

# MACPAC MARCH 2022 MEETING

## EXECUTIVE SUMMARY

On March 3 and 4, 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:

- **Directed payments in managed care: Decisions on recommendations for the June report to Congress** — Commissioners generally supported the five recommendations offered by Commission staff regarding directed payments in Medicaid managed care. These recommendations will be included in the June report to Congress.
- **Improving the uptake of electronic health records by behavioral health providers: Decisions on recommendations for the June report to Congress** — Commissioners generally supported staff recommendations regarding ways to increase behavioral health provider use of electronic health records (EHR). Many Commissioners advocated for a fully integrated health information technology (IT) system, suggesting that behavioral health EHRs be but a component of a larger, better-connected system of records among a wide range of providers.
- **Levering Medicaid and policy levers to promote health equity** — Commissioners discussed aspects of the Medicaid program that can improve health equity for beneficiaries and pointed to the need for better data collection efforts. Some commissioners pointed to community health centers as a successful model for addressing racial and ethnic disparities.
- **Requiring states to develop a formal strategy for integrating care for dually eligible beneficiaries: Review of draft chapter and recommendation for the June report** — Overall, commissioners were generally supportive of requiring states to develop a strategy for integrating Medicaid and Medicare care for dually eligible beneficiaries, though some commissioners requested that more emphasis be placed on implementing health equity into strategy guidelines.
- **Managed care rate setting and actuarial soundness: Federal oversight and implications for efficiency, access, and value in Medicaid** — Commissioners discussed both federal- and state-level policy issues related to managed care organization (MCO) rate setting and actuarial soundness, debating the implications of these rate settings and soundness on efficiency, access, and value in the Medicaid program. Some commissioners advocated for the inclusion of social determinants of health into MCO rate setting.
- **Risk mitigation and rate setting: Report on discussion at expert roundtable** — Generally, commissioners supported the concept of CMS expedited reviews for MCO risk mitigation and rate setting over multi-year mitigation plans.

- **Vote on integrated care strategy recommendation** — Commissioners unanimously supported the draft recommendation to require states to develop an integrated health strategy for dually-eligible beneficiaries.
- **Considerations in redesigning the home-and community-based services benefit** — Some commissioners supported the development of a standardized core HCBS benefit. However, other commissioners raised concerns over the impact such a policy would have on workforce capacity and state budgetary constraints and innovation.
- **Access to vaccines for adults enrolled in Medicaid: Decisions on recommendations for the June report to Congress** — Some commissioners raised concerns about budgetary impacts a vaccine coverage mandate would have on state Medicaid programs. Commissioners agreed to revisit these draft recommendations during the April meeting.

Detailed summaries of these sessions are included below. Due to the coronavirus pandemic, the next MACPAC meeting will take place virtually on April 7-8, 2022.

### **DIRECTED PAYMENTS IN MANAGED CARE: DECISIONS ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS**

In the first session of MACPAC's March meeting, Commission staff proposed five recommendations on directed payments in managed care for the June report to Congress. These recommendations include: (1) better transparency of existing directed payment information; (2) new, provider-level data on directed payment spending; (3) clarifying directed payment goals and their relationship to network adequacy requirements; (4) guidance for directed payment evaluations; and (5) coordinating reviews of directed payments and managed care rates. Commissioners were generally supportive of the recommendations and some commissioners had questions related to ensuring timely and accurate transparency of directed payments.

#### **Staff Presentation**

**Principal Policy Analyst Robert Nelb** provided background information on directed payments in managed care. In MACPAC's review, he found that the use of and spending on directed payments has grown significantly in recent years. Specifically, he stated that projected spending is larger than disproportionate share hospital (DSH) and upper payment limit (UPL) supplement payments. Mr. Nelb outlined the types of directed payments and broke down the number of arrangements and projected spending by type of directed payment from 2020.

From a staff-conducted interview with state officials, the Centers for Medicare and Medicaid Services (CMS) officials, providers, actuaries, and health plans, Mr. Nelb presented key themes the stakeholders gathered about their experience with directed payments. He noted that many directed payment arrangements are similar to supplemental payments in fee-for-service (FFS) systems and do not have a clear link to quality or access goals, which makes assessing whether they are meeting their objectives more difficult.

