Report to Congress on Medicaid and CHIP

JUNE 2022

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) 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). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, Section 1900 of the Social Security Act, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

Report to Congress on Medicaid and CHIP

JUNE 2022

MACPAC | Medicaid and CHIP Payment and Access Commission

June 15, 2022

The Honorable Kamala Harris
President of the Senate
The Capitol
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
The Capitol
Washington, DC 20515

Dear Madam Vice President and Madam Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the June 2022 *Report to Congress on Medicaid and CHIP*. This report addresses a range of important issues facing the Medicaid program: monitoring access to care; improving the oversight and transparency of directed payments; improving access to vaccines for adults; encouraging the use of health information technology (IT) among behavioral health providers; requiring states to integrate care for people who are dually eligible for Medicaid and Medicare; and advancing health equity in Medicaid.

Chapter 1 makes recommendations to create a new and more robust system for monitoring access to care for Medicaid beneficiaries that would allow for comparisons across states and delivery systems. The chapter discusses the challenges and limitations of the current monitoring approach and the goals and key elements for a new system. The Commission approved a package of five recommendations that would direct the Centers for Medicare & Medicaid Services (CMS) to develop a new system for access monitoring that is transparent and involves stakeholder input. The Commission also calls for CMS to conduct an annual survey of Medicaid beneficiaries. In addition, we recommend that CMS further standardize the Transformed Medicaid Statistical Information System (T-MSIS) data and provide technical assistance for states to collect and report data.

Chapter 2 focuses on the oversight and transparency of managed care directed payments, which have become a large and growing share of Medicaid payments and exceed other types of supplemental payments. The Commission recommends improving the transparency of directed payment approval documents, rate certifications, and evaluations; collecting new provider-level data on directed payment spending; clarifying directed payment goals and their relationship to network adequacy requirements; providing guidance for more meaningful, multiyear assessments of directed payments; and enhancing the coordination of reviews of directed payments and managed care rate setting.

Chapter 3 makes recommendations to improve access to vaccines for adults enrolled in Medicaid, a population with lower vaccination rates than

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those covered by private insurance and who have inequitable access to these public health tools. The Commission recommends a set of complementary actions to improve uptake, including making coverage of recommended vaccines a mandatory benefit for all adult Medicaid beneficiaries. In addition, CMS should implement regulations for vaccine payment and encourage the broad use of Medicaid providers in administering vaccines. Moreover, the Commission recommends a coordinated effort to improve vaccine outreach and education to Medicaid and State Children's Health Insurance Program (CHIP) beneficiaries as well as improving immunization information systems and providing funding to support these efforts.

Chapter 4 looks at how Medicaid policy can be used to support adoption of health IT among behavioral health providers to better integrate behavioral health and physical health care. The chapter explores the barriers that behavioral health providers face in adopting electronic health records and outlines where federal actions could explicitly encourage health IT adoption. The Commission recommends that CMS issue guidance to help states use Medicaid authorities and other federal resources to promote behavioral health IT adoption and that the Office of the National Coordinator for Health Information Technology and the Substance Abuse and Mental Health Services Administration work together to develop a voluntary certification to encourage health IT uptake appropriate for behavioral health.

Chapter 5 takes an important step forward in making integrated care a standard for the 12.2 million people who are dually eligible for Medicaid and Medicare. While integrating care for beneficiaries of these programs has the potential to improve care and reduce federal and state spending, only about 1 million full-benefit dually eligible beneficiaries were enrolled in integrated care models in 2020. Moreover, some states are further along than others in integrating care for these beneficiaries. To raise the bar on integration, the Commission recommends requiring all states to develop an integrated care strategy within two years. The strategy should include an integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, and quality measurement—and be structured to promote health equity. The recommendation includes federal financing to support states in developing the strategy.

The final chapter of the June report addresses how to advance health equity in Medicaid, which has become a cross-cutting theme across all of MACPAC's work. More than half of adults and two-thirds of children enrolled in Medicaid and CHIP are beneficiaries of color. Health disparities have long existed for Medicaid beneficiaries of color, and the chapter provides the context for understanding these racial disparities and inequities. It highlights data showing the racial and ethnic composition of the Medicaid population and the disparities affecting these beneficiaries. In addition, the chapter discusses policy levers that states and the federal government can use to promote equity and lays the groundwork for future MACPAC work.

