MACPAC March 2021 Meeting

EXECUTIVE SUMMARY

On March 4-5, 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:

- **Behavioral Health Services for Adults** — Commissioners chose to move to recommendations regarding better guidance for crisis services, improved coordination between SAMHSA and CMS, and more technical assistance that would strengthen service quality, accessibility, and coordination.

- **Behavioral Health Services for Children and Adolescents** — Commissioners agreed with policy options that would provide additional guidance and technical planning and support to bolster access to care.

- **High-Cost Specialty Drugs** — Commissioners supported staff reconditions that would increase the minimum rebate percentage on drugs approved and boost inflationary rebates on such drugs until they complete confirmatory trials.

- **Medicaid Policy Issues Related to the COVID-19 Vaccine** — Commissioners discussed strategies that could assist in vaccination efforts.

- **Medicaid Innovation Accelerator Program** — While states benefitted from the program, Commissioners recognized that states may not have the capacity and funding for implementation.

- **Issues Facing the Territories** — Panelists from U.S. territories discussed their funding cliffs, with imminent threats of unrolling beneficiaries.

Detailed summaries of the sessions are included below. The next meeting will be held virtually on April 8-9.

**POLICY OPTIONS TO IMPROVE ACCESS TO BEHAVIORAL HEALTH SERVICES FOR ADULTS**

In the first session of the March MACPAC meeting, commissioners discussed the Substance Abuse and Mental Health Services Administration’s (SAMHSA) upcoming implementation of the National Suicide Prevention Lifeline, racial disparities in behavioral health (BH) treatment, and SAMHSA’s current crisis care model. Overall, commissioners were pleased with the delineated policy options and suggested moving to the recommendation stage in the next meeting to enable a vote. For those recommendations, commissioners asked that agency coordination be more specific and possibly include more agencies. They also considered including language to address racial disparities.

*Staff Presentation*

**Principal Analyst Erin McMullen** outlined current efforts to address BH crises. She first provided background on racial disparities. She reviewed SAMHSA’s National Guidelines for Behavioral Health
Crisis Care Best Practices Toolkit which established crisis call centers, mobile crisis response, and stabilizing facilities. SAMHSA is also anticipating its National Suicide Prevention Lifeline (988) which goes live in July 2022. Ms. McMullen cited stakeholder concerns that 988 will not have sufficient capacity and funding to meet increased demand. She explained that current federal guidance lacks the necessary detail for states to use various Medicaid authorities and administrative funding to support crisis hotlines.

To address these concerns, Ms. McMullen identified three policy options:

- **Improving Coordination Between CMS and SAMHSA.** The Secretary of Health and Human Services (HHS) should direct the Assistant Secretary for Mental Health and Substance Use and the Administrator of the CMS to work together to support states in developing and implementing a crisis continuum to support children and adults with behavioral health conditions.

- **Improved Guidance for Crisis Services.** The Secretary of HHS should direct relevant agencies to issue joint sub-regulatory guidance that addresses how Medicaid and the State Children's Health Insurance Program (CHIP) can be used to fund a crisis continuum for beneficiaries experiencing behavioral health crises.

- **Technical Assistance and Planning for Crisis Care.** The Secretary of HHS should direct a coordinated effort by relevant agencies to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in crisis in real-time. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of crisis services.

**Commissioner Discussion**

Ms. McMullen clarified for **Commissioner Martha Carter** that substance use disorder (SUD) is included in the BH data. **Commissioner Brian Burwell** of Ventech Solutions added that different types of BH crises require different response tactics. For the 988 hotline, **Commissioner Kisha Davis, M.D.**, of Aledade drew attention to the importance of texting capabilities and telehealth. **Commissioner Fred Cerise, M.D.**, of Parkland Health and Hospital System also suggested broadening the recommendations to include more payers that could help cover 988 costs. Commissioners Carter and **Sheeldon Retchin, M.D.**, of the Ohio State University also drew attention to the inclusion of certified community behavioral health clinics (CCHBCs).

Commissioner Davis suggested training support staff to address cultural differences in treating BH issues in Black communities. Commissioners Retchin and Cerise agreed, and Commissioner Cerise suggested further collaboration with the Department for Housing and Urban Development (HUD). **Vice Chair Charles Milligan** also suggested the inclusion of the Department of Labor (DoL). Commissioner Retchin also suggested a mental health czar for the first policy option to help coordination. **Commissioner Darin Gordon** of Gordon and Associated agreed but instead suggested a task force to provide clarity to states on how to operationalize Medicaid's role.
POLICY OPTIONS TO IMPROVE ACCESS TO BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

In the second session of the March MACPAC meeting, commissioners elaborated on hurdles to BH care for children and teens. Commissioners were supportive of policy options that would provide additional guidance to states regarding Medicaid and CHIP beneficiaries. They also supported a recommendation to provide technical assistance and implementation support. The commissioners agreed that access and implementation issues are critical to program success and discussed areas to consider for better access.