Mr. Nelb presented the proposed recommendations on directed payment in managed care for the June report to Congress:

- **Proposed Recommendation 1** — To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should make directed payment approval documents, managed care rate certifications, and evaluations for directed payments publicly available on the Medicaid.gov website.
- **Proposed Recommendation 2** — To inform assessments of whether managed care payments are reasonable and appropriate, the Secretary of the U.S. Department of Health and Human Services should make provider-level data on directed payments amounts publicly available in a standard format that enables analysis.
- **Proposed Recommendation 3** — To provide additional clarity about the goals and uses of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to quantify how directed payment amounts compare to prior supplemental payments and clarify whether these payments are necessary for health plans to meet network adequacy requirements and other existing access standards.
- **Proposed Recommendation 4** — To allow for more meaningful assessments of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to develop rigorous, multi-year evaluation plans for directed payment arrangements that increase provider payment rates above the rates described in the Medicaid state plan.
- **Proposed Recommendation 5** — To promote more meaningful oversight of directed payments, the Secretary of Health and Human Services should coordinate the review of directed payments and review of managed care capitation rates by clarifying roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services.

Finally, Mr. Nelb outlined the Commission's next steps, which includes discussing the draft chapter and voting on final recommendations at the April 2022 meeting. He noted that the draft chapter will discuss issues to consider when setting an upper limit on directed payment amounts, but it will not include a recommendation. He expressed the staff's desire to have more aggregate spending data in the future as a result of CMS's new directed payment pre-print form. Mr. Nelb also suggested that adoption of transparency recommendations could help inform analyses of the effects of an upper limit on directed payment amounts. Finally, he anticipated that the Commission would vote on these recommendations as a single package.

#### Commissioner Discussion

- **Commissioner Stacey Lampkin**, of Mercer Government Human Services Consulting, endorsed each of the recommendations but offered technical clarifications for each of them.

Specifically, she suggested increased guidance around the types of access and adequacy standards for health plans in Proposed Recommendation 3, as well as improving the data within Transformed Medical Statistical Information System (TMSIS) to ensure quality assessments in Proposed Recommendation 2. Commissioner Lampkin also suggested adding more clarity to the Proposed Recommendation 5 regarding the implications for actuaries and how to determine the goals of directed payments.

- **Commissioner Tricia Brooks**, of Georgetown University Center for Children and Families, suggested adding language to ensure for more timely transparency in Proposed Recommendation One. Otherwise, she supported the other recommendations.
- **Commissioner Darin Gordan**, of Gordon and Associates, stated that the recommendations were “fine” but emphasized that the definition of directed payments has become much broader, especially as the payment models evolve.
- **Commissioner Fred Cerise, M.D.**, of Parkland Health and Hospital System, suggested — with respect to Proposed Recommendation 2 — being more descriptive in provider-level payments and specifying the types of provider groups within Medicaid.
- **Commissioner Heidi Allen, Ph.D.**, of Columbia School of Social Work, raised concerns that the “back channel” methods of paying providers may impact providers’ perception of treating Medicaid patients and the stigma patients face when encountering these systems.

#### **IMPROVING THE UPTAKE OF ELECTRONIC HEALTH RECORDS BY BEHAVIORAL HEALTH PROVIDERS: DECISIONS ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS**

In the second session of MACPAC’s March meeting, commissioners reviewed — and generally supported — recommendations surrounding ways in which to increase behavioral health provider use of electronic health records (EHR). Commissioners advocated for a fully integrated health information technology (IT) system, suggesting that behavioral health EHRs be but a component of a larger, better-connected system of records among a wide range of providers.

MACPAC staff offered policy recommendations surrounding states’ use of Medicaid authorities for behavioral health provider EHR adoption, advocating for increased guidance from the Centers of Medicare and Medicaid Services (CMS) to do so. Additionally, staff proposed the use of voluntary standards for behavioral health IT to increase uptake. Confirming that the contents of the upcoming MACPAC meeting in April of 2022 would include a vote on the recommendations offered during this March meeting, staff added that MACPAC plans to publish a chapter on behavioral health in its June 2022 report.

#### Staff Presentation

**Senior Policy Analyst Aaron Hervin** offered brief background on the issue, outlining MACPAC’s documentation of the role that health IT plays in supporting care integration efforts. He explained that, while MACPAC has carried out initiatives in this space, behavioral health providers were excluded from previous incentive programs suggested by MACPAC to digitize health records and adopt health IT.

