percent or 100 percent federal participation in the final recommendation, Commissioner Davis noted that female commissioners overwhelmingly voted for 100 percent, while the male commissioners voted for 90 percent or Commissioner Retchin's ACA option. Pointing this out led a couple of the commissioners to switch their vote from 90 percent to 100 percent. Either way, most commissioners agreed that either percentage was better than nothing at all. In the end, Commission Chair Bella requested that Ms. Heberlein come back with a 100 percent recommendation with the ACA plan as a fallback option.

The Commission voted 16-0, with **Commissioner Bill Scanlon, Ph.D.**, abstaining, to approve Recommendation 1. The Commission voted 17-0 to approve Recommendations 2 and 3.

MEDICAID ESTATE RECOVERY: DRAFT CHAPTER AND RECOMMENDATIONS

In the second session of MACPAC's January meeting, Commissioners discussed avenues to create a more equitable estate recovery system. While there is much to be recovered, Commissioners were concerned that recovered assets are being squeezed from lower-asset populations while higher-income beneficiaries sequester funds. While some Commissioners believed that the draft recommendations were not ambitious enough, MACPAC voted to approve all three recommendations.

Staff Presentation

Analyst Tamara Huson walked the Commission through the draft chapter for the March report to Congress. She expanded upon long-term services and supports (LTSS) financial eligibility, legislative history and requirements, program administration, state variation in estate recovery policies, and estate collections. Ms. Huson found that estate recovery programs vary by state, with some more expensive than others, and an aggregate recovery of $733.4 million by states in 2019. She noted that

average recoveries are modest, and few beneficiaries are granted hardship waivers. Stakeholders said that beneficiaries with significant means can avoid estate recovery through estate planning, and estate recovery can deter individuals from seeking Medicaid coverage for LTSS.

Based on these findings, Principal Analyst Kristal Vardaman outlined three draft recommendations:

- **Draft Recommendation 1** — Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law.
- **Draft Recommendation 2** — Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary was less than the capitation payment made to a managed care plan.
- **Draft Recommendation 3** — Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for: (1) any asset that is the sole income-producing asset of survivors; (2) homes of modest value; or (3) any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards.

Commissioner Discussion and Votes

Commission Chair Melanie Bella expressed her support for all three recommendations and urged her colleagues to distinguish the discussion from eligibility concerns. **Vice Chair Charles Milligan**, and **Commissioners Darin Gordon**, of Gordon & Associates, and **Kit Gorton, M.D.** supported all three recommendations. However, Commissioner Gorton and Vice-Chair Milligan voiced frustration that while these recommendations are a step in the right direction, the recovery system is regressive and hinders upward mobility for generations. **Commissioner William Scanlon, Ph.D**., expressed similar concerns that while some LTSS users do not have the resources for protecting and building their assets, others shelter assets inappropriately. Despite concerns, he supported Recommendations 2 and 3 and suggested that Recommendation 1 be optional.

Commissioner Brian Burwell's frustration with the program led him not to support two of the recommendations due to a need for a more radical change. **Commissioner Sheldon Retchin, M.D.**, of The Ohio State University, wondered about hardship applications and echoed Commissioner Scanlon's concerns, but he was ultimately puzzled in attempting to find an appropriate policy.

Recommendation 1 was adopted with 13 yes votes, with Commissioners Burwell and Scanlon voting no and Commissioners Lampkin and Retchin abstaining. Recommendation 2 was adopted unanimously. Recommendation 3 was adopted with 15 yes votes and Commissioner Burwell voting no and Commissioner Retchin abstaining.

AUTOMATIC COUNTERCYCLICAL FINANCING ADJUSTMENT: DRAFT CHAPTER AND RECOMMENDATIONS

During the third session of the January MACPAC Meeting, Commissioners reviewed and voted on a recommendation to encourage Congress create a statutory mechanism to automatically adjust the federal medical assistance percentage (FMAP) formula if certain conditions are met. The Commission unanimously approved a recommendation to Congress stating that it should adopt a statutory mechanism to amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office (GAO) as the basis, among other policy specifics. Commissioners noted that the mechanism is tailored to get to the root of states' need and will provided much needed budget predictability.