Staff Presentation
Senior Analyst Melinda Becker Roach described the multiple agencies that serve children and adolescents with mental health conditions. Coincidentally, she explained that meeting federal requirements requires a great deal of collaboration. Children and adolescents with significant mental health conditions often lack access to services that help prevent hospitalization and the use of residential treatment. Ms. Roach also elaborated on the difficulties of designing Medicaid benefits, noting constraints on Section 1915(c) waivers and Section 1915(i) planning authority.

She outlined two policy options:

- **Additional Guidance.** The Secretary of HHS should direct CMS, SAMHSA, and the Administration for Children and Families (ACF) to issue joint sub-regulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and CHIP.
- **Technical Assistance and Planning Support.** The Secretary of HHS should direct a coordinated effort by CMS, SAMHSA, and ACF to provide education and technical assistance to states on improving access to home and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and CHIP. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services.

Commissioner Discussion
Commissioners Peter Szilagyi, M.D. of the University of California, Los Angeles, and Tricia Brooks of Georgetown University Center for Children and Families agreed that the policy options are steps in the right direction, and Commissioner Szilagyi suggested integrating BH and pediatric care. Commissioner Brooks also agreed with Commissioner Sheldon Retchin, M.D. of The Ohio State University that provider shortages are a pervasive roadblock to accessible care. Commissioners Martha Cater and Vice-Chair Charles Milligan discussed other challenges, namely the scarcity of race, ethnicity, and geographic data.

Vice-Chair Milligan wondered about existing funding through the Center for Medicare and Medicaid Innovation (CMMI) to address the technical assistance policy option. Ms. Roach agreed, noting that the Integrated Care for Kids (InCK) Model may be relevant. Commissioner Brian Burwell brought up the importance of crisis intervention funding in the American Rescue Plan (ARP) (H.R. 1319), while
Commissioner Toby Douglas of Kaiser Permanente voiced reimbursement concerns regarding new and emerging technologies in the Medicaid space.

MOVING TOWARDS RECOMMENDATIONS ON HIGH-COST SPECIALTY DRUGS

In the third session of MACPAC's March 2021 meeting, commissioners discussed two potential recommendations on differential rebates in the Medicaid program for drugs approved under an accelerated pathway. One recommendation would increase the minimum rebate percentage on drugs approved through the accelerated approval pathway until they complete confirmatory trials. The other would boost inflationary rebates on such drugs until they complete confirmatory trials. Most commissioners were supportive of the recommendations, though there was more enthusiasm for the increased minimum rebate percentage. Only Commissioner Tom Barker of Foley Hoag expressed significant concerns with the first recommendation.

Staff Presentation
Principal Policy Analyst Chris Park presented two potential recommendations to the Commission:

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

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

Mr. Park told the Commission that additional rebates may result in delayed market access for drugs that would have been approved under the accelerated pathway. He also said that drug manufacturers could build an increased rebate into the launch price. Under the recommendations, beneficiaries would maintain access once a drug enters the market but could lose early access to certain products should manufacturers decide against using the accelerated approval pathway.

Commissioner Discussion
Commissioners were generally supportive of Recommendation One but were more lukewarm on Recommendation Two. Commissioner Tom Barker of Foley Hoag voiced the loudest concerns, saying that Congress created the accelerated approval for a set of drugs for which there is an unmet medical need. The enhanced rebate, he said, could disincentivize using the accelerated approval.
pathway, leading to delayed access. He called for the Commission to “hold off” on the recommendations.

**Commissioner Kit Gorton, M.D.**, said that the drugs in question are “unproven” and that payment policy should incentivize confirmatory trial completion as soon as possible. **Commissioner Stacey Lampkin** of Mercer said that it is being taken as an “article of faith” that there is a rebate amount that would be significant enough to encourage confirmatory trial completion while not discouraging the use of the pathway. Mr. Park told her that a particular amount has not been identified and that such a decision would be up to Congress.

**Vice Chair Chuck Milligan** said that he would want to know if any drug would get caught with no pathway for a confirmatory trial and thus a permanently higher rebate.

Both Commissioners Lampkin and Milligan said that they did not find Recommendation Two to be as strong as Recommendation One, though both supported it.

**Chair Melanie Bella** of Cityblock Health said that both potential recommendations will be brought back for consideration and a potential vote during MACPAC’s April meeting.

