MACPAC

Advising Congress on
Medicaid and CHIP Policy

April 18, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Information: Access to Coverage and Care in Medicaid & CHIP

Dear Administrator Brooks-LaSure:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am offering these comments in response to the request for information (RFI) on access to coverage and care in Medicaid and the State Children's Health Insurance Program (CHIP). As you know, MACPAC is a nonpartisan 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 CHIP.

The Commission appreciates the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with feedback on a wide range of access-related topics, including enrolling in and maintaining coverage, accessing services, and ensuring adequate payment rates. This letter draws on the Commission's work over the years, and also highlights pertinent recommendations in the issue areas identified in the RFI. In particular, we note that the Commission recently approved a number of recommendations for improving the system for monitoring access to care for Medicaid beneficiaries; these recommendations will appear in our forthcoming June report.

We provide specific comments below, but also wish to highlight several priority issues that cut across the topic areas identified in the RFI. First, while we are encouraged by CMS's commitment to addressing health disparities and inequities, in particular those related to race and ethnicity, the agency should honor this commitment by maintaining an equity focus in all aspects of its work to examine and improve access to care. It should also be specific about the steps it intends to take to address disparities.

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Second, CMS's efforts to maintain and improve access to care and coverage should include a focus on beneficiaries who are especially vulnerable to experiencing poor health outcomes when facing barriers to care. These include, for example, children with special health care needs, people with disabilities, sexual and gender minorities, and people of color, as well as those who may be marginalized for multiple reasons. While broad actions to address access will certainly help these populations, specific actions will likely be needed to address their unique needs or the higher intensity of care they may require across their lifespan.

Finally, we encourage CMS to be transparent in its actions, both by releasing data and actively engaging stakeholders in policymaking processes. Making data collected by CMS and states publicly available will be essential for identifying access concerns, opportunities for improvement, and accountability. The agency should engage stakeholders in the development of new policies, not only through RFIs and other forms of public notice, but also through roundtables and workgroups. In addition, the agency should be transparent in its actions, sharing information in accessible and plain language formats, and being clear about the rationale for its decisions.

The Commission urges CMS to keep these priority areas top of mind as the agency considers its next steps, policies, and actions to improve access to care in Medicaid and CHIP. Our comments below follow the five key objectives identified by CMS in the RFI and were also submitted through Medicaid.gov.

Medicaid and CHIP Reach Eligible People

As CMS considers strategies to ensure eligible individuals enroll in and retain coverage, the agency may want to draw on MACPAC's prior research showing that efforts at simplification, including using electronic data sources and automating processes, can lead to administrative savings and streamlined procedures for both states and beneficiaries. Further, automating the renewal process has also been associated with lower rates of churn (disenrolling and re-enrolling in Medicaid within 12 months), as discussed more in our commentary on Objective 2 below (MACPAC 2021a). While streamlined application processes are helpful to people applying for coverage, in-person assistance is still necessary, especially for certain populations (e.g., mixed-coverage families, populations in highly transient communities, largely immigrant communities, and those with lower computer literacy).

Streamlining processes

Changes to Medicaid enrollment and renewal processes under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) were intended to simplify and streamline those processes for all Medicaid populations. In doing so, there was an expectation that the share of eligible people that successfully enroll in and retain Medicaid coverage would increase, and errors associated with administering complex eligibility rules would decrease.

States took different approaches to implementing the changes. For example, some states prioritized real-time enrollment and renewal for individuals eligible on the basis of modified adjusted gross income

(MAGI); other states prioritized eligibility worker involvement in the process. States noted the positive effect of combined online applications on beneficiary access to programs and the efficiencies gained through connections to electronic data sources and business rules software systems. Even as states were streamlining and automating eligibility determination and enrollment processes and systems, in-person assistance remained in high demand for many individuals (MACPAC 2018a, Zylla et al. 2018).

