MACPAC | Medicaid and CHIP Payment and Access Commission

RELEASE: IMMEDIATE
March 15, 2018

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MACPAC Recommends Steps to Streamline Managed Care

March 2018 report to Congress also highlights opportunities in telehealth to improve health care delivery

Washington, DC—The Medicaid and CHIP Payment and Access Commission (MACPAC) today released its March 2018 *Report to Congress on Medicaid and CHIP*, focusing in its first two chapters on managed care and telehealth, areas of high interest to Congress as it considers strategies for the Medicaid program to improve efficiency and impact in the delivery of critical health services to over 80 million low-income beneficiaries.

Over its 50 year history, Medicaid has evolved with changes in delivery of care and advances in technology. "Managed care is commonplace in Medicaid, and states should have more streamlined mechanisms to enroll beneficiaries in such systems," said MACPAC Chair Penny Thompson. "State Medicaid programs are also innovating by offering services via telehealth, potentially improving both access and efficiency." Chapter 1 of the March report addresses streamlining the multiple legal authorities states use to run their managed care programs, and Chapter 2 discusses how states are using telehealth as a strategy for addressing access barriers. The third chapter of the report fulfills MACPAC's annual, statutorily mandated obligation to report on Medicaid disproportionate share hospital (DSH) allotments.

Today, 80 percent of Medicaid beneficiaries—even those with complex health needs—receive health care through some type of managed care. States can operate managed care using three separate legal authorities under the Social Security Act—waiver authority in Sections 1115 and 1915(b), and state plan authority in Section 1932. These differ in terms of which beneficiary populations can be required to enroll, approval periods, and reporting requirements. Many states operate more than one managed care program, often under multiple authorities or through multiple waivers.

In Chapter 1, the Commission offers three recommendations to reduce the administrative burden for states to implement managed care programs without compromising beneficiary protections:

(1) amend Section 1932(a)(2) to allow states to require all beneficiaries to enroll in Medicaid managed care programs under state plan authority;
(2) extend approval and renewal periods for all Section 1915(b) waivers from two to five years; and
(3) revise Section 1915(c) waiver authority to permit Section 1915(c) waivers to waive freedom of choice and selective contracting.

Allowing states to have a more streamlined mechanism to select managed care as their delivery system and requiring beneficiaries to enroll in such systems is appropriate at this time, according to the Commission, given the present strong regulatory framework for beneficiary protection and oversight, the large share of beneficiaries now enrolled in managed care, managed care's value in coordinating care, and the need to conserve state and federal resources.

Chapter 2 describes coverage of telehealth in state Medicaid programs. Federal policy places few restrictions in terms of adopting or designing telehealth coverage; as a result, states have wide flexibility in defining telehealth as well as in establishing the scope of coverage. The Commission observes that advances in telehealth technology have potential for improved access to services in rural areas and specialized services with limited provider supply, but presently evidence on the effectiveness of telehealth outcomes is mixed. States seeking to implement or expand coverage of telehealth would likely benefit from additional research, including Medicaid-specific research, and other states' experiences, the Commission said.

Chapter 3 builds on MACPAC's prior work to increase understanding of how safety-net hospitals have been affected by changes in insurance coverage. The analysis continues to find little meaningful relationship across the country between DSH allotments and number of uninsured individuals, hospitals' uncompensated care costs, and the number of hospitals providing essential community services that have high levels of uncompensated care. Total hospital charity care and bad debt continue to fall, especially in states that expanded Medicaid coverage, but Medicaid shortfall showed an uptick as a result of increased Medicaid enrollment. Now that Congress has delayed DSH allotment reductions for two years, the Commission will explore opportunities to improve the targeting of DSH payments in future reports.

Download the March 2018 *Report to Congress on Medicaid and CHIP* and each of its chapters—Streamlining Medicaid Managed Care Authority, Telehealth in Medicaid, and Annual Analysis of Disproportionate Share Hospital Allotments to States—at macpac.gov.

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ABOUT MACPAC

The Medicaid and CHIP Payment and Access Commission is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). For more information, please visit www.macpac.gov.