Staff Presentation

Policy Director Moira Forbes and **Principal Policy Analyst Chris Park** reminded commissioners that Medicaid is a countercyclical program by nature, as enrollment and spending increase during economic downturns, and these economic effects during downturns vary by state. Currently, Congress must act to provide additional funds to states when economic conditions decline or to provide federal stimulus, and it can be difficult to be proactive in identifying state needs, take action early, and target assistance to states. The analysts explained that policymakers have suggested Congress could create a permanent statutory mechanism to automatically increase the federals hare of Medicaid expenditures, and Commissioners determined a mechanism should be automatic; have a trigger that is sensitive but not too sensitive; and additional financing for states should be targeted.

The GAO developed a prototype formula to trigger a temporarily enhanced FMAP and adjusts the amount of federal relief to state-level conditions. In prior economic downturns caused by the regular business cycle, the GAO model triggered assistance months before Congress acted. The analysts noted that the prototype seems sufficiently sensitive to respond to major recessions but not minor economic fluctuations. Other policy issues relating to Medicaid financing could be addressed in conjunction with a permanent change to the federal financing mechanism, including: (1) whether additional rules should be attached to the use of federal matching funds; (2) whether to have an upper bound or cap on increased FMAPs; and (3) whether additional FMAP should be applied to special matching rates.

The analysts offered the following draft recommendation:

- 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. The Commission also recommends this policy change should also include:
    - An eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
    - An upper bound of 100 percent on countercyclical adjusted matching rates; and

- An exclusion of countercyclical adjusted federal matching rate from services and populations that receive special matching rates or are otherwise capped or have allotments.

Commissioner Discussion and Vote

Commissioners voted unanimously to approve the recommendation for Congress. **Commissioner Toby Douglas** noted the recommendation was a huge step forward in providing budget predictability for states. **Commissioner Charles Milligan** explained that the mechanism ties the need more directly to the root cause of the need in terms of state revenue.

DESIGN CONSIDERATIONS IN CREATING A NEW UNIFIED PROGRAM FOR DUALLY ELIGIBLE BENEFICIARIES

The fourth session of the January MACPAC meeting focused on how to increase enrollment of dually eligible beneficiaries in integrated models and increase availability of such models across geographic areas. Staff presented a draft chapter for the March 2021 report that examines key design considerations that would have to be addressed to establish a unified program. Analysts offered specific policy considerations for issues related to eligibility, beneficiary protections and enrollment, benefits, the delivery system and model of care, administration, and financing. The chapter draws examples from two existing proposals to create a fully integrated system for dually eligible beneficiaries. Commissioners were supportive of including the chapter in the March report but had several outstanding concerns they wanted addressed before the chapter is finalized.

Staff Presentation

Principal Policy Analyst Kirstin Blom explained that two publicly available proposals for fully integrated systems have been developed by the Bipartisan Policy Center (BPC) and Dual Eligible Coalition. The BPC model would develop a fully integrated options — building on the current structure — with federal fallback, whereas the Dual Eligible Coalition model would establish an entirely new program. She noted that the Commission will include a chapter in the March 2021 report to Congress on a potential program encompassing Commissioner feedback on the following considerations.

Commissioners have previously noted eligibility for such a program should limit eligibility to full-benefit dually eligible beneficiaries, continuous eligibility for Medicaid, population carve-outs, and maintenance of effort. Such a program should also have certain beneficiary protections and enrollment considerations, such as beneficiary choice, access to existing providers, enrollment processes, and an appeals and grievances system. The program would encompass a uniform benefit package with Medicaid benefit carve-outs and would operate off a managed care delivery system with provider participation. Ms. Blom also noted that such a program would require federal oversight with a state option to participate. There would be federal and state shares of financing, with shared savings for states. Risk mitigation and establishing spending levels would need to be considered further.

Commissioner Discussion

Commissioners were supportive of the chapter's inclusion in the March 2021 report but had outstanding questions about how such a program might operate. **Commissioner Sheldon Retchin, M.D.** of the Ohio State University noted that while the chapter focuses on national integrated models, there will be challenges incorporating integrated clinical models of care. He explained that many areas with high dual eligibly populations face primary care deserts. Commissioner Martha Carter asked that the chapter address how a new program would encompass federally qualified health centers more so than current models do. **Commission Chair Melanie Bella** of Cityblock Health questioned how the program could be made attractive states and providers if given optional participation. She added that states need to be armed with the tools and funding needed to ensure that have the support and capacity to take this program on. She also acknowledged that many beneficiaries currently face too many plan options already, and that creating a new program runs the risk of adding to that confusion. She stressed the goal needs to be in creating a unified program easy for states and providers to navigate and be held accountable, but also for easy enough for beneficiaries to understand.