Addressing remaining barriers

While states have made progress in streamlining eligibility and enrollment processes, obstacles still remain for individuals to enroll and renew coverage; many of these are longstanding issues and predate implementation of the ACA. MACPAC's analysis of the remaining barriers and mitigation strategies states can use to address them specifically identified concerns about notices regarding the information needed to complete the eligibility determination process (SHADAC 2020). We found the language used in these notices should be crafted to be more easily understandable to the recipient. In addition, there are substantial logistical concerns regarding delivery of notices and receiving responses from beneficiaries, a process that is often hampered by inaccurate contact information. Strategies for addressing this included using more up-to-date contact information, providing multiple methods for communication (discussed more in response to Objective 2), and providing additional time for beneficiaries to respond (Zylla et al. 2020).

Medicaid and CHIP Beneficiaries Experience Consistent Coverage

In seeking to promote continuous coverage and limit gaps during transitions, CMS should focus its attention on several key areas. Foremost is the upcoming unwinding of the continuous coverage requirements at the end of the public health emergency (PHE). However, improving continuity and coverage transitions will be an ongoing task, especially for individuals who may be likely to experience a change in circumstance that makes them ineligible for Medicaid. CMS should continue encouraging states to use available options, such as adoption of 12-month continuous eligibility, and modes of communication that are supported by research and meet the needs of beneficiaries.

Unwinding the public health emergency

Panel discussions at MACPAC meetings (January 2022 and October 2020) identified strategies to facilitate transitions at the end of the PHE. During these discussions, state officials and advocates described their concerns related to the potential for coverage loss by individuals who remain eligible but do not complete renewals, as well as overloaded eligibility systems and workers. They also noted concerns about long call center wait times, and whether beneficiaries losing eligibility will enroll in exchanges. Strategies to help mitigate coverage loss include spreading out renewals over the full period available to states to complete this task and updating beneficiary contact information (including working with managed care

organizations (MCOs) to do so). Additionally, CMS may find it helpful to consult some of the findings noted in our response to Objective 1.

Promoting continuous coverage

About one third of beneficiaries who disenroll subsequently re-enroll in the program within a short period of time, a phenomenon often referred to as churn.[1] Although some beneficiaries may experience temporary income fluctuations that make them ineligible, churn may also be an indicator of administrative barriers that disrupt coverage for those who continue to meet income and other eligibility requirements. MACPAC's recent analysis found that 8 percent of full-benefit Medicaid and CHIP beneficiaries enrolled in 2018 disenrolled and reenrolled within 12 months. Rates of churn were highest for children enrolled in separate CHIP and adults enrolled through MAGI-based eligibility pathways, and lowest for beneficiaries eligible for Medicaid on the basis of a disability and for those age 65 and older (MACPAC 2021a). While most children exiting separate CHIP enrolled in Medicaid without a gap in coverage, such results may indicate that particular attention should be paid to the redetermination and transition process for children and adults in groups that experience higher rates of churn.

Our analysis also found substantial state variation in rates of churn and average lengths of coverage that appears to be explained in part by state policy differences. On average, beneficiaries in states with 12-month continuous eligibility and states that do not conduct midyear data checks for changes in circumstances were more likely to be enrolled in coverage for at least 12 months and were less likely to experience churn. In addition, states that made greater use of automated renewals had fewer beneficiaries disenroll and re-enroll within a year, on average. These findings suggest that greater use of these policies may help reduce churn and increase rates of continuous coverage (MACPAC 2021a).

The Commission has previously noted that 12-month continuous eligibility reduces churning (and associated negative health effects), ensures access to care for these enrollees, and allows them to maintain their same provider network for the year. This may lead to better health outcomes and help minimize the use of more expensive care, such as costly emergency room visits or avoidable hospital admissions. Given this evidence, the Commission previously recommended Congress should explicitly create a statutory state option for 12-months continuous eligibility for children enrolled in CHIP and adults enrolled in Medicaid (MACPAC 2013).[2]

The Commission has also recommended a permanent extension of the state authority to use express lane eligibility (ELE) for children in Medicaid and CHIP.[3] ELE authority allows states to streamline their Medicaid and CHIP application and renewal processes, and has resulted in favorable gains in coverage and administrative savings (MACPAC 2017a).

Beneficiary communication

CMS should encourage states to use multiple modes of communicating with beneficiaries, as beneficiary preferences and comfort with technology differs. While states are required to offer multiple modes, not all

states provide them. Furthermore, electronic forms of communication, such as email and text messaging, are not as widely adopted (Brooks et al. 2022).