Discussing barriers to EHR adoption among behavioral health providers, Mr. Hervin noted that software, hardware, and training surrounding EHRs is costly and often poses a challenge for providers. He also suggested that behavioral health providers are often unsure of which product to purchase to properly meet the requirements for EHRs, pointing towards voluntary standards as a way to aid providers in purchasing the correct health IT product.

With regard to improving the clarity of guidance on financing, Mr. Hervin explained that multiple authorities could be used to finance EHR adoption, though he suggested that states lack explicit guidance from CMS. To this end, Mr. Hervin pointed towards section 1115 demonstration authorities, Medicaid managed care organizations' issuance of directed payments, and updated Medicaid Information Technology Architecture guidance as a means to remedy this issue.

Mr. Hervin offered the following recommendations:

- **Recommendation 1** — Guidance to States on Using Medicaid Authorities for EHR Adoption: The Secretary of Health and Human Services should direct Center for Medicare and Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), and Office of the National Coordinator for Health IT (ONC) to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability.
- **Recommendation 2** — Voluntary Standards for Behavioral Health IT: The Secretary of Health and Human Services should direct Substance Abuse and Mental Health Services Administration (SAMHSA) and Office of the National Coordinator for Health IT (ONC) to jointly develop voluntary standards for behavioral health information technology.

#### Commissioner Discussion

- **Commissioner Martha Carter**, Independent Consultant, offered her support for both recommendations. She suggested that staff — in either Recommendation 2 or the accompanying narrative discussion — explicitly state the Commission's interest in an integrated EHR system that includes records for primary care, oral health, vision care, and social services in addition to behavioral health.
- Regarding substance use disorders (SUD) services, Commissioner Carter noted that providers outside of the behavioral health services realm are now able to deliver this care, adding that these providers may not have to meet compliance requirements that behavioral health providers face. To this end, she stressed that fully functional and compliant EHRs are necessary to provide person-centered, integrated care.
- **Chair Melanie Bella** expressed her satisfaction with the Commission's intent to impose voluntary standards for behavioral health IT, to which **Commissioner Verlon Johnson**, of Client Network Services, Inc., agreed.

## LEVERAGING MEDICAID POLICIES TO PROMOTE HEALTH EQUITY

In the [third](#) session of MACPAC's March meeting, commissioners discussed aspects of the Medicaid program that can improve health equity for beneficiaries. While the April chapter on health equity will not include recommendations on the subject, MACPAC staff noted that it will be an outline of the Commission's future work on health equity concerns. During the discussion, commissioners were especially focused on data collection efforts, community-based care, and the provider workforce. Notably, **Executive Director Anne Schwartz** said that MACPAC will be publishing a report on community health workers.

### Staff Presentation

**Senior Analyst Audrey Nuamah** reviewed the framework for MACPAC's April chapter on health equity, explaining that while the Commission will not be prepared to provide recommendations, the chapter will provide directions for future work. She said that key themes in the chapter will include several areas for policy consideration, including federal actions to advance health equity, state Medicaid agency leadership, delivery system levers, a culturally competent workforce, and beneficiary engagement.

Ms. Nuamah noted that MACPAC staff will be releasing a brief on equitable data collection efforts in each state, including assessments of the data's quality. Medicaid enrollment and redetermination were also amongst her chief concerns, and she explained that the redetermination process after the public health emergency (PHE) will likely have disproportionately negative impacts on communities of color. She suggested that MACPAC promote more accessible renewal materials and more funding for plan navigators to help keep beneficiaries enrolled.

Ms. Nuamah wrapped up her presentation by providing an overview of MACPAC's ongoing work, which includes access to behavioral health care for beneficiaries leaving the incarceration system and the general availability of race and ethnicity data. She added that the Commission is also heavily focused on improving the collection and reporting of race and ethnicity data, as well as coverage for doula services.

### Commissioner Discussion

- **Commissioner Heidi Allen, Ph.D.**, of the Columbia University School of Social Work, reiterated the importance of beneficiary engagement, as well as aggregation of race and ethnicity data across state lines. She also drew attention to the segregation of care delivery sites, noting that Medicaid-only hospitals and clinics are generally underfunded. She then suggested that graduate medical education (GME) funding in Medicaid be leveraged to enforce workforce quotas.
- **Commissioners Verlon Johnson**, of Client Network Services, Inc., **Katherine Weno**, and **Bill Scanlon, Ph.D.**, reiterated data collection concerns.
- Commissioners Weno and Johnson called for Medicaid policy decision-makers to diversify and better reflect the populations they serve, and **Vice Chair Kisha Davis, M.D.**, of Aledade



Health, added that the MACPAC Commission members should also be more reflective of the Medicaid population.