REVIEW OF SECRETARY'S REPORT ON MEDICAID HOUSING SUPPORTS FOR INDIVIDUALS WITH SUBSTANCE USE DISORDER

During the fifth session of the January MACPAC meeting, Commissioners reviewed a HHS report to Congress on housing services and supports for individuals with substance use disorder (SUD) who are experiencing or at risk of experiencing homelessness. The report was mandated by Congress by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). Staff summarized key findings from the report and identified potential areas for MACPAC comment. Commissioners will send a letter to HHS and leadership of relevant congressional committees addressing a potential Medicaid roadmap to work towards a coordinated solution on housing supports.

Staff Presentation

Senior Analyst Melinda Becker Roach noted that the SUPPORT Act directed the HHS Secretary to report to Congress on: (1) Medicaid authorities states may use to cover housing-related services and lessons learned from the use of Sections 1115 and 1915 of the Social Security Act; (2) state initiatives that have increased housing stability for Medicaid beneficiaries with SUD experiencing or at risk of homelessness; (3) strategies used by plans and providers to provide housing-related services; and (4) state Medicaid efforts to identify and enroll eligible individuals with SUD experiencing or at risk of homelessness.

Ms. Roach explained that states can use federal authorities such as health homes, home- and community-based services (HCBS) waivers, HCBS state plan authority, and Section 1115 demonstrations. State efforts target high-cost, high-need Medicaid beneficiaries, including many individuals with SUD. Many states coordinate federal, state, local, and philanthropic resources to provide non-Medicaid funded services. Strategies broadly adopted include providing local flexibility,

peer supports, care coordination, and technical assistance to providers. Outcomes are promising, but more research is needed to establish a causal relationship.

It is often difficult for states to determine appropriate authority for providing housing-related services to individuals with SUD. Section 1115 demonstrations are used most often, and few states use section 1915(c) HCBS waivers for this purpose because it can be challenging. Many plans and providers are also expanding services to improve health outcomes and avoid unnecessary costs. States are also using CMS flexibilities to identify and enroll individuals with SUD experiencing or at risk of homelessness.

Ms. Roach suggested several areas for potential MACPAC comment. The Commission could encourage CMS to provide more guidance on: (1) Medicaid HCBS for individuals with behavioral health conditions; (2) how Section 1115 demonstrations can be used to address housing for people with behavioral health conditions; and (3) opportunities to address housing in Section 1115 guidance on release from correctional facilities.

Additionally, the Commission could comment on the importance of addressing non-Medicaid barriers to housing stability that may require congressional action, such as: (1) time-limited ban against living in U.S. Department of Housing and Urban Development-assisted housing for individuals evicted due to drug-related activities; (2) federal policies allowing housing agencies to prohibit or limit housing assistance to individuals who have a past history of drug use or considered at risk for engaging in illegal drug use; and (3) limited funding for rental assistance.

Commissioner Discussion

Commissioners worried about over-reliance on the Medicaid program to address solutions for multiple issues in the nation, such as the housing crisis. **Commissioner Brian Burwell** of Ventech Solutions noted that the overhead required to address the issue at hand can be challenging but stated that a simplified approach such as a home health program for this population might work — in which individuals would be supplied housing and care in the same environment. **Commissioner Fred Cerise, M.D**. of Parkland Health and Hospital System stated that much of the activity in this space is very uncoordinated and advocated for the comments on identifying a Medicaid roadmap to support working towards a solution with community housing organizations, HUD, and other funding streams.

PANEL: STATE BUDGET OUTLOOK AND IMPLICATIONS FOR MEDICAID

During the sixth session of its January public meeting, MACPAC convened a panel discussion on the outlooks of state budgets and the implications for Medicaid. Commissioners heard from **Shelby Kerns** of the National Association of State Budget Officers (NASBO), **Susie Perez Quinn** of the National Governors Association (NGA), and **Emily Blanford** of the National Conference of State Legislatures (NCSL) about the current fiscal condition of state budgets amid the COVID-19 public health emergency. The panelists noted that the pandemic has impacted state budgets and fiscal outlooks, while also increasing demand for public assistance programs. Commissioner questions

focused on the health of state balance sheets and revenues, federal medical assistance percentage (FMAP) policy, and Medicaid managed care capitation rates.