To gain and retain Medicaid coverage, beneficiaries need clear information about how to apply for and renew coverage. Without clear communications about requirements and procedures, coverage may be inappropriately terminated and some individuals will remain uninsured even though they may be eligible. Providing effective and timely communications to beneficiaries is particularly salient now as states prepare for resuming normal operations at the end of the PHE.

Effective communications strategies require understanding the needs and preferences of Medicaid beneficiaries. In 2021, MACPAC conducted focus groups to learn directly from Medicaid beneficiaries about their preferences communicating with state Medicaid agencies during the enrollment and renewal processes. While communication preferences and the ability to access technology vary, providing multiple avenues to connect with the program helps to ensure that individuals complete processes in a way that best meets their needs (PerryUndem 2022). Advocates and assisters also noted concerns with the readability and timeliness of notices (MACPAC 2022a).

States are required to provide multiple modes of communication for individuals to apply for and renew Medicaid, and many are using technology to help facilitate those communications. They use technology to different degrees to facilitate communication, with some states keeping pace more than others, but all states face barriers to making improvements. Some stakeholders noted that setting standards for communication practices could benefit from a human-centered approach to design and user testing among beneficiaries (MACPAC 2022a).

Medicaid and CHIP Beneficiaries Can Access Services

In the Commission's view, access to care should not depend on whether an individual is enrolled through fee for service (FFS) or managed care. Furthermore, Medicaid beneficiaries often have complex physical health, behavioral health, and long-term care needs, and experience social risk factors that are associated with poor health. Understanding the needs of beneficiaries and how their unique characteristics may affect access to care are key to both ensuring and monitoring access to care.

In addition, state and federal officials need timely and consistent information on the extent to which beneficiaries can access services. Thus, the agency should establish consistent and comparable measures that can be used across delivery systems and states.

Consistent access measures

A forthcoming chapter in MACPAC's June report to Congress makes a series of recommendations for a new regulatory system to monitor access to care in Medicaid. Although monitoring and ensuring access to care is a requirement under both FFS and managed care, the separate statutory and regulatory

requirements leads to variation in the approaches. This limits the ability of CMS, states and other stakeholders to make meaningful comparisons, detect access problems, and identify priorities for improvement (MACPAC n.d. a).

A new system should include a core set of standardized access measures that allow for comparison across states and delivery systems, and are stratified by key demographic characteristics. In addition, access measures should reflect all three key domains of access: provider availability and accessibility, use of services, and beneficiary perceptions and experiences. Measures should be chosen to reflect the services of particular importance to Medicaid beneficiaries, and be constructed to permit analysis of disparities in access to care among historically marginalized populations (MACPAC n.d. a). Such measures could include barriers to care, unmet need, and the experience of care. Although we do not recommend specific measures, we note the need for measures of provider availability to include accessibility for individuals with language barriers and disabilities (MACPAC n.d. a).

The Commission's recommendations also call upon CMS to field an annual Medicaid beneficiary survey and engage beneficiaries in the development of a new access monitoring system.

Minimum standards and benchmarks

MACPAC's forthcoming chapter also discusses the approaches CMS could take in establishing standards or benchmarks for access to care. Specifically, CMS should be responsible for setting standards, but states should be involved in the process in setting benchmarks so that they are feasible and meaningful. One approach would be for CMS to calculate baseline measures for states over a multi-year period. These data would provide a range of state-level results to determine reasonable minimum thresholds of access to care and benchmarks for improved access over time (MACPAC n.d. a).

CMS could determine benchmarks for adequate access in several ways. For example, these could be state specific, with CMS monitoring improvement over time against each state's baseline. However, it may be important to have a national threshold for adequate access. A hybrid approach in which CMS establishes a minimum threshold or floor for states with the expectation for improvement over the state baseline, could be a way to accomplish both of these objectives (MACPAC n.d. a). As part of any consideration of a national threshold or floor, it will be important to assess the appropriateness of the standard and its feasibility, especially in states with substantial rural or frontier regions.

