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MACPAC Meeting Insights: ATI's Take

January 25-26, 2024

ATI provides insights into the topics addressed in MACPAC's January 2024 meeting.

Click to navigate directly to the key themes or a meeting session below:

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KEY THEMES

Beneficiary Voices & Protections

- Centering needs and voices of beneficiaries continued as a salient theme, amid ongoing COVID-19 redeterminations and several pending CMS rules aimed at increasing beneficiary representation and protections.
- This month, MACPAC discussions focused on policy recommendations to increase protections in the managed care denials and appeals process, improve data collection on disabilities, and increase enrollment in the Medicare Savings Programs.

State Policy Levers

- MACPAC shared recommendations to increase transparency into states' approaches to non-federal share financing, including options to make existing documentation public (e.g., preprints). MACPAC also conducted a roundtable discussing the impact of payment rates on beneficiary access to care, since fewer providers accept individuals covered by Medicaid than any other coverage option.
- MACPAC revisited its discussion on state barriers to maximizing use of Dual Eligible Special Needs Plas (D-SNP) state Medicaid agency contracts (SMAC) to advance integration goals.

Sustainability of HCBS Delivery and Funding

- MACPAC built on its recent focus on policies governing the delivery of home- and community-based services (HCBS).
- This month, MACPAC conducted a roundtable diving deeper into concerns about the financial cliff states will experience when enhanced HCBS funding expires in 2025.
- Fewer than half of state Medicaid programs expect to continue existing HCBS rate increases and other initiatives after enhanced funding expires in 2025. MACPAC is exploring concerns related to this financial cliff.

DENIALS AND APPEALS IN MEDICAID MANAGED CARE

Issue

Medicaid beneficiaries experience challenges with the managed care appeals process, such as intimidating and burdensome interactions with managed care organizations (MCOs). Further, prior-authorization requests are denied by Medicaid MCOs more often than by Medicare Advantage organizations. Although some federal requirements to monitor denials exist, there are also gaps in public transparency and oversight. In response, MACPAC shared seven recommendations for CMS to address these issues.

- In weighing MACPAC's policy recommendations, CMS must **balance the varied—and sometimes conflicting—perspectives of stakeholders** (e.g., MCOs, beneficiaries, states, providers). CMS may consider a robust stakeholder engagement period prior to adopting policies to protect and empower beneficiary voices, while also understanding the practical impacts to plans and states.
- CMS will need to assess the possible impacts and unintended consequences of policy changes to the managed care appeals process, including issues related to **conflicts of interest, state autonomy, beneficiary protections, and use of state and MCO resources**. For example, certain MACPAC recommendations may require bolstering state staff capacity to support clinical reviews or effectuate enhanced reporting requirements.
- MACPAC's recommendation to conduct routine clinical appropriateness audits **aligns with processes in Medicare Advantage**. Such alignment may introduce administrative efficiencies for MCOs serving dual eligible individuals.

MEDICAID SELF-REPORTED DISABILITY DATA COLLECTION

Issue

There is a need to **collect consistent and accurate disability information on Medicaid beneficiaries—beyond what is required for eligibility requirements**. Individuals with disabilities are more likely than those without disabilities to have poor health, unmet medical and dental needs, and poor provider experiences. Robust and accurate data collection on disabilities can support improved clinical and programmatic outcomes as well as realized access to care for beneficiaries with disabilities.

- Currently, **disability data collection efforts vary by state and are limited primarily to program eligibility determination purposes**. However, CMS' updated framework for health equity prioritizes expanding standardized data collection to include additional information on disabilities.
- States working to improve disability data collection **face administrative burdens and barriers**—for example, states require **CMS approval** to update Medicaid enrollment applications.
- Other stakeholders, including beneficiaries and advocates, share concerns about how states may **use disability data not required for program eligibility processes** and seek clear data privacy policies. MACPAC notes that improved data could support beneficiaries though understanding:
  - The **prevalence of disabilities** (functional impairments, serious mental illnesses (SMI), intellectual/development disabilities (I/DDs)).
  - **Provider network adequacy** to provide services to beneficiaries with disabilities (e.g., dental providers that can meet specific I/DD needs).
  - **Gaps in provider resources** that are required to provide specialized care for individuals with disabilities.