MACPAC is committed to providing in-depth, non-partisan analyses of Medicaid and CHIP policy. This document fulfills our statutory mandate to report each year by June 15, and we hope it will prove useful to Congress as it considers future policy development affecting these programs.

Sincerely,

Melanie Bella

Melanie Bella, MBA
Chair

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Medicaid and CHIP Payment
and Access Commission
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MACPAC's June 2022 *Report to Congress on Medicaid and CHIP* addresses a range of important issues facing the Medicaid program: monitoring access to care, improving the oversight and transparency of directed payments, improving access to vaccines for adults, encouraging the use of health information technology (IT) among behavioral health providers, requiring states to integrate care for people who are dually eligible for Medicaid and Medicare, and advancing health equity in Medicaid.

CHAPTER 1: A New Medicaid Access Monitoring System

Chapter 1 makes recommendations to create a new and more robust system for monitoring access to care for Medicaid beneficiaries that would allow for comparisons across states and delivery systems. States and the federal government both have statutory obligations to ensure that Medicaid provides access to services. However, the current approach to monitoring access does not measure key domains of access or provide comparable or actionable data, which are needed for policymakers and stakeholders to assess whether the program is meeting this obligation.

The Commission recommends that the Centers for Medicare & Medicaid Services (CMS) develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. CMS should issue timely public reports and data at the state and national level in a consumer-friendly and research-ready format. The process for establishing and modifying a new access monitoring system should be public and transparent and involve key stakeholders.

The Commission also recommends that a new monitoring approach include an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care. In addition, CMS should further standardize and improve the Transformed Medicaid Statistical Information System (T-MSIS) data to allow for meaningful cross-state comparisons and provide technical assistance to states to collect and analyze access measures.

CHAPTER 2: Oversight of Managed Care Directed Payments

Chapter 2 focuses on improving the oversight and transparency of managed care directed payments, which have become a large and growing share of Medicaid payments and outstrip other types of supplemental payments. Although information on spending under this new option is extremely limited, state projections indicate that total spending exceeded $25 billion in 2020.

States use directed payment arrangements for a variety of purposes, including to set base payment rates for services provided in managed care, to increase the adoption of value-based payment methods, or to make large additional payments to providers, similar to supplemental payments in fee for service. More transparency is needed to understand how much is being spent and the extent to which these payments are advancing quality and access goals.

To improve the transparency of Medicaid spending and promote more meaningful oversight, the Commission makes several recommendations in this chapter to the Secretary of the U.S. Department of Health and Human Services (HHS) and to states. The Commission recommends that HHS make directed payment information publicly available on the Medicaid.gov website, make provider-level data on directed payment amounts publicly available in a standard format that enables analysis, 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.

In addition, the Commission recommends that states develop rigorous, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan. To promote more meaningful oversight of directed payments, we also recommend that HHS clarify the roles and responsibilities of states, actuaries, and divisions of CMS responsible for the review of directed payments and managed care capitation rates.

CHAPTER 3: Acting to Improve Vaccine Access for Adults Enrolled in Medicaid

Chapter 3 makes recommendations to improve access to vaccines for adults enrolled in Medicaid. Vaccines are important tools to promote public health, yet adult Medicaid beneficiaries have lower vaccination rates than those covered by private insurance for nearly all vaccines. This is due in part to limited coverage of recommended vaccines for beneficiaries who are not enrolled in the new adult group. Vaccine coverage is optional for many adults in Medicaid and varies by state and vaccine, which creates unequal access to cost-effective, preventive care.

In the March report to Congress, the Commission highlighted several policy considerations to improve vaccine access for Medicaid beneficiaries. These considerations include addressing low provider payment, limited provider networks, and inadequate support and education for beneficiaries.