**MEDICAID POLICY ISSUES RELATED TO THE COVID-19 VACCINE**

In the *fourth* session of MACPAC’s March 2021 meeting, staff delivered an update on Medicaid policy issues related to the COVID-19 vaccine. **Commission Chair Melanie Bella** of Cityblock Health noted that the reconciliation bill currently under consideration in the Senate will address many of the concerns that it had with COVID-19 vaccine policy. The Commission may pursue future work related to best practices identified during the COVID-19 pandemic.

**Staff Presentation**

**Principal Policy Analyst Chris Park** and **Senior Analyst Michelle Millerick** delivered an overview of the current environment regarding Medicaid coverage of COVID-19 vaccines and discussed stakeholder perspectives and future action. They noted concerns about payment adequacy and equity, in particular.

The analysts told the Commission that ARP, currently under consideration, would require mandatory coverage of the COVID-19 vaccine without cost-sharing for all Medicaid beneficiaries and includes a 100 percent federal match for vaccine spending for one year post-public health emergency. It also provides funding to advance vaccine distribution, uptake, transparency, and surveillance.

With regard to payment adequacy, they found that 39 states are paying at or above the Medicare rate for COVID-19 vaccine administration and ten states are paying less than Medicare. It is unclear what
the final states’ policy is. Staff noted that the bill being considered by Congress right now does not require a minimum rate for vaccine administration.

In addition, staff said that there is a need to improve data collection and reporting on vaccination by race and ethnicity and to improve coordination of immunization information between Medicare and Medicaid for dual-eligible beneficiaries as well as information sharing with managed care plans.

**Commissioner Discussion**

*Chair Melanie Bella* of Cityblock Health said that there is no action required on MACPAC’s part at this time and added that many of the Commission’s concerns are being addressed by the reconciliation bill. Several commissioners emphasized the need to engage individuals who may have vaccine hesitancy and people of color in particular. *Commissioner Peter Szilagyi, M.D.*, of UCLA noted “chatter” about using the Johnson & Johnson vaccine to reach hard-to-reach populations, such as the homeless and homebound. *Commissioner Darin Gordon* of Gordon & Associates noted that the ability of managed care organizations to conduct outreach has been hindered by a lack of data sharing. *Vice-Chair Chuck Milligan* suggested future work to identify best practices associated with COVID-19 vaccination.

**Building State Capacity: What We Learned from the Medicaid Innovation Accelerator Program**

In the fifth session of the March MACPAC meeting, commissioners discussed the Medicaid Innovation Accelerator Program (IAP) through CMS’ Center for Medicare and Medicaid Innovation (CMMI). Commissioners agreed that due to Medicaid’s small funding share of CMMI projects, the Commission needs to address state ability to implement IAP before it considers changes to the program. However, commissioners still offered some prospective changes to help bolster IAP efficacy while addressing state capacity to implement programs.

**Staff Presentation**

*Principal Analyst Robert Nelb* provided an overview on the IAP through CMMI. When discussing his findings, Mr. Nelb noted that states showed interest in IAP, particularly SUD and long-term services and supports (LTSS) tracks. Many states also used IAP to help take advantage of new CMS opportunities for SUD waivers and LTSS housing supports. He found that states benefited from coaching and learning from other states. Despite these benefits, Mr. Nelb also delineated several barriers. States often experience staffing challenges, budgetary constraints, and unaligned priorities within states.

Looking forward, he predicted that CMMI could continue IAP or create new technical assistance (TA) models, or it could increase investments in other Medicaid-specific models. However, he was unsure of the direction the Biden Administration is likely to take CMMI efforts. Mr. Nelb offered three policy questions for commissioners: (1) What is the value of federal investments in state TA? (2) Where should CMS focus its TA efforts? And (3) How can federal TA be better coordinated with the tools and authorities that states are using to pursue Medicaid program innovations?
**Commissioner Discussion**

Commissioner Sheldon Retchin, M.D. of the Ohio State University was “taken aback” by the small fraction of CMMI funding designated for Medicaid, and Chairwoman Melanie Bella of Cityblock Health agreed. Commissioner Brian Burwell of Ventech Solutions suggested expanding opportunities to use virtual TA during the pandemic, and he noted that contractors and consultants require better program integration. Commissioner Toby Douglas of Kaiser Permanente called TA “essential” for states, especially for BH services.

Commissioner Fred Cerise, M.D. of Parkland Health and Hospital System wondered if a heavier focus on models with lower costs would help encourage state uptake of TA, but Mr. Nelb was not optimistic. Overall, Chairwoman Bella said that the Commission needs to address state capacity before any other issue in the TA space. She asserted that Medicaid needs to be at the decision-making table and presumed that Elizabeth Fowler, the new director of CMMI, would be receptive to the idea.