Integrating physical and behavioral health

The RFI asks for commentary on how to account for whole person care when establishing minimum standards for access as well as how to promote such care. The Commission has noted that many state Medicaid programs do not cover the full continuum of mental health services (MACPAC 2021b). This continuum includes ongoing access to outpatient treatment, supportive services, such as supported employment and peer supports—supportive services delivered by a trained and certified individual who has lived experience with a mental health condition—as well as crisis services (e.g., hotline services, mobile

crisis care, and crisis receiving and stabilization centers) (MACPAC 2021c). The absence of a full continuum, including a sufficient number of psychiatric beds and real-time access to community-based care, has serious access consequences for beneficiaries.

Furthermore, despite state efforts to identify inequities in treatment limitations for behavioral health services, MACPAC found that the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343) does not appear to have substantially improved access to behavioral health care for Medicaid and CHIP beneficiaries. Parity analyses required under MHPAEA focused on a narrow set of barriers that may limit access to care (e.g., prior authorization, step therapy) and ultimately did not result in large-scale changes to behavioral health benefits. Moreover, states and MCOs found the required parity analyses, particularly for non-quantitative treatment limitations, to be complex and time consuming (MACPAC 2021d).

Some states carve out behavioral health services from MCO contracts to FFS or limited benefit prepaid health plans, which can add complexity for beneficiaries accessing those services as well as the behavioral health providers serving them (MACPAC 2016). When behavioral health services are carved out, beneficiaries must navigate multiple points to obtain needed services, and providers face multiple rules and procedures for prior authorization. MACPAC has noted that carve-out models can lead to segmentation of care, poor coordination, restrictions on choice, and disruptions in continuity of care. (MACPAC 2016)

Additionally, behavioral health providers were excluded from the Medicaid electronic health record (EHR) incentive payment program, leading to low levels of health IT adoption, which in turn limit the ability to integrate care. As part of the June 2022 report to Congress, MACPAC will recommend that CMS provide clarifying guidance outlining how states can implement an EHR incentive payment program for providers who were ineligible for prior incentive payments. This includes clarifying how an EHR incentive payment program can be implemented using Section 1115 demonstration authority, state directed payments under managed care, and Center for Medicare and Medicaid Innovation Section 1115(A) demonstration authority. The recommendation will also request CMS to clarify how Medicaid Information Technology Architecture's enhanced federal match could be used to help connect behavioral health providers to health information exchanges (MACPAC n.d. b).

Integrating substance use disorder treatment for pregnant and postpartum women

Although pregnant women in Medicaid are more likely than pregnant women with other forms of insurance to misuse substances or have substance use disorder (SUD), they are also more likely to have received treatment for their SUD. However, relatively few pregnant women with SUD seek treatment, in part due to obstacles such as balancing caregiver roles and fear of losing custody of their children. State Medicaid programs can use multiple authorities, including those under the state plan and waivers, to tailor benefits for pregnant women with SUD and many states are expanding the continuum of services offered to

individuals with SUD. State systems are highly fragmented, with no single agency responsible for addressing the range of needs of pregnant and postpartum women with SUD, which can further complicate access. New models of care that seek to improve access to well-coordinated, evidenced-based care for pregnant women and their children are currently being tested and could provide insights to CMS as it seeks to establish minimum standards for accessing such services (MACPAC 2020a).

Support integration for individuals dually eligible for Medicaid and Medicare

As CMS establishes standards for whole person care, it should focus on integrating Medicaid and Medicare coverage and establishing standards for coordinating care for individuals who are enrolled in both programs. Lack of alignment between the two programs can lead to fragmented care and also creates opportunities for cost shifting between Medicaid and Medicare. For example, Medicaid covers long-term services and supports (LTSS) while Medicare covers inpatient stays, but these policies were not designed to work together and do not create appropriate incentives to ensure that services are provided based on what is best for the beneficiary. A few states have prescriptive contract standards regarding care coordination across services, such as primary care and behavioral health, but most states provide MCOs with a great deal of flexibility. In interviews conducted by MACPAC in 2020, stakeholders indicated that engaging primary care providers in care coordination can be difficult and that MCOs could more effectively partner with consumer advocates and home- and community-based services (HCBS) providers to improve care coordination (Barth et al. 2019). In 2020, MACPAC recommended additional funds to enhance state capacity to implement integrated care models across Medicaid and Medicare and in its forthcoming report will recommend that states develop an integrated care strategy for dually eligible individuals (MACPAC n.d. c, MACPAC 2020b). An earlier MACPAC recommendation also highlighted the need for promoting coordination of physical, behavioral, and community support services (MACPAC 2012a).