In our June report, the Commission recommends making coverage of recommended vaccines a mandatory benefit for all adult Medicaid beneficiaries. To further improve access, CMS should implement regulations for vaccine payment and encourage the broad use of Medicaid providers in administering vaccines. In addition, the Commission recommends a coordinated effort to improve vaccine outreach and education to Medicaid and State Children's Health Insurance Program (CHIP) beneficiaries as well as to improve immunization information systems and provide

funding to support state-level activities to improve the availability of these services.

CHAPTER 4: Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

Chapter 4 looks at how Medicaid policy can be used to support adoption of health IT among behavioral health providers to better integrate behavioral health and physical health care. Delivery systems for physical and behavioral health are often fragmented, impeding access to care and resulting in inappropriate or limited use of services, poor health status, and increased costs for people with behavioral health conditions. Medicaid programs play a critical role in financing behavioral health services and are increasingly focused on ways to provide behavioral health in more integrated settings.

Adoption of health IT and certified electronic health record technology, which can improve communication between providers and allow them to electronically retrieve and transfer patient information in real time, is one strategy to promote integration. However, behavioral health providers have adopted IT at lower rates compared with other providers because they were not eligible for federal incentive payments to do so. Other impediments to adoption include the costs of technology and training, challenges related to sharing information about substance use disorder, and the lack of industry guidelines for behavioral health IT.

In this chapter, the Commission recommends that CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the National Coordinator for Health Information Technology (ONC) develop and issue joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability. The Commission also recommends that SAMHSA and ONC jointly develop a voluntary certification for IT used in

behavioral health and integrated care settings to support ongoing integration efforts.

CHAPTER 5: Raising the Bar: Requiring State Integrated Care Strategies

Chapter 5 takes an important step forward in making integrated care a standard for the 12.2 million people who are dually eligible for Medicaid and Medicare. While integrating care for beneficiaries of these programs has the potential to improve care and reduce federal and state spending, only about 1 million full-benefit dually eligible beneficiaries were enrolled in integrated care models in 2020. Moreover, some states are further along than others in integrating care for these beneficiaries.

State officials point to several impediments to integration. These include competing priorities, lack of Medicare expertise, limited staff capacity to manage integrated care initiatives relative to other responsibilities, and limited experience with enrolling dually eligible beneficiaries in Medicaid managed care. While the Commission appreciates these dynamics, it continues to press for action to increase enrollment in integrated models, expand the availability of these models, and achieve higher levels of integration.

To provide the impetus for action, the Commission recommends that all states be required to develop a strategy to integrate care for dually eligible beneficiaries. The strategy should address how the state will approach integration, eligibility, benefits, enrollment strategy, beneficiary protections, data analytics, and quality measurement and be structured to promote health equity. Given the level of effort and specialized expertise needed to integrate care, we also recommend that Congress provide additional federal funding to support states in developing their strategies.

In the coming year, the Commission plans to continue its work on integrated care for dually eligible beneficiaries, which could include a focus on the beneficiary experience in integrated care.

CHAPTER 6: Medicaid's Role in Advancing Health Equity

Chapter 6 addresses how to advance health equity in Medicaid, which has become a cross-cutting theme in MACPAC's analyses. More than half of adults and two-thirds of children enrolled in Medicaid and CHIP are beneficiaries of color. Health disparities have long existed for Medicaid beneficiaries of color, and the chapter provides the context for understanding these racial disparities and inequities.

The chapter discusses policy levers that states and the federal government can use to promote equity and lays the groundwork for future MACPAC work. Key areas in which Medicaid policy can advance health equity include collection and reporting of race and ethnicity data; the role of state leadership in prioritizing a health equity agenda; beneficiary engagement in the policymaking process; enrollment, redetermination, and renewal processes; delivery system levers, including managed care contracting, payment approaches, and quality strategies; and development of a diverse and culturally competent workforce.

Over the next year, the Commission will continue using a health equity lens throughout our work. For example, the Commission has work underway examining strategies to improve the collection and reporting of race and ethnicity data, exploring Medicaid's role in improving access for those with limited English proficiency, and leveraging Medical Care Advisory Committees to increase beneficiary engagement. In addition, we plan to build our analyses of inequities for other beneficiaries who have been historically marginalized based on age, geography, disability, sexual orientation, and gender identity, as well as the intersection of these identities with race and ethnicity. The Commission will continue to monitor federal and state efforts to promote equity to understand their effects.