- **Commissioner Martha Carter** provided several examples of ways in which community health centers are successfully addressing racial and ethnic disparities, including screening for social determinants of health (SDOH) and engaging beneficiaries. However, Commissioner Carter was frustrated that managed care organizations (MCO) are not contracting with local community health centers, calling for a Commission recommendation to address this concern. Commissioner Weno echoed support for community-based health centers — as well as telehealth — to better engage with beneficiaries.
- Several commissioners discussed workforce issues, with **Commissioner Darin Gordon**, of Gordon & Associates, characterizing community health workers as a “phenomenal tool,” and **Commissioner Dennis Heaphy**, of the Massachusetts Disability Policy Consortium, stressing the importance of peer specialists and recovery coaches. **Commissioner Laura Herrera Scott**, of Anthem, inquired about additional funding opportunities for community-based workers. Executive Director Schwartz noted that MACPAC is getting ready to publish a brief on community health workers “relatively soon,” which will include a discussion of Medicaid authorities, how these workers are paid, and examples of how states are utilizing this workforce.
- **Commissioner Fred Cerise, M.D.**, of Parkland Health and Hospital System, said that access to care is a major hurdle in Medicaid non-expansion states, and he inquired about the details of health equity commitments from state Medicaid leadership.
- In response to **Commissioner Stacey Lampkin**, of Mercer Government Human Services Consulting, Ms. Nuamah said that while the Centers for Medicare and Medicaid Services (CMS) has health equity tool kits and plans, these materials mostly apply to Medicare. She added that CMS also provides some technical assistance to Medicaid agencies but is unsure of their efficacy. Ms. Lampkin asserted that CMS informed her that it is implementing Medicaid health equity initiatives through section 1115 waivers.
- Commissioner Lampkin warned that capitation rates should be discussed in conjunction with contract requirements and environmental inabilities to act as effective financial incentives to reduce barriers to care. Commissioner Heaphy added that capitation rates must be appropriate for each population, specifically highlighting the intersection of disability and race.
- Vice Chair Davis closed the discussion by saying that the Commission should first explore data availability then move to a recommendation, highlighting the difference in self-reported data and purchased data.

#### **REQUIRING STATES TO DEVELOP AN INTEGRATED CARE STRATEGY FOR DUALY ELIGIBLE BENEFICIARIES**

In the fourth session of MACPAC’s March meeting, commissioners discussed recommendations regarding a new requirement to develop a strategy for integrating Medicaid and Medicare care for dually eligible beneficiaries. Commissioners broadly supported the measure but requested that more emphasis be placed on implementing health equity into strategy guidelines.

Much of the discussion focused on the prospective timeline for strategy development and implementation. MACPAC staff advocated for a standardized integration approach, requiring strategies to: 1) detail eligibility and benefits covered; 2) outline beneficiary protections; 3) utilize data analytics; 4) focus on quality management; and 5) meet the needs of diverse subpopulations among those who are dually eligible.

### Staff Presentation

**Principal Policy Analyst Kirstin Blom** and **Policy Analyst Ashley Semanskee** provided context on the current landscape of integrated models and advocated for fully integrated care across states, further advocating for federal support to do so. Ms. Blom highlighted the ability of integrated care to improve outcomes and promote efficient and effective coordination between agencies, including increased enrollment and availability. She described the ideal fully integrated care system as one which would cover all benefits, provide coordination, establish an integrated care team, include beneficiary protections, provide a mechanism for beneficiary input, and foster complete financial alignment.

Ms. Blom gave a brief overview of the state-by-state variation in Dual Eligible Special Needs Plan (D-SNP) integration, which can range from fully integrated models — such as Medicare-Medicaid Plans (MMPs), Fully Integrated D-SNPs (FIDE SNPs), and the Program of All-Inclusive Care for the Elderly (PACE) — to coordination-only D-SNPs and Highly Integrated D-SNPs (HIDE SNPs). She also brought up typical challenges states face to integration, citing issues such as: (1) a lack of state capacity as a result of other priorities and a lack of expertise in Medicare; and (2) a lack of experience with Medicaid managed care.