Panel Presentation

Ms. Kerns began the presentation with an overview of the fiscal health of state budgets based on NASBO's fiscal 2020 survey. States are continuing to face financial distress as a result of the pandemic, and several states are facing their first general fund spending decreases since the great recession. While 2020 stimulus measures did help prop up state economies, Ms. Kerns noted that tax collection has lagged and that the recoveries for each state vary on a case-by-case basis. As states press forward during the remainder of the pandemic and beyond, public assistance programs — such as Medicaid and food security programs — will continue to be a pressure point as utilization of these programs grow. COVID-19 vaccine distribution, testing, and treatment also stand as potential budgeting challenges in the months ahead.

Ms. Quinn further elaborated on some of the financial pressure points that states are facing, specifically citing Medicaid and National Guard expenses as two of the most significant issues affecting state revenue. While NGA advocated for an increase to the FMAP, the provisions passed in last year's Families First Coronavirus Response Act (FFCRA) was "not what the governor's had in mind," particularly with respect to the Maintenance of Effort (MOE) language. Ms. Quinn emphasized that moving forward, certainty for states is a top priority for the NGA as it looks to address states' cash flow. While there has been some successful relief on the cost and expense side of the pandemic, more relief is needed to ensure that states can avoid mishaps with future revenue projections.

Ms. Blanford closed out the panel discussion with a summary of an NCSL pandemic survey. She echoed the NGA's concerns about revenue shortfalls but noted that states largely have the financial capacity — either in their coffers or by way of federal aid — to cover certain pandemic-related costs. As state legislatures pivot toward recovery, there are active conversations about provisions to restore certain across-the-board cuts that were implemented to ease the economic blow of the pandemic. Ms. Blanford also noted that Medicaid expansion continues to be a hot topic of discussion for states that have not expanded the program so far.

Commissioner Discussion

Commissioner Stacey Lampkin of Mercer asked how capitated managed care is performing during the pandemic from a state perspective, noting that she has seen significant growth in capitation rates as a result of the pandemic. The panelists each noted that their organizations do not have information at this level of granularity, but Ms. Kerns pointed out that there has been much discussion on this particular issue. **Commissioner Sheldon Retchin, M.D.** of the Ohio State University noted that a large portion of the managed care portfolio is managed through big companies and expressed concern about a swing in post-pandemic demand.

Commissioners Retchin and **Darin Gordon** of Gordon & Associates each asked about the current landscape for state revenues. In particular, Commissioner Gordon questioned if some states are looking at reducing or raising taxes. Ms. Kerns noted that there is anecdotal evidence that suggests

more states are cutting taxes as a result of the pandemic. Commissioner Retchin followed up with a question about the health of state balance sheets, to which Ms. Kerns stated there have not been many downgrades as many still have savings and revenue to fall back on.

Vice Chair Charles Milligan of Health Management Associates stated that there is anecdotal evidence suggesting that states that have a better means of generating revenue are faring better than others, asking if this is an emerging pattern amid the pandemic. Ms. Kerns emphasized that variation in state tax regimes is a key factor in state economic recovery. States that have a sales tax — particularly an online and/or grocery tax — are seeing healthier balance sheets, she said.

Commissioner Peter Szilagyi, M.D. of UCLA spoke at length about the need to bolster public health infrastructure, especially as the pandemic has exacerbated existing gaps and inequities. He asked the panel if there have been discussions at the state level about overall funding for public health infrastructure. Ms. Blanford stated that educating policymakers on the existing gaps within public healthcare infrastructure is an important step toward improvement.

VALUE-BASED PAYMENT FOR MATERNITY CARE IN MEDICAID

During the seventh session of its January meeting, MACPAC reviewed an analysis of value-based payment (VBP) for maternity care in Medicaid. **MACPAC Principal Analyst and Research Officer Martha Heberlein** provided an overview of the Commission's prior work in this space, as well as existing VBP models for maternity care that are currently in use. MACPAC contracted with RTI International to set up a case study analysis for five states to examine the functionality of current VBP methods that are currently in place. Commissioners appeared underwhelmed at the quality metrics that were reported in this analysis but encouraged additional studies into VBP payment methods that are currently in use by states.

Panel Presentation

Ms. Heberlein provided a quick overview of prior MACPAC work on VBP models. In a recent review of Medicaid programs, MACPAC found that: (1) 14 states implemented pay-for-performance programs; (2) 10 states have implemented a single payment for the perinatal episode of care, and (3) four states have implemented pregnancy medical homes. Of these models, episode of care payment is a single, fixed payment for a group of services that considers quality and cost thresholds. Pay-for-performance models give providers financial incentives to meet certain qualities. Ms. Heberlein also noted that pregnancy medical homes aim to improve maternal health outcomes by addressing clinical, behavioral, and social aspects of care.