A New Medicaid Access Monitoring System

A New Medicaid Access Monitoring System

Recommendations

1.1 The Centers for Medicare & Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should:

- capture potential access, realized access, and beneficiary perceptions and experiences;

- prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and

- be adaptable to reflect changes in measurement, policy priorities, and care delivery.

  CMS should issue public reports and data at the state and national level in a consumer-friendly and research-ready format in a timely manner.

1.2 The Centers for Medicare & Medicaid Services should involve stakeholders in the development and future modifications of a new system. The agency should actively solicit and incorporate input from key stakeholders, including, but not limited to, states, beneficiaries, consumer groups, health plans, providers, researchers, and other policy experts. The process for establishing a new access monitoring system should be public and transparent.

1.3 The Centers for Medicare & Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.

1.4 The Centers for Medicare & Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.

1.5 To assist states in collecting and analyzing access measures, the Centers for Medicare & Medicaid Services should provide analytical support and technical assistance.

Key Points

- States and the federal government both have statutory obligations to ensure that Medicaid provides access to services. However, the current approach to monitoring access does not measure key domains of access or provide comparable or actionable data, which are needed to assess whether the program is meeting this obligation.

- A new access monitoring system should be developed with stakeholder involvement to ensure the inclusion of measures and services that are meaningful, promote health equity, and allow for changes over time.

- Public reporting of access data and assessments will provide the Centers for Medicare & Medicaid Services, states, and other key stakeholders with information to identify problems, guide program improvement, and serve as a means of accountability.

- Fielding a federal Medicaid beneficiary survey will serve as an important tool to measure beneficiary perceptions and experiences with care, a key area where measures are currently lacking.

CHAPTER 1: A New Medicaid Access Monitoring System

Medicaid provides coverage for health care and other related services to more than 82 million of the nation's most economically disadvantaged people, including low-income children and their families, pregnant women, people over the age of 65, and people with disabilities (MACPAC 2021a).[1] A key measure of the effectiveness of any health coverage program is whether it provides timely access to high-quality services. Given the effects of poverty and related socioeconomic factors on the health and ability of many Medicaid beneficiaries to obtain services, ensuring access to needed services is particularly important. Further, federal and state governments have a statutory obligation to ensure access. Thus, Medicaid should have a robust monitoring system both to ensure that these requirements are being met, as well as to help identify problems and guide program improvement.

However, the current systems to monitor access are insufficient to this task, due to their design, data availability, and state capacity constraints. Current monitoring requirements in fee for service (FFS) focus on a limited number of services, do not include key services such as long-term services and supports (LTSS), and are reported only every three years. In managed care, access requirements overly rely on structural measures (e.g., network adequacy) rather than direct measures of care. Neither captures information on care that was needed but not received nor information specific to particular subpopulations. Finally, the wide variation in the measures and standards used across states limits the ability to make meaningful comparisons.

In the Commission's view, the Centers for Medicare & Medicaid Services (CMS) should establish a new regulatory structure to monitor access and address these inadequacies. A new access monitoring system should capture the three key domains

of access: provider availability and accessibility, service use, and beneficiary perceptions and experiences of care (MACPAC 2011, Kenney et al. 2016).[2] In building this system, CMS should develop the measures needed to capture these domains and take steps to improve the ability to collect, analyze, and respond to access monitoring data. Specifically, such a system should have consistent requirements and comparable measures across delivery systems and states, while allowing states to add measures to meet their priorities. Measures should be chosen to reflect the priorities of multiple stakeholders, including beneficiaries, and designed to capture disparities in access to care among historically marginalized populations. Additionally, given state concerns regarding administrative burden, data collection and analysis should be designed with clear roles and expectations for CMS, states, and managed care plans; capitalize on existing efforts; and adapt over time to reflect changes in care delivery and data availability. The data collected also should be timely and actionable, allowing CMS, states, and other stakeholders to assess and respond to access issues as they are identified.