Understanding the social risk factors

The social determinants of health (SDOH) are the conditions in the places where people live, learn, work, and play that affect health and quality of life. Strategies to address SDOH, combined with timely access to health care and LTSS, can promote health and reduce unnecessary use of the most expensive medical care. A number of state Medicaid programs are looking to address housing, transportation, food insecurity, among other factors that affect health, often in partnership with other state and local agencies and community-based organizations. Understanding the broader social needs of beneficiaries, including how factors such as disability status can complicate their ability to address those needs, as well as how their circumstances may affect access to care, can provide a more comprehensive picture of access and present opportunities to address access barriers.

Increasing the pool of providers

The availability of providers is a key factor affecting access to care for Medicaid enrollees. Prior MACPAC work has found that physicians were less likely to accept new patients insured by Medicaid compared to those with Medicare or private insurance (MACPAC 2021e, 2019a). In the RFI, CMS suggests that expanding the pool of available providers, either by increasing the use of telehealth or broadening who can

participate as a provider, could help address provider availability issues (CMS 2022a). Including these types of providers in an assessment of access is important for understanding potential access, whether access is improved by expanding the use of these modalities and provider types, and what barriers may remain (MACPAC n.d. a).

States have substantial flexibility to determine whether to cover telehealth and the scope of that coverage. Telehealth has the potential to mitigate barriers such as an insufficient supply of providers, inadequate transportation options, and long distances and associated travel time, particularly for patients in rural and frontier areas. It also may help assuage patients' concerns about confidentiality and stigma, particularly for behavioral health services (MACPAC 2018b). The experience of many states during the COVID-19 pandemic has demonstrated how telehealth can address access barriers, with many states expanding the primary care, acute, and specialty services that can be provided via telehealth (including oral health and HCBS); the provider types who may use telehealth; and the permissible modalities (Libersky et al. 2020). The pandemic experience presents an opportunity for CMS and states to gain an understanding of the effects of telehealth on access to care for Medicaid beneficiaries, an area in which historically there has been little research. A number of these opportunities were discussed during a panel at MACPAC's April 2021 public meeting.

CMS may also want to examine state activities, both past and those newly established with funds made available under the American Rescue Plan Act (ARPA, P.L. 117-2), as it considers ways to increase the pool of HCBS providers. MACPAC has recently examined state efforts to address workforce shortages in HCBS. High rates of turnover driven by low wages, lack of advancement opportunities, and worker dissatisfaction all contribute to shortages of HCBS workers. States have taken a variety of approaches to address this shortage, focusing on wages and benefits; training, recruitment and retention; and support for family caregivers (MACPAC 2022b). Earlier work from MACPAC also discusses HCBS workforce issues and possible options for addressing them (Bernacet et al. 2021, Barth et al. 2020).

CMS Has Data to Monitor Access

The current access monitoring requirements are confined to a limited number of services and overly rely on structural or process measures, rather than direct measures of whether beneficiaries are able to access needed care. Furthermore, as noted in Objective 3, the wide variation in the measures and standards used by states limits the ability to make meaningful comparisons. CMS should identify the data needed to understand access across states, delivery systems, and key populations, and provide states with the support to collect and report these data. CMS should also ensure public reporting of data so they can be used to promote accountability, conduct oversight, and be used for research on access.

Data sources

The forthcoming chapter on monitoring access in our June report describes the current data sources states use to assess access and their limitations. As noted above, our recommendations for

improvements in access monitoring specifically call on CMS to measure and report access measures for multiple domains. Gathering and analyzing data across these domains will require multiple sources of data (MACPAC n.d. a).

We specifically call on CMS to standardize and improve the Transformed Medicaid Statistical Information System (T-MSIS) to allow for meaningful cross-state comparisons of the use of particular services and access to providers and stratification by key demographic characteristics, such as race and ethnicity. The most feasible way to improve provider availability data is to standardize the provider type definitions (and ensure that providers correctly self-identify) in T-MSIS. This would help identify active Medicaid providers, as well as the type of providers, across states. Similarly, T-MSIS is the best and most consistent data source on utilization across states, and more attention to standardization would make it an even more useful source for monitoring service use. For example, efforts could focus on standardizing definitions of service categories and improved collection of encounter data from managed care plans (MACPAC n.d. a).