Ms. Heberlein then went onto provide an analysis of MACPAC's case studies in AR, CT, NC, CO, and TN that examined VBP models for maternity care. She noted that the study models are not designed to fundamentally alter the approach for maternity care and use payment incentives related to quality improvements and spending reductions. The incentives are not tied directory to reductions in maternal outcomes, but instead are tied to standard clinical care practices, Ms. Heberlein explained.

Ms. Heberlein concluded the presentation by saying that evidence is mixed as to whether the models improve quality on targeted measures. However, she pointed out that the studies suggest sharing information through performance reports often engages practices and providers in quality improvement efforts.

Commissioner Discussion

MACPAC Chair Melanie Bella of Cityblock Health questioned if any of these findings were surprising to Commission staff, and also asked if there is a sentiment that VBP is an inappropriate tool for maternal care. Ms. Heberlein expressed that she is skeptical of these payment models as a whole.

Commissioner Martha Carter stated that these findings did not surprise her but expressed a desire to look at additional VBP models beyond the ones highlighted in this analysis. She stated that there are some "interesting proposals" that exist in VBP for maternal care but emphasized that factoring in social determinants is an important step that is missing from these models.

Commissioner Darin Gordon of Gordon & Associates expressed his appreciation for the "various experiments" on VBP for maternity care. In response to previous commissioner comments, he emphasized that implementation of VBP takes time to truly show significant movement. **Commissioner Fred Cerise, M.D.** of Parkland Health and Hospital System agreed with these sentiments, and encouraged future work on "lessons learned" about VBP for maternity care.

The Role of Medicaid for People with Intellectual and Developmental Disabilities

In the eighth session of MACPAC's January meeting, commissioners heard from a panel on how Medicaid can support individuals with intellectual and developmental disabilities (ID/DD). Commissioners and panelists emphasized the need to address discrimination against individuals with disabilities and to provide individualized, supportive care to individuals with ID/DD.

Panel

The Commission heard from a panel of three experts on Medicaid and care for individuals with ID/DD.

- **Sharon Lewis** of Health Management Associates noted that the ID/DD population is very heterogenous population with differing health and support needs. She also noted that waitlists and limited home- and community-based services (HCBS) affect the ID/DD population a lot. Those services, she said, allow good quality of life. Person-centered practices and supports coordination are critical for caring for the ID/DD population, said Ms. Lewis. In addition, Medicaid agencies are increasingly working to support families of individuals with ID/DD. One critical challenge in caring for the ID/DD population, she said, is workforce shortages in direct support workers.

- **Melissa Stone** of the State of Arkansas Division of Developmental Disabilities Services told Commissioners about a managed care arrangement that Arkansas stood up for the ID/DD

population. Clients are independently assessed and those with high needs are moved into the model. All needs are based on functional need, Ms. Stone said. A particular hurdle has been that providers want to stay in their lanes, making holistic care difficult. During the pandemic, certain providers have been allowed to cross over in terms of services they provide, which has been a success, she said.

- **Elizabeth Weintraub** of the Association of University Centers on Disabilities emphasized that individuals with disabilities have to fight for fair access to treatment. CMS should seek better data on individuals with ID/DD diagnosed with COVID to improve care. She also emphasized that the ID/DD population needs to be trusted to make decisions and that individuals with ID/DD can ask for help when necessary. She mentioned three lessons that she wants to leave with the Commission: (1) inclusivity across races, cultures, and disabilities is important; (2) it is possible to teach individuals with ID/DD to accomplish things and support them; and (3) relationships between caregivers and patients matter.

Commissioner Discussion

Commissioner Kit Gorton, M.D., echoing Ms. Weintraub, said that policies should not be restrictive and parental. In addition, he said, it is important to think about bias and discrimination against people with disabilities. There are also too many silos in caring for people with ID/DD, he said.

Commissioner Sheldon Retchin, M.D., of the Ohio State University noted the direct support workforce shortage and added that there is a reliance on immigrants for such workers. **Commissioner Leanna George** added that it is necessary to increase the reliability of support workers.

Vice Chair Chuck Milligan said that it is important to address abuse in care of individuals with ID/DD without being patronizing and paternalistic. He said he wants to better understand how to balance the need to customize and tailor services for individuals with the ability to treat similar people in similar ways.