Ms. Blom recommended the development of a fully integrated care strategy that: 1) details eligibility and benefits covered; 2) outlines beneficiary protections; 3) utilizes data analytics; 4) focuses on quality management; and 5) meets the needs of diverse subpopulations among those who are dually eligible. She stipulated a two-year timeline on the development of such a strategy for all states and recommended allocating federal funds to support states' efforts.

### Commissioner Discussion

- Much of the discussion following the presentation focused on the proposed timeline for developing an implementation strategy. While some Commissioners believed that two years was more than enough time for states to develop their strategies, others believed it to be appropriate or too little. Those who expressed support for the two-year development period pointed to the variability in state legislatures and the implementation of stakeholder input.
- Another major focus of this discussion was the role of health equity in creating integrated care strategies. Though the draft did mention the integration of health equity, many commissioners believed that the draft should be revised to refocus implementation on health equity, as opposed to making it an afterthought.



- Others voiced concerns about implementation of developed strategies, noting that the strategy requirements did not outline an implementation phase.

### **MANAGED CARE RATE SETTING AND ACTUARIAL SOUNDNESS**

In the fifth session of MACPAC's March meeting, commissioners discussed both federal- and state-level policy issues related to managed care organization (MCO) rate setting and actuarial soundness. Commissioners further debated the implications of these rate settings and soundness on efficiency, access, and value in the Medicaid program.

Staff presented their study on the Medicaid actuarial soundness standard as it relates to capitation rates and federal standards, ultimately finding that, while federal oversight aims to determine whether rates provide for reasonable, appropriate, and attainable costs, this oversight does not explicitly examine whether rates represent the most efficient use of Medicaid funds or provide for adequate quality of, or access to care. Staff noted that these findings suggest potential areas for future Commission recommendations in the next report cycle.

#### *Staff Presentation*

**Principal Policy Director Moira Forbes** presented findings from a recent MACPAC study that examined how federal oversight of managed care payments relates to Medicaid program objectives using recent capitation rate certifications from seven states and federal statutes, rules, and guidance. She explained that MACPAC conducted interviews with state Medicaid officials, MCO managers, actuaries, and staff from the Centers for Medicare & Medicaid Services (CMS) and found that federal guidance provides states with the flexibility to control cost growth, increase efficiency, and manage plan profits. Ms. Forbes explained that, ultimately, the study found that federal rules neither encourage nor prevent states from using managed care payment approaches to advance program goals.

Ms. Forbes identified the following opportunities to improve managed care rate setting:

- **Option 1** — Additional subregulatory guidance via CMS in issue areas where MACPAC has identified a lack of clarity, including: (1) accounting for emerging rate setting issues — such as social determinants of health and promoting health equity — and (2) aligning the goals of state-directed payments with actuarial soundness requirements.
- **Option 2** — Changes to the federal rate review process, including: (1) developing a schedule for changes to the annual rate guide and shortening the timeline for rate reviews; and (2) clarifying roles of state and federal actuaries in reviewing state-directed payments.
- **Option 3** — Changes to federal statutes and rules, including: (1) adding transparency requirements to the rate development process; and (2) authorizing CMS to defer non-compliant components of a rate certification.

Looking ahead, Ms. Forbes noted that MACPAC plans to incorporate commissioner feedback on the above opportunities for potential recommendations and will provide revised options, as appropriate, at a future meeting.

#### Commissioner Discussion

- **Commissioner Heidi L. Allen, Ph.D.**, of Columbia University School of Social Work, suggested reframing rate setting as an equity issue in addition to the other issue areas it currently coincides with.
- Commissioner Allen called for more information surrounding the implications of using prior years' utilization to benchmark future years' utilization, expressing concern that doing so would result in issues surrounding access.
- **Commissioner Stacey Lampkin**, of Mercer Government Human Services Consulting, observed that rates do not reflect, or drive towards, state goals.
- In discussing best practices, **Commissioner Darin Gordon**, of Gordon & Associates, called for more work — on behalf of the Commission — to ensure that states understand ways in which to engage actuaries to be most effective.
- Commissioner Gordon encouraged MACPAC to examine ways in which to increase the timeliness of CMS approval of these rates.
- With regard to administrative expenses and social determinants of health, **Commissioner Robert Duncan**, of Connecticut Children's – Hartford, explained that the rate-setting process does not account for these expenses. To this end, Commissioner Duncan suggested that the Commission explore means to factor in social determinants of health into that rate calculation.
- In discussing the alignment of directed payments with actuarial soundness, **Commissioner Frederick Cerise, MD**, of Parkland Health and Hospital System, suggested that care for the poor is implicitly devalued when lower rates in Medicaid emerge in comparison to Medicare and other federal programs.
- **Commissioner Toby Douglas**, of Kaiser Permanente, stressed the importance of the connection between the programmatic and policy levers at play with regard to access to HCBS, adding that actuaries play into this connection as well.
- Commissioner Allen inquired about the "access feedback loop," communicating her understanding that utilization — a measure of care received rather than a measure of care needed — is used to project future care received. She further inquired about where information sources are derived from to determine inadequate access and questioned how this feeds back into changing rates to ensure that the rates produced are actuarially sound to ensure access.
- Commissioner Allen suggested that actuarial soundness be used as a tool in areas with low access to behavioral health services via Medicaid.