The Commission also recommends that CMS field an annual survey of beneficiaries, much like it already does for Medicare beneficiaries. A Medicaid beneficiary survey would be particularly useful to measure unmet need, barriers to care, knowledge of benefits, and how beneficiaries perceive they are being treated. A federal survey could also address data gaps by including questions related to provider availability, service use, and unmet need, and collect more complete demographic information (MACPAC n.d. a).

We understand that CMS plans to use performance indicator data, which states have been reporting since October 2013, as well as additional measures, to monitor state progress in making eligibility determinations and renewals when the PHE ends. In addition to tracking the status of enrollment, these data may provide insights on other factors that may affect those processes (e.g., call center volume) (CMS 2015, CMS 2022b). Adding information on reason for denial and disenrollment codes to future reporting would also shed light on the specific reasons why individuals do not gain or retain Medicaid. In addition, ensuring the quality of data reported by states will be important for purposes of public reporting.

Data on complaints, grievances, and appeals are another potential source of information for measuring access but these are not consistently captured by states or plans, and are not always shared with states and CMS. In considering how these data can be used for access monitoring, it will be important to understand which beneficiaries (e.g., English speakers vs those with limited English proficiency) are or are not likely to have complained, or filed grievances and appeals. CMS has developed a standard data collection tool that is being piloted with states, and may want to review this effort before further standardizing data (CMS 2021).

Home- and community-based services

Monitoring access to LTSS, particularly HCBS, is especially important given the predominant role of Medicaid in funding these services, and racial and ethnic disparities in outcomes and use of services among HCBS users (Georges et al. 2019, Fabius et al. 2018). However, there are unique challenges to

measuring LTSS access and few established measures. The forthcoming chapter on access monitoring discusses some of the limitations in more detail (MACPAC n.d. a).

Beneficiary surveys could be used to address the limitations of relying on claims data alone. For example, CMS or states could use information from nationally accredited beneficiary surveys, including the National Core Indicators, the National Core Indicators of Aging and Disabilities, and the HCBS Consumer Assessment of Healthcare Providers and Systems to monitor access (MACPAC n.d. a).

Technical support

The forthcoming June report also includes a recommendation for CMS to provide analytic support and technical assistance to states in recognition of their likely need for technical assistance and tools to improve the quality of data reported to T-MSIS and to collect and analyze additional access measures. For example, states may benefit from templates and data dictionaries to calculate core access measures consistently. States are in different places in terms of their analytical capabilities, partnerships with university researchers, and access to software and tools needed to monitor access. For some states, the administrative capacity to collect additional data, analyze and calculate new access measures, or report on new requirements may be limited, and they could require more targeted assistance. Some states also told MACPAC that technical assistance from CMS would be important to help states address access issues identified through monitoring (MACPAC n.d. a).

Payment Rates are Sufficient

Assessments of payment adequacy require having data on all types of Medicaid payments to providers and examining how capitation rate setting incorporates considerations of access. CMS may also want to consider the feasibility and appropriateness of establishing minimum payment standards for particular services, such as vaccines, as part of its efforts to improve access. Furthermore, assessments of payment adequacy will require understanding of different state payment approaches. Finally, as noted in the RFI, given that provider participation is affected by factors beyond payment rates, CMS could consider ways to streamline provider enrollment processes to ease administrative burden and promote participation.

Payment data availability

CMS needs complete information on all types of Medicaid payments that providers receive to ensure that those payments are sufficient to enlist enough providers so that beneficiaries have adequate access to services. Such access must be comparable to the general population within the same geographic area as well as across Medicaid and CHIP beneficiary groups, delivery systems, and programs.

The Commission has a long track record of calling for improved transparency in payments and making provider-level data available. However, despite recent efforts to improve the transparency of supplemental payments in FFS, much less information is available about directed payments in managed care, some of

which appear to be similar to FFS supplemental payments. In some states, directed payments appear to account for more than half of Medicaid payments to hospitals, physicians, and other types of providers, and so lack of information about these payments severely limits our ability to understand whether Medicaid payments are consistent with the statutory principles of efficiency, economy, quality, and access. A forthcoming chapter on directed payments in MACPAC's June report includes recommendations on several actions that CMS can take to improve transparency of directed payments and clarify the relationship between directed payments and quality and access goals (MACPAC n.d. d).