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POLICY OPTIONS FOR IMPROVING THE TRANSPARENCY OF MEDICAID FINANCING

Issue

Medicaid payment and financing mechanisms are characterized by complexity and a lack of transparency. With an increasing proportion of non-federal share financing being satisfied through taxes and intergovernmental transfers (IGTs), which can effectively increase federal matching levels, stakeholders have concerns about the impact on federal spending. MACPAC set forth policy recommendations to improve transparency into state financing methodologies and impacts.

- → CMS collects **limited information on non-federal share financing—** primarily through state plan amendments and directed payment preprints. However, data are incomplete and not publicly available; further, there are no requirements for provider-level financing reports.
- → **MACPAC's policy recommendations primarily focus on reporting requirements to give both CMS and the public insight into state financing approaches**. Implementing such recommendations will add both administrative and financial burdens to states. As such, establishing a feasible implementation timeline for new policies will be critical to successful state adoption.
- → As a result of ongoing discussions regarding private hold harmless arrangements, **Texas established a system linking provider-level financing data to provider-level payment levels**. This process could serve as a model for other states to increase transparency.

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STATE MEDICAID AGENCY CONTRACTS (SMACS): INTERVIEWS WITH KEY STAKEHOLDERS

Issue

State relationships with dual eligible special needs plans (D-SNPs) are governed by a State Medicaid Agency Contract (SMAC), which includes minimum federal requirements to coordinate Medicaid benefits for enrollees. **While states can go beyond these minimum requirements to further Medicare-Medicaid integration, practical barriers prevent states from fully leveraging the SMAC.** MACPAC interviews with states, CMS, and D-SNPs highlighted key challenges and opportunities.

- States cite limited staff capacity and lack of expertise on Medicare and dual eligible individuals as limiting factors in maximizing SMACs to achieve integration goals. **Additional support and technical assistance could build staff knowledge on Medicare requirements to complement Medicaid expertise and build robust SMAC requirements**.
- The Medicare-Medicaid Coordination Office (MMCO) and the Integrated Care Resource Center (ICRC) play a critical role in collecting and sharing best practices among states. In addition to highlighting actions states can take, these groups could **delineate specific steps and tactics to effectuate recommended policies and program changes and identify needed investments, timelines, and other implementation details**.
- Efforts to support states in operationalizing SMACs may also **highlight policy opportunities for alignment with Medicare**, push states to prioritize integration goals, and support state staff in understanding unique care delivery challenges impacting dual eligible individuals.

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FINDINGS FROM EXPERT ROUNDTABLE ON EVALUATING THE EFFECTS OF MEDICAID PAYMENT CHANGES ON ACCESS TO PHYSICIAN SERVICES

Issue

Fewer providers accept individuals covered by Medicaid than any other coverage option. Although acceptance rates vary significantly by state, provider specialty, and provider ownership structure, data show that Medicaid beneficiaries are primarily served by a small number of safety net providers, such as Federally Qualified Health Centers (FQHCs). MACPAC convened a roundtable of experts to evaluate how provider payments impact Medicaid networks and patient access.

- → Due to the **significant variation in provider payment rates** (both among and within states) and the **lack of transparency into managed care payment** levels, assessing the impact of payments on Medicaid beneficiary access to care can be challenging.
- → Physicians often cite low payment rates as a primary reason not to accept Medicaid; however, limited existing **studies find mixed results in the relationship between provider payment levels and provider acceptance of Medicaid**. For example, other factors, such as high rates of Medicaid claim denials and higher administrative burdens, may have an equal impact on provider participation in Medicaid.
- → Given that a small number of providers serves the majority of Medicaid beneficiaries, policymakers should consider the **impact of payment change policies on provider network capacity**—which is more likely to impact beneficiary access to care—in addition to the sheer number of providers within Medicaid networks.

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MEDICAID COVERAGE OF PHYSICIAN-ADMINISTERED DRUGS (PADs)

Issue

Increases in Medicaid spending on prescription drugs in recent years are primarily driven by high-cost specialty drugs—including PADs. Payment policies governing PADs are complex—primarily driven by differences between medical and pharmaceutical billing. As a result, states' abilities to obtain significant statutory rebates on PADs (e.g., Medicaid Drug Rebate Program [MDRP]) may be restricted based on claims processing limitations or bundled payment arrangements with providers.