#### **RISK MITIGATION AND RATE SETTING: REPORT ON DISCUSSION AT EXPERT ROUNDTABLE**

In the sixth session of MACPAC's March meeting, staff reviewed stakeholder feedback from managed care organizations (MCO) regarding risk mitigation and rate setting. As the COVID-19

pandemic exposed unexpected shocks to risk adjustment mechanisms, the Commission considered two policy options — pertaining to expedited rate review and multi-year risk mitigation — that would provide additional flexibilities to rate-setting adjustments. Commissioners favored the concept of expedited review over multi-year mitigation plans, though MACPAC staff will provide more information on the aspects of multi-year mitigation policies at the Commission’s request.

#### Staff Presentation

**Principal Analyst and Data Analytics Advisor Chris Park** provided background on Medicaid beneficiaries in comprehensive managed care and discussed how risk mitigation strategies can help account for the inherent uncertainty in rate setting to limit MCO gains and losses. He also reviewed the range of unexpected shocks and risks to rate setting, noting that risk levels shift over time. Mr. Park then gave an overview of themes from the expert roundtable — which included federal and state officials, actuaries representing states and MCOs, and provider organizations — that discussed: (1) shocks that current risk mitigation tools are unable to address; and (2) administrative and process challenges to implementing these tools once an unexpected shock occurs.

After reviewing stakeholders’ strategies from the roundtable, Mr. Park explained that regulations and the approval process require risk mitigation mechanisms prior to the start of the rating period. He also flagged that states and actuaries expressed a need for Centers for Medicare and Medicaid Services (CMS) guidance on what support materials are required to gain approval for a mid-year change to implement a risk mitigation strategy. Lastly, Mr. Park outlined two policy options for commissioners to consider, though he noted that any formal recommendations would not be included in the June report. The options included:

- **Expedited rate review** — CMS could institute an expedited rate review process that would be triggered under certain situations, such as the public health emergency (PHE). This could be similar to the Appendix K that states may utilize during emergency situations to request an amendment to approved 1915(c) waivers.
- **Multi-year risk mitigation** — A rating period would be defined as twelve months in regulations, meaning risk mitigation mechanisms are expected to be settled at the end of the rating period. Allowing risk mitigation to combine financial experience over multiple rating periods could reduce some administrative complexity and the number of financial settlements.

#### Commissioner Discussion

- **Commissioner Stacey Lampkin**, of Mercer Government Human Services Consulting, said that expedited rate reviews are “worth exploring.” However, she said that the complexity of a multi-year risk mitigation strategy would require additional exploration before she made a judgment on its validity.
- **Commissioner Darin Gordon**, Gordon & Associates, echoed Commissioner Lampkin and elaborated on concerns that rates are overly retroactive, especially in cases such as the COVID-19 PHE. **Chair Melanie Bella**, of Cityblock Health, pushed back on “opening a can of

worms” regarding retroactivity guidance from CMS, but Commissioner Gordon felt that it is necessary to consider.

- **Commissioner Toby Douglas**, of Kaiser Permanent, reiterated Commissioner Lampkin’s comments and remarked that there is “no reason” why states and CMS cannot speed up rate reviews in urgent situations.
- In response to Chair Bella, Commissioners Gordon, Lampkin, and Douglas clarified that they would like to see more information from MACPAC staff on use cases and examples of multi-year mitigation strategies.