To meet these goals, the Commission draws on prior research, comments on proposed and final rules, and key informant interviews to make a series of recommendations for a new access monitoring plan:

1.1 The Centers for Medicare & Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should:

- capture potential access, realized access, and beneficiary perceptions and experiences;

- prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and

- be adaptable to reflect changes in measurement, policy priorities, and care delivery.

CMS should issue public reports and data at the state and national level in a consumer-friendly and research-ready format in a timely manner.

1.2 The Centers for Medicare & Medicaid Services should involve stakeholders in the development and future modifications of a new system. The agency should actively solicit and incorporate input from key stakeholders, including, but not limited to, states, beneficiaries, consumer groups, health plans, providers, researchers, and other policy experts. The process for establishing a new access monitoring system should be public and transparent.

1.3 The Centers for Medicare & Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.

1.4 The Centers for Medicare & Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.

1.5 To assist states in collecting and analyzing access measures, the Centers for Medicare & Medicaid Services should provide analytical support and technical assistance.

This chapter begins by describing current requirements for monitoring access under FFS and managed care and the limitations with these approaches. It then describes the goals and key elements of a new access monitoring system, including stakeholder engagement, access

measures, data collection, and implementation. The chapter concludes with the Commission's recommendations and its rationale.

Current Approach for Monitoring Access

Monitoring access to care for Medicaid beneficiaries is a requirement under both FFS and managed care. However, there are separate statutory and regulatory requirements for how states and managed care plans must monitor and ensure access to care. Even so, CMS has acknowledged that the same principles for determining access, specifically that Medicaid beneficiaries have appropriate access to services and care, apply regardless of delivery system and expressed support for a more uniform and comprehensive strategy (CMS 2022a, 2019a, 2015a; OMB 2021).

Monitoring access under fee for service

The key requirement to ensure access to Medicaid services under FFS is commonly known as the equal access provision. Specifically, § 1902(a)(30)(A) of the Social Security Act (the Act) requires that Medicaid provider payment rates be "consistent with efficiency, economy, and quality of care," and "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Historically, compliance with the equal access provision requirement to "enlist enough providers" had been assessed primarily through the adequacy of provider payment rates. For many years, this was enforced as a result of lawsuits filed by providers and beneficiaries. Those rulings found that payment rates were too low to ensure equal access to Medicaid services. However, on March 31, 2015, in

Armstrong v. Exceptional Child Center, Inc., 135 S. Ct. 1378 (2015), the Supreme Court ruled that Medicaid providers and beneficiaries do not have a private right of action to contest state-determined Medicaid payment rates in federal courts. In response, both the Commission and CMS concluded that federal enforcement of the equal access provision is now the primary mechanism for ensuring that Medicaid beneficiaries have sufficient access to care. As such, CMS must play a leading role in establishing and administering an access monitoring system (MACPAC 2018; CMS 2015b).

Partially in response to the *Armstrong v. Exceptional Child Center, Inc.* ruling, CMS published a final rule with comment in November 2015, describing how states must monitor and report on access to care under FFS to comply with the equal access provision. Previously, there were no federal regulations to guide states in meeting the equal access provision.[3] The final rule described the processes to review the effect of changes to provider payment rates on access (CMS 2015b).

The goal of the rule was to create a more systematic and transparent approach to monitoring access in FFS that would allow CMS and others to make informed, data-driven decisions (CMS 2015b).[4] The rule required states to submit an access monitoring review plan (AMRP) by October 1, 2016, to be updated subsequently at least every three years. States were required to make the plan available for public review and comment prior to the initial submission.[5] The rule also required that states submit a recent access review with any state plan amendment (SPA) proposing a reduction or restructuring of payment rates that could result in diminished access. States must monitor the effects of such changes for at least three years.