- **Statutory rebates (e.g., MDRP) on prescription drugs represent a significant amount of savings to both CMS and states**. In fiscal year 2021, for example, Medicaid spent about $80 billion on prescription drugs, but offset these costs with more than $42 billion in rebates.
- PADs are eligible for rebates if the drug meets the definition of a covered outpatient drug; statute limits this definition to exclude drugs that are billed as part of a bundled service within certain settings (e.g., drugs provided as part of a clinic visit or hospital stay). However, a **proposed CMS rule would allow PADs included in bundled payments to be classified as outpatient drugs** if their costs are identified separately on claims, both enabling and directing states to seek rebates on these PADs.
- MACPAC recently released a **brief on high-cost drugs and outlines recommendations** to address the challenges associated with them. In the March 2024 meeting, MACPAC will continue the conversation on PADs and other high-cost specialty drugs.

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MEDICARE SAVINGS PROGRAMS (MSPs): ENROLLMENT TRENDS

Issue

Administered by state Medicaid agencies, **Medicare Savings Programs (MSPs) are jointly financed between CMS and states, and they assist low-income individuals in paying premiums and cost sharing associated with Medicare**. There are four types of MSPs, with each offering varying levels of coverage and cost sharing support. Sustained federal and state efforts are needed to bolster enrollment in the programs to increase the access and affordability of care.

- **CMS finalized a rule on MSP eligibility and enrollment in 2023**, which:
  - Codifies existing CMS guidance on accepting leads data from the Social Security Administration (SSA) to initiate MSP applications, and
  - Encourages states to align MSP eligibility processes with the SSA and requires states that have not aligned, despite existing regulations, to accept self-attestations.
- Despite overall support for the CMS final rule, **states have expressed concerns about their limited capacities to come into compliance** with the most recent provisions by April 1, 2026. This is of particular concern given states' ongoing efforts to execute redeterminations following the expiration of the COVID-19 Public Health Emergency.
- MSP policy changes support the goal to increase program participation. In addition to the CMS rule, federal and state efforts include **increased funding for outreach and expanded state income/asset eligibility thresholds** (to date, more than 15 states have adopted such policies).

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PANEL ON THE AMERICAN RESCUE PLAN ACT (ARPA): SUSTAINABILITY AND EVALUATION

Issue

ARPA's Section 9817 gave states a temporary 10% increase to the federal medical assistance percentage (FMAP) to invest in home and community-based services (HCBS) infrastructure and care delivery. CMS expects states to use all the available ARPA funds by March 2025. As this funding expiration approaches, policymakers are considering the impact on HCBS care delivery and how states are approaching the long-term sustainability of ARPA initiatives.

- In initial ARPA HCBS spending plan responses, CMS encouraged states to consider sustainability of their initiatives and detail plans for continued funding. However, limited information is available on state approaches to program sustainability; stakeholders are **concerned about upcoming "cliffs" in benefits and provider payments after March 2025.**
- Of particular concern is funding to support the continuation of payment increases to direct care workers, particularly in states with intentionally temporary payment increases (e.g., bonuses). **Direct care workers may experience reduction in payment levels that they assumed were permanent**, which could prompt an exodus of workers and further exacerbate existing HCBS workforce challenges.
- Several state Medicaid agencies pushed state legislatures for funding commitments early on, leaning on early ARPA initiative evaluation outcomes to make the case. As such, **program evaluation is likely to be a key focus in the coming year for ARPA-funded initiatives**; however, to date, many states have yet to identify firm evaluation plans.

No slides for this session

ATI knows Medicaid.

Our team can guide you through the complex regulatory landscape and bring to bear actionable and innovative policy insights.

ATI has experience working directly with state Medicaid agencies, managed care plans, providers, and advocates to advance Medicaid delivery system and payment reforms.

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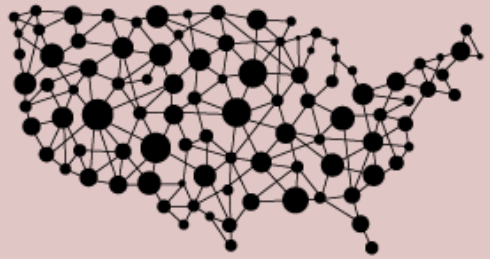

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