### **VOTE ON INTEGRATED CARE STRATEGY RECOMMENDATION**

In the seventh session of MACPAC’s March meeting, commissioners voted on a draft recommendation aimed at better integrating care for dually eligible beneficiaries. Specifically, the recommendation seeks to require states to develop an integrated care strategy for people who are dually eligible for Medicaid and Medicare.

#### Staff Presentation

**Policy Director Kristal Vardaman, Ph.D.**, offered the following draft recommendation:

- **Draft Recommendation**— Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy, to be specified by the Secretary. The strategy should include the following components — integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, and quality measurement — and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries.

#### Commissioner Discussion

- **Commissioners unanimously voted in support of the draft recommendation.**

### **CONSIDERATIONS IN REDESIGNING THE HOME- AND COMMUNITY-BASED SERVICES BENEFIT**

In the eighth session of MACPAC’s March meeting, commissioners considered the possibility of redesigning the Medicaid home- and community-based services (HCBS) benefit following a December 2021 roundtable held by MACPAC on the subject. Commissioners generally supported a core benefit, though concerns arose over workforce capacity and state budgetary constraints and control.

The presentation focused on tradeoffs and considerations for designing a core HCBS benefit, where staff presented key takeaways from the roundtable, offering commissioners’ insight into core HCBS benefit design considerations to prompt Commission discussion. Staff noted that future work on the

subject will include consideration of commissioner comments and roundtable participant insight to inform continued work on designing a core HCBS benefit.

#### Staff Presentation

**Policy Director Kristal Vardaman, Ph.D.,** and **Senior Policy Analyst Asmaa Albaroudi** discussed considerations in redesigning the Medicaid HCBS benefit, offering an overview related to the challenges and delivery of HCBS.

Dr. Vardaman delivered an overview of the roundtable discussion that MACPAC convened late last year and noted key takeaways from this discussion, including: (1) several different proposed benefit structures for a core benefit; (2) focus of a tiered model approach that would include a core HCBS benefit supplemented by higher tiers with more expansive services; (3) emphasis on the idea that a core benefit should be designed to promote person-centeredness and equitable access to services; (4) prioritization of maintaining state flexibility as opposed to promoting uniformity and standardization of the core benefit; and (5) underlying concern over workforce capacity in HCBS settings as it relates to access.

Resulting from these discussions, staff relayed considerations in designing a core HCBS benefit. Primarily, staff homed in on services, administration, monitoring, and eligibility determinations as key considerations moving forward, prompting commissioner discussion on these points.

#### Commissioner Discussion

- **Commissioner Brian Burwell**, of Ventech Solutions, expressed apprehension about moving forward with a core benefit for HCBS, highlighting work being done in Congress around HCBS — specifically, in the Build Back Better Act legislation — as already making substantial changes to the benefit. **Commissioner Verlon Johnson**, of Client Network Services, Inc., echoed the need for mindfulness around timing.
- Stating his support for promoting models of care that integrate Medicare and Medicaid, Commissioner Burwell noted the growth in demand for long term care services across all persons of all socio-economic categories. He asserted his belief that political support for a more expansive solution to long-term services and supports is growing rapidly, further asserting that it is inevitable that a broader financing program for HCBS services not linked to the Medicaid program will be adopted, citing this as reason to deeply consider whether to move forward with a core benefit for HCBS.

#### **ACCESS TO VACCINES FOR ADULTS ENROLLED IN MEDICAID DECISIONS ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS**

In the ninth and final session of MACPAC's March meeting, **Senior Analyst Amy Zettle** discussed barriers that Medicaid beneficiaries face in accessing vaccines. In response to these concerns, Ms. Zettle outlined five draft recommendations for Commissioners to consider, with the intent to determine which recommendations to include in the June report to Congress. Notably, commissioners disagreed over the recommendation to require that Medicaid cover vaccinations, though most commissioners were supportive of the recommendation. In April, the Commission will

vote on the recommendations discussed in this meeting, with a focus on ensuring adequate provider payments.