MACPAC STUDY ON NON-EMERGENCY MEDICAL TRANSPORTATION

In the ninth session of MACPAC's January meeting, Commissioners reviewed the findings of a mandated MACPAC study on Non-Emergency Medical Transportation (NEMT) use in the Medicaid program. The Senate Appropriations Committee report language for fiscal year (FY) 2020 directed MACPAC to examine the benefits of NEMT for beneficiaries, and the benefits of improving coordination of NEMT with public transportation and other federally assisted transportation services. To respond to the committee's request, MACPAC is conducting a multi-pronged study, and previously reported preliminary findings at the October 2020 meeting. Analysts described the findings from two additional components of the larger study: analysis of transformed Medicaid statistical information system (T-MSIS) data to describe NEMT utilization and spending and focus groups with beneficiaries who have used NEMT. Specifically, the presentation included background

information on the NEMT benefit and federal requirements, reviewed MACPAC's analytic plan for this study, and outlined what the Commission has learned to date from its analysis.

Staff Presentation

Analysts Kacey Buderi and **Aaron Pervin** reminded Commissioners that the Consolidated Appropriations Act of 2021 codified NEMT requirements into the Social Security Act, whereas NEMT was previously required by regulation and not statute. It is no longer possible to make NEMT an optional benefit via administrative action, as proposed by the Trump administration. States are required to provide NEMT and use the most appropriate form of transportation, and NEMT is delivered through fee for service (FFS), a third-party broker, or Medicaid managed care.

MACPAC analysts found that NEMT is used extensively by a small number of beneficiaries, with aged and disabled persons being the most frequent users when compared to other eligibility groups. Beneficiaries diagnosed with end-stage renal disease use NEMT most frequently, and those with intellectual or developmental disabilities and serious mental illnesses also use NEMT more frequently than those with none of these conditions. NEMT users primarily ride in a van or taxi — which includes Uber and Lyft — and the most common NEMT destinations are to the home or a physician's office.

Insight from beneficiary focus groups, prepared for the Commission by PerryUndem, revealed that beneficiaries faced a variety of transportation barriers to accessing the care they needed prior to enrolling for NEMT. Beneficiaries reported increased ability to manage their physical health and chronic conditions, and it improved the emotional health of those with disabilities or physical limitations. Additionally, it gave beneficiaries more independence, lessening reliance on family members. While beneficiaries were overall positive about NEMT, there was a variation of experiences with using the services and many had run into challenges. Beneficiaries suggesting improving the dispatching process, preventing overcrowding of shared vehicles, reducing excessive wait times, and more.

Commissioner Discussion

Commissioners were supportive of the analysts' work being included in the June 2021 report to congress, and analysts reminded Commissioners that they are not mandated to include policy recommendations. **Vice Chair Charles Milligan** asked that the analysts include data on how often beneficiaries used NEMT to access pharmacy services in the chapter, as many are unable to get their prescription through mail order or delivery. He noted challenges with Uber and Lyft, as some states require different state licenses for transporting medical patients. Drivers are not willing to become certified to receive this license, limiting these services in those states. He asked analysts to include information in the chapter on whether other forms of transportation are subject to regulation that could serve as a barrier to entry. Additionally, he asked for clarity around whether dual eligible individuals are able to use NEMT to access Medicare services, as CMS has not been explicit on the subject in the past.

INTEGRATION OF CARE FOR DUALLY ELIGIBLE BENEFICIARIES: NEW ANALYSES

In the tenth session of MACPAC's January meeting, commissioners discussed dual-eligible special needs plans (D-SNPs). They discussed how to attract beneficiaries, the role of brokers and agents, and barriers to state management of D-SNPs. Commissioners selected the most promising avenues for program solvency to develop draft recommendations for March 2021. Commission staff will look into ways that states can receive support for utilizing mechanisms to attract and integrate duals, supplement the broker and agent pool with impartial advisors for beneficiaries, and encourage states to better integrate the dual-eligible population.

Staff Presentation

Analyst Ashley Semanskee covered a discussion of Medicare agents and brokers. In her research, she examined the role of Medicare agents and brokers in enrolling dually eligible beneficiaries into Medicare-Medicaid Plans (MMPs) and D-SNPs. Stakeholders are concerned that Medicare agents and brokers steer dually eligible individuals away from integrated plans. Ms. Semanskee found that Medicare agents and brokers are increasingly interested in marketing and selling D-SNPs. Overall, views were mixed on the value added by Medicare agents and brokers. She also found that dually eligible beneficiaries often lack access to a single, impartial source of information that can help them compare all available coverage options. Ms. Semanskee suggested that future work could explore whether there are ways to improve coordination between Medicare agents and brokers and Medicaid enrollment brokers in the hopes that this would improve enrollment in integrated plans.