Managed care oversight

A recent MACPAC study of capitation rate setting highlighted gaps in current oversight processes relevant to ensuring that rates are appropriately set. The Commission found that CMS review of actuarial soundness does not explicitly examine whether capitation rates support access. First, CMS generally assumes capitation rates are sufficient to ensure adequate access and meet state network adequacy standards unless there is a significant reduction in the rates that would create a risk to plans' ability to meet these requirements. Second, while federal rules require capitation rates to be set in a manner that ensures MCOs can meet the requirements related to availability of services, network adequacy, and coordination and continuity of care, CMS has not issued guidance on how rates should account for enrollee access to care and there is no professional actuarial guidance on this topic (42 CFR 438.4(b)(3)).

The absence of guidance to evaluate network adequacy and overall access in the context of actuarial soundness has been complicated by the introduction and growth of state directed payments, many of which states have implemented to improve performance on access-related goals.[4] However, it is not clear how states align the goals of directed payments arrangements, particularly those that make additional payments to providers, with requirements relating to actuarial soundness. In addition, state actuaries noted that there is little basis or opportunity for review of these payments when setting rates. MACPAC's forthcoming chapter on directed payments includes recommendations for CMS to clarify roles and responsibilities in the review of directed payments and managed care capitation rates. The Commission also recommends that states provide additional clarity about whether directed payments are necessary to meet network adequacy requirements and other existing access standards (MACPAC n.d. d).

MACPAC's forthcoming June report will detail how CMS can improve evaluations of directed payments. Specifically, the Commission recommends that CMS require states to develop rigorous, multi-year evaluation plans for directed payments that substantially increase provider payments. Written guidance about the types of measures that states should monitor and the timing for submitting results would be particularly helpful (MACPAC n.d. d).

Minimum payment standards for vaccines

CMS should set minimum standards for payment for adult vaccines. Most vaccines administered by Medicaid are provided to children at no cost to the states through the federal Vaccines for Children Program, but states have been left to develop their own payment policies for the small proportion of vaccines provided to adults. However, MACPAC's ongoing work examining vaccine access for Medicaid-enrolled adults has identified payment inadequacy as a key factor in low vaccination rates. In our March 2022 report, the Commission commented that some Medicaid programs may not cover a provider's costs of purchasing or administering adult vaccines, which may discourage some providers from administering vaccines and thus reduce access for beneficiaries (MACPAC 2022c).

In its forthcoming June report to Congress, MACPAC recommends that CMS implement minimum payment regulations for vaccines under the authority of Section 1902(a)(30)(A) of the Act (MACPAC n.d. e). This would be consistent with policies for other services. For example, for outpatient prescription drugs, CMS requires states to pay providers based on the actual prices available in the marketplace (i.e., actual acquisition cost) and a professional dispensing fee to cover reasonable costs associated with dispensing the drug to a Medicaid beneficiary (42 CFR 447.518(a)(2)).

Arrangements and services unique to Medicaid

CMS asks for comments on how it can assess the effect of state payment policies and contracting arrangements that are unique to Medicaid on access to care. As noted above, it is the Commission's view that CMS should take steps to improve evaluations of directed payments in Medicaid managed care to better understand their effects on access to care.

The RFI also asks about data sources, methods, and benchmarks for assessing the sufficiency of rates for services that are not covered by Medicare. The Commission acknowledges that Medicare payment rates are not an appropriate benchmark for certain services (MACPAC 2017b). For example, we have documented the fact that long-stay, Medicaid-covered residents generally have much lower patient acuity than short-stay, Medicare-covered residents. Thus, it may be appropriate to assume that the costs of care for Medicaid-covered residents should be lower than Medicare-covered residents (MACPAC 2020d).

The Commission has also noted that costs of care may not be the most appropriate benchmark. For example, the Commission's recent analyses of nursing facility staffing found that facilities that serve a high share of Medicaid patients have lower staffing levels than other facilities (MACPAC 2022d). As a result, measures of current staffing costs may not be reflective of the costs of providing adequate staffing to meet resident care needs.