### Staff Presentation

Ms. Zettle provide an overview of vaccines access barriers for adults, which included: (1) limited coverage of recommended vaccines; (2) low provider payment for vaccines; (3) a limited setoff provider types for administering vaccines; and (4) vaccines hesitancy. She then presented five draft recommendations aimed at addressing these access barriers:

- **Improve coverage** — Congress should amend Section 1902(a)(10)(A) of the Social Security Act to make coverage of vaccines recommended by the Advisory Committee on Immunization Practices a mandatory benefit and amend Sections 1916 and 1916A to eliminate cost sharing on vaccines and their administration.
- **Ensure adequate provider payment** — The Centers for Medicare & Medicaid Services should implement payment regulations for vaccines and their administration. Payment for vaccines should be established at actual acquisition cost and a professional fee for administration, similar to the payment requirements established for outpatient prescription drugs under 42 CFR 447.512(b) and 447.518(a)(2).
- **Expand provider networks** — The Centers for Medicare & Medicaid Services should issue federal guidance encouraging the use of pharmacies and other providers in providing adult vaccinations in Medicaid.
- **Provide beneficiary support and education** — The Secretary of Health and Human Services should direct a coordinated effort with the Centers for Medicare & Medicaid Services (CMS), the Office of the Assistant Secretary for Health, and the Centers for Disease Control and Prevention to provide guidance and technical assistance to improve vaccine outreach and education to Medicaid and CHIP beneficiaries. Additionally, CMS should release guidance on how to use existing flexibilities and funding under Medicaid and CHIP to improve vaccine uptake.
- **Provide beneficiary support and education** — Congress should provide additional federal funds to improve immunization information systems (IIS). In addition, Congress should require the Secretary of Health and Human Services to coordinate efforts across relevant agencies within the department to release federal guidance and implement standards to improve IIS data collection and interoperability with electronic health records and state Medicaid Management Information Systems (MMIS). The Centers for Medicare & Medicaid Services should also provide guidance on matching rates available and ways to integrate IIS and MMIS to be eligible for the 90 percent match for the design, development, installation, or enhancement of MMIS and the 75 percent match for the ongoing operation of MMIS.

### Commissioner Discussion

- **Commissioner Martha Carter** was interested in expanding provider reimbursement in the third recommendation, though she focused on the importance of reimbursing additional provider types for vaccine administration.
- **Commissioner Fred Cerise, M.D.**, of Parkland Health and Hospital System wanted to know why staff did not include recommendations on mechanisms to lower vaccine costs through Centers for Disease Control (CDC) negotiation or the Medicaid drug rebate program (MDRP). Ms. Zettle explained that commissioners and stakeholders voiced concerns that such mechanisms would be “overly complex.”
- Commissioner Cerise was worried about the additional costs for states that would result out of vaccine coverage mandates. He was also concerned that variable costs by wholesalers make it difficult to determine if coverage mandates would create incentives for manufacturers to raise their product’s wholesale acquisition cost (WAC).
- **Commissioner Darin Gordon**, of Gordon & Associates, noted that mandates and payment rates will have an impact on payment adequacy, for which the implications must be handled by the states. He said that straining state recourses could then impact other initiatives to increase vaccination rates, such as policies included in recommendations regarding education efforts and expanding provider networks. **Commissioners Toby Douglas**, of Kaiser Permanente, and **Stacey Lampkin**, of Mercer Government Human Services Consulting, echoed these concerns, with Commissioner Lampkin explaining that she does not want to require a policy that states already have the authority to leverage.
- Commissioner Gordon added that creating an unfunded mandate for vaccines would be harmful, though **Commissioners Heidi Allen, Ph.D.**, of Columbia University School of Social Work, **Dennis Heaphy**, of Massachusetts Disability Policy Consortium, **Verlon Johnson**, of Client Network Services, Inc., **Tricia Brooks**, of Georgetown University Center for Children and Families, and **Chair Melanie Bella**, of Cityblock Health, still felt that the mandate would be a positive signal to promote public health vaccination initiatives.
- To address the concern that vaccine coverage requirements would go unfunded, **Vice Chair Kisha Davis, M.D.**, of Aledade, asked commissioners if they were interested in retaining the mandate and including a funding provision. However, **Executive Director Anne Schwartz, Ph.D.** noted that such a policy would be “politically unfavorable” upon being received by Congress. Some commissioners suggested that staff acquire a Congressional Budget Office (CBO) score to determine the cost impact of negotiated vaccines prices for Medicaid. However, **Principal Analyst and Data Analytics Advisor Chris Park** noted that such a report would not be ready by the April 2022 MACPAC meeting — at which point the Commission would need to vote on recommendations.
- In conclusion, Chair Bella said that the Commission would revisit these recommendations in April — with additional staff research and possible tweaks to their wording — with a focus on ensuring provider payment adequacy.