Principal Analyst Kirstin Blom continued the conversation regarding contracting strategies that states can use to integrate care through D-SNPs. After researching ways that states can maximize their existing authority to promote integration and enrollment in D-SNPs, she found several opportunities for changes in state policy, as well as Medicare policy. Ms. Blom elaborated that states could:

- require D-SNPs to enroll full-benefit and partial-benefit dually eligible beneficiaries in separate plan benefit packages;
- review Medicaid information in DSNP materials, require D-SNPs to use specific care coordination methods;
- allow D-SNPs to default enroll newly dually eligible Medicaid enrollees into the D-SNP that is affiliated with their Medicaid managed care plan;
- minimize Medicaid benefit carveouts; or
- CMS could encourage states to align Medicaid managed care open enrollment periods with Medicare.

Opportunities for change were less variant for Medicare policy. Namely, CMS could require eligible beneficiaries to enroll in D-SNPs, or CMS could develop a waiver process for D-SNPs that cannot meet network adequacy requirements in certain areas of a state. Ms. Blom noted that the Commission will discuss draft recommendations at the upcoming March meeting and vote on the recommendations in April.

Commissioner Discussion

Commissioner Stacey Lampkin of Mercer Government Human Services Consulting asked why so many states were not taking advantage of more contracting strategies available to them. This concern was a major theme in the discussion. Ms. Blom noted that many states lack the necessary Medicare and Medicaid knowledge to identify and implement solutions. **Commissioner Darin Gordon** of Gordon & Associates and **Commission Chair Melanie Bella** agreed with Ms. Blom. In fact, Commission Chair Bella was adamant about crafting a recommendation that would encourage more structured state support around Medicaid concepts like enrollment and state contracting.

While Commission Chair Bella and Commissioner Gordon agreed on recommending more support to states, he disagreed with her support of the recommendation to auto-enroll eligible beneficiaries in D-SNPs. Commissioner Gordon worried that the ambitious recommendation would ignore states' roadblocks with contracting. **Commissioner Kit Gorton, M.D.**, objected to autoenrollment as well, noting that auto enrollees quickly opt-out. He explained that potential beneficiaries are skeptical of managed care programs due to a lacking public information campaign and understanding of the program's benefits. **Commissioner Brian Burwell** of Ventech Solutions also took issue with autoenrollment, and he suggested the inclusion of more stakeholder input moving forward.

Vice Chair Charles Milligan discussed nuances in the agent and broker sphere, noting that these individuals are incredibly helpful with early onboarding services since they only receive a commission when they retain beneficiaries. He also indicated that a highly rated D-SNP plan may offer superior coverage than a lesser dual program. Ms. Blom wrapped up the discussion and indicated that MACPAC Staff will return with recommendations that touch upon increased support for states, impartial advisors to supplement brokers and agents, possible state integration strategies, and state maximization of contracting mechanisms.

PAYMENT AND COVERAGE OF HIGH-COST SPECIALTY DRUGS

In the eleventh session of MACPAC's January 2021 meeting, the Commission heard two options for addressing coverage of high-cost drugs in the Medicaid program. There appears to be interest in further fleshing out both options, a differential rebate for accelerated approval drugs that have not completed confirmatory trials, and a new national benefit for cell and gene therapies. One commissioner, **Tricia Brooks** of Georgetown University, said that moves should not threaten the beneficiary protection of an open formulary. Another, **Stacey Lampkin** of Mercer said that the Commission should be careful that pulling one lever does not have unintended consequences, such as increased list prices.

Staff Presentation

Principal Policy Analyst Chris Park described two different options for covering high-cost drugs in Medicaid that were developed by a technical advisory panel, which included stakeholder perspectives. Specifically, the group focused on: (1) cell and gene therapies; (2) drugs receiving accelerated approval; and (3) specialty drugs for sensitive populations. Out of these focuses, the panel developed two policy options:

- **Differential Rebate for Accelerated Approval Drugs.** This option would make a statutory change in the Medicaid Drug Rebate Program (MDRP) to create a higher rebate for accelerated approval drugs until confirmatory trials are completed. The panel says that this would reduce Medicaid spending while there is limited evidence of clinical effectiveness. In addition, it would create incentives for manufacturers to complete confirmatory trials of accelerated approval drugs, Mr. Park said. Manufacturers, he said, would need to weigh the costs of confirmatory trials against the cost of the additional rebate for not having completed them. The panel considered using differential rebates based on how closely accelerated approval drugs achieved clinical endpoints; however, it was determined that exceptions would be too difficult to implement.