**CURRENT AND FUTURE ISSUES FACING THE TERRITORIES**

The final session focused on Medicaid issues faced by U.S. territories. A panel representing the Medicaid programs of Puerto Rico, the U.S. Virgin Islands, and the Northern Mariana Islands explained multiple problems with their Medicaid programs and how to best address them. They also touched on how the COVID-19 pandemic has affected their territory’s health care. Commissioners commented on the need for increasing or eliminating funding caps and generally recognized the hurdles these programs faced.

**Panelist Statements**

Helen Sablan, Medicaid Administrator, Commonwealth of the Northern Mariana Islands State Medicaid Agency (CMA), implored that treating the Northern Mariana Islands as states would eliminate the constant threat of losing funding and would allow CMA to plan future programs. Medicaid funding for the CMA is critically important to the territory’s population and health care system, but funding shortfalls persist regarding MAP and CHIP programs. Ms. Sablan noted that the pandemic has increased presumptive Medicaid beneficiaries from 16,000 to 27,000. Nonetheless, making reasonable progress in compliance and transparency requirements is a fundamental priority for the CMA. She emphasized that the fiscal cliff is the highest need for the Northern Mariana Islands’ Medicaid program.

Jorge Galva Rodriguez, Executive Director, Puerto Rico Health Insurance Administration (ASES), explained that Puerto Rico required funding for its sustainability initiatives, which include (1) alleviating poverty levels; (2) raising reimbursement to providers; (3) providing supplementary reimbursement to hospitals; (4) providing increases to primary physicians; and (5) providing coverage for hepatitis C patients. He explained that physicians have been leaving Puerto Rico in large numbers making Medicaid reimbursements integral in maintaining the island’s professional workforce. He added that hospitals are facing extreme financial issues, with losses larger than
Congress has compensated. However, oversight and accountability measures are going well, and Puerto Rico has already exceeded many accountability requirements and has engaged in substantial contracting reform.

Mr. Rodriguez elaborated that the Financial Oversight and Management Board for Puerto Rico compiled a fiscal plan that includes a $1.4 billion gap in funding if not provided for by Congress. Without this, they would have to roll back all sustainability goals and disenroll up to 400,000 beneficiaries from Medicaid. He argued that doing away with Section 1108 cap is the best option for Puerto Rico, as it needs $3.5 billion to run the program, provide adequate care, and ensure reimbursements. Mr. Rodriguez also wants to purchase Part B coverage for dual-eligible beneficiaries because to close coverage gaps.

Gary Smith, Medicaid Director, U.S. Virgin Islands (USVI) Department of Human Services, outlined USVI’s Medicaid program priorities, which include:

- Implementing the health information exchange;
- Expanding benefits to members as they move towards a more community-based program;
- Extending home community-based services by shifting to more long-term support services such as behavioral health initiatives; and
- Overseeing the implementation of electronic visit verification (EVV), cybersecurity measures, and patient access to information.

Mr. Smith emphasized that the USVI Medicaid program is facing another fiscal cliff by on September 30, 2021. Services will be cut and beneficiaries will be taken off rolls if funding is not provided. He suggested that a permanent fix would ensure officials do not have to face this cliff every two years. At a minimum, Mr. Smith said that a solution needs to:

- Remove of the annual dollar cap of Medicaid funding;
- Eliminate of the Federal Medical Assistance Percentage (FMAP);
- Provide for Medicaid Disproportionate Share Hospital (DSH) payments; and
- Allow Section 1902(j) waiver to apply to all U.S. territories.

Commissioner Discussion

When Commissioner Christopher Gorton, M.D., of Kaiser Permanente asked about how to lengthen planning horizons and address pressing needs, Mr. Rodriguez echoed Mr. Smith's sentiments. Mr. Rodriguez and Ms. Sablan supported an FMAP greater than the current 55 percent. Mr. Rodriguez, Mr. Smith, and Ms. Sablan told Commissioner Charles Milligan, J.D. of Health Management Associates that they would be willing to accept other mandates that U.S. states have for eligibly and benefits in exchange for FMAP provisions. Mr. Rodriguez explained to Commissioner Sheldon Retchin, M.D. of The Ohio State University that the intensity of care in the territories much higher than the states, thus demanding a larger density of medical professionals.

Commissioner Kisha Davis, M.D. of Aledade and Commissioner Frederick Cerise, M.D. of Parkland Health and Hospital System supporting increased funding for territories. Commissioner
Darin Gordon of Gordon & Associates added how expensive mainland rates are for citizens of territories seeking treatment off the islands. Vice-Chair Milligan echoed these comments. He brought up linking rates charged to territories to the rates providers are willing to accept from their local Medicaid jurisdictions. Commissioner Martha Carter also highlighted the lack of DSH payments, and how that accelerates the instability of the territories’ Medicaid programs.

Executive Director Anne Schwartz, Ph.D. noted that the Section 1108 funding caps are not scaled to objective levels of a Medicaid program due to outdated measures.