The RFI notes the agency's interest in promoting non-financial policies to promote provider participation in Medicaid and CHIP. CMS may also want to identify appropriate benchmarks for payment to providers and practices that include a mix of clinicians. A MACPAC analysis of physician acceptance of new Medicaid patients using data from the National Electronic Health Records Survey (NEHRS) found that the presence

of a mix of providers such as physicians, nurse practitioners, physician assistants, and nurse midwives, was associated with greater acceptance of new Medicaid patients. Overall, 73.7 percent of physicians accepting new patients accepted new Medicaid patients, but acceptance was higher (80.5 percent) among physicians in practices with an above-average ratio of these clinicians and lower (68.9 percent) among physicians in practices with a below-average ratio (MACPAC 2021e).

Administrative burden related to provider enrollment

The Commission agrees with CMS's focus in the RFI on identifying policies to reduce provider burden; administrative and program integrity requirements that affect payment, while necessary, should not place an undue burden on providers. We previously recommended that the Secretary of the U.S. Department of Health and Human Services (in collaboration with the states) create feedback loops to simplify and streamline regulatory requirements; determine which current federal program integrity activities are most effective; and take steps to eliminate programs that are redundant, outdated, or not cost-effective. The Commission has also recommended that the Secretary should, under the Medicaid Integrity Program, conduct a rigorous examination of current state program integrity activities to identify the features of policy design and implementation associated with success (MACPAC 2019b, 2012b). MACPAC has also recommended making certain program integrity activities optional (e.g. recovery audit contractors, estate recovery) given the low yield of these activities in many states (MACPAC 2021f, 2019b).

There may be opportunities to permanently streamline the provider enrollment processes for providers who routinely serve patients from different states. For example, a MACPAC analysis of out-of-state hospital use found that on average, children's hospitals served beneficiaries enrolled in more than six states (MACPAC 2020c).

Additional Comments

As noted at the beginning of this letter, the Commission urges CMS to be transparent as it works to measure and improve access to care and coverage. We note however, that the transparency of this RFI process is not readily apparent. Because the RFI directs respondents to submit written comments only through the portal, options that are typically available through the formal rulemaking process (i.e., email, mail, hand delivery) do not appear to be available. As such, the ability to respond may not be available to all interested parties. In addition, while CMS plans to post a summary of themes from responses to this RFI and make individual comments submitted available upon request, to date, this plan has not been widely publicized. Moreover, the process for requesting the information or the timeframe for receiving it is unclear.

The Commission encourages CMS to make the comment process on this RFI and any subsequent rulemaking public and transparent. Furthermore, as noted in the Commission's forthcoming report, meaningful stakeholder engagement should extend beyond providing public notice and comment periods in the formal rulemaking process. CMS should also engage stakeholders through multiple avenues, such

as roundtables and workgroups, throughout the process. Actively working with a broad range of stakeholder groups can help ensure an access monitoring system that is designed with input from multiple perspectives, including from those who benefit from the services, and can facilitate stakeholder understanding of the standards and processes being used to monitor access (MACPAC n.d. a).

We hope these findings from MACPAC's work examining enrollment and renewal processes, monitoring access, and payment policies are helpful as CMS develops a more comprehensive access strategy. If you have questions about the information in this letter, please reach out to Martha Heberlein (martha.heberlein@macpac.gov).

Sincerely,

Melanie Bella
Chair

Endnotes

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[1] About one in five Medicaid and CHIP beneficiaries disenroll each year. Some of those who disenroll transitioned to other coverage. For example, in 2018, about one in five children who disenrolled from Medicaid enrolled in separate CHIP and about half of children who disenrolled from separate CHIP enrolled in Medicaid. However, only about 3 percent of adults and children who disenroll from Medicaid and separate CHIP transition to exchange coverage in 2018.

[2] This recommendation was reiterated in 2014 (MACPAC 2014a).

[3] The Commission noted its support for this policy in a 2014 letter to the Secretary of HHS (MACPAC 2014b).

[4] Directed payments are used to establish minimum payment rates for certain types of providers or to require participation in value-based payment arrangements that advance the state's quality and access goals.

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