- **New Benefit for Cell and Gene Therapies.** This option would carve out coverage of durable cell and gene therapies from the MDRP, creating an entirely new, nationwide benefit. Mr. Park said that this option would create flexibility in coverage requirements, increase federal funding, as well as pool utilization and purchasing power. Such a program would be mandatory for Medicaid programs and could be expanded to include other payers, such as Medicare. To determine prices, Mr. Park said, the benefit could use a minimum standard rebate, negotiate outcomes-based contracts, and/or use value-based payments that derive from independent assessments of product value. Manufacturers, Mr. Park said, weighed in saying that value-based pricing could be used to start negotiations, but should not be a price ceiling. This benefit would be funded with either increased FMAP or full federal funding. Such a benefit could result in additional authorization requirements, but likely would not change decision-making, Mr. Park said.

Commissioner Discussion

Commissioner Stacey Lampkin of Mercer said that she is supportive of continuing conversations on both models presented today and possibly moving towards recommendations. She said that the differential rebate model is more straightforward. Additionally, she said that MACPAC would have to make sure that care provided is not skewed by having a different funding source than it does now. She cautioned that moving any lever should not result in pushing a higher list price.

Commissioner Peter Szilagyi, M.D., of UCLA said that he is "intrigued" by a new national benefit for cell and gene therapies, asserting that there should not be disparities by state. **Commissioner Fred Cerise, M.D.,** of Parkland Health and Hospital System said that these coverage and payment issues are too complicated for all state Medicaid programs to solve.

Commissioner Sheldon Retchin, M.D., of the Ohio State University said that he did not want to make the solution to costs to increase FMAP, saying that that would have deleterious effects on cost controls.

Commissioner Darin Gordon of Gordon and Associates asked if a new national benefit would

include ancillary services. Mr. Park said that the panel considered this and settled on just paying for the therapy itself.

Commissioner Tricia Brooks of Georgetown University said that Medicaid's open formulary is a beneficiary protection. Any move to a targeted closed formulary is contrary to that, she said. In addition, she said that nationally negotiated rebates do not have to go outside the MDRP.

IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT IN MEDICAID AND CHIP

In the twelfth session of MACPAC's January meeting, Commissioners mulled over options for bolstering mental health parity. Commissioners agreed that states often lack the necessary resources to analyze parity. The discussion will follow up in March with options to improve access.

Staff Presentation

Principal Policy Analyst Erin McMullen discussed parity requirements, accompanying outcomes, and Mental Health Parity and Addiction Equity Act's (MHPAEA) shortcomings. She reviewed that the state or MCO is required to identify and test each benefit classification, for each benefit, in five specific areas: (1) aggregate lifetime limits; (2) financial requirements; (3) quantitative treatment limitations; (4) non-qualitative treatment limitations; and (5) availability of information. Ms. McMullen explained that states and MCOs generally experience similar challenges when conducting parity analysis due to a lack of resources and experience.

Specifically, she highlighted limitations in analyzing non-qualitative treatment limitations. Documenting compliance was incredibly difficult in this area, especially considering that non-quantitative treatment limitations were assessed and interpreted differently both within and across states. To compound those issues, analyses can be particularly complicated if payment methodologies used for behavioral health and medical and surgical benefits differ.

Lastly, Ms. McMullen expanded upon shortcomings related to the MHPAEA. Stakeholders agreed that MHPAEA has helped raise awareness and generate state-level conversations regarding access to behavioral health care. However, states and MCOs have not made large-scale changes to their behavioral health benefits as a result of parity analyses. She ultimately found that other Medicaid policies are more relevant in ensuring access to community-based services. In her wrap up, Ms. McMullen projected that March's meeting will focus on access issues with a policy option to improve access, as well as a discussion about improving clinical integration of electronic health records.

Commissioner Discussion

Ms. Blom clarified for **Commissioner Martha Carter** that prior authorization has little impact on parity analysis. **Commissioner Sheldon Retchin, M.D.**, of The Ohio State University, drew attention to the unfulfilled demand within the behavioral health workforce, noting that psychiatrist participation in Medicaid is dropping. He added that the trend is especially disconcerting while the pandemic causes substance use disorder (SUD) issues to mushroom. **Commissioner Toby Douglas**,

of Kaiser Permanente, agreed with Ms. McMullen's finding that with such complex issues, states lack the expertise and resources to handle parity discrepancies.