Despite the intention to create a more systematic approach to access monitoring, the lack of specific guidance led to wide variation across states. The original state AMRPs submitted in 2016 varied in how they approached the task and their benchmarks for sufficient access; lack of consistency in measures continues to make

it difficult to compare access across states.[6] Although most states reported baseline data for the five required types of services (primary care, specialist care, behavioral health, pre- and postnatal obstetric services, and home health services), the scope of monitored services is limited. Some states reported on services for which access issues had been identified, such as oral health and transportation services. States used a variety of state-specific data sources, such as utilization data from claims, self-reported access measures from beneficiary surveys, and provider enrollment figures. States also differed in the extent to which they included demographic or other enrollee characteristics that would allow them to monitor access for different populations. Although most states collected data on similar types of services and access measures, the measures often relied on multiple state-specific data sources and so are often not comparable across states (MACPAC 2017). Updated AMRPs were submitted in 2019 but as of yet are not publicly available (Silanskis 2021). Given demands on Medicaid agencies during the COVID-19 public health emergency (PHE) and concerns regarding the representativeness of the data, CMS has delayed submission of updated AMRPs, initially due in 2022, until 2024 (CMS 2022b).

In comments on the final 2015 rule, many states, especially those with high managed care enrollment, expressed concerns about the administrative burden associated with monitoring access to care and analyzing the effect of payment rate changes affecting the relatively small number of Medicaid beneficiaries in FFS.[7] In response to these comments, the Trump Administration proposed changes to the FFS monitoring rule, but these were never finalized. The first proposed rule would have established exemptions for states with high managed care enrollment and for those making payment rate changes below a threshold (CMS 2018). The second proposed rule would have rescinded all the state requirements established in the final 2015 rule, with the goal of instead developing a new rule with a more comprehensive

approach to monitoring access, reducing the burden on states (CMS 2019a).

Assessing access in managed care

Unlike in FFS, in which states are solely responsible for ensuring access, under managed care, states contract with managed care organizations (MCOs), which are responsible for monitoring and enforcing access and quality standards and contracting with providers. Provisions for ensuring access to Medicaid services for enrollees in managed care are governed under different statutory sections: §§ 1903(m) and 1932 of the Act. MCOs are required to demonstrate and document compliance that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity (§1932 of the Act). States approve contracts, determine the provider network adequacy standards, and have an obligation to ensure that beneficiaries receive appropriate services. State contracts with MCOs describe how access to providers will be monitored and deficiencies will be corrected.

On May 16, 2016, CMS issued a comprehensive managed care rule that established new requirements for how states should assess network adequacy and accessibility of services in MCOs (CMS 2016).[8] The rule was updated in 2020 to require states to develop and publish quantitative network adequacy standards, which could include, but were not limited to, time and distance standards for primary and specialty care providers, obstetricians and gynecologists, behavioral health providers, hospitals, pharmacies, and pediatric dental providers (42 CFR 438.68, CMS 2020a).[9] Additionally, the rule requires states to establish quality strategies. This includes developing performance improvement projects to assess the quality and appropriateness of care and improve access, and to have an external review of access, including network adequacy standards (CMS 2016).

MACPAC's 2018 review of Medicaid managed care contracts and quality strategies found wide variation in how states established, measured, and monitored provider network adequacy. Measures of network adequacy included provider-to-member ratios, appointment scheduling and appointment wait-time standards, requirements for after-hours access, and specifications for physical and communication accessibility. Several states had separate standards for rural and urban areas. Additionally, most states used multiple methods to monitor access, including review of periodic MCO provider network files and additional network reports. Many contracts also require MCOs to submit other information that could be used for access and network adequacy monitoring, such as grievances, surveys, and encounter data (MACPAC 2018).

Limitations of the Current Approach

In the Commission's view, the current approach has several limitations. The existing system does not measure key domains of access or provide comparable and actionable data. This limits the ability of CMS and states to compare access issues across states and populations, understand policies that affect access, and identify priority areas for improvement.

First, the existing system does not capture all the domains of access, most notably beneficiary experience. For example, many states rely on administrative data to monitor access and utilization of services, but this approach does not capture unmet health needs, barriers to care, beneficiary perceptions of care, or self-reported health status. Additionally, these data do not always capture all relevant demographic or socioeconomic measures. Further, measures of provider accessibility, such as availability of translation and interpretation services for beneficiaries with limited English proficiency and

accommodations for individuals with disabilities, are often lacking.

Second, the current approach does not monitor access to many services that are of high priority to Medicaid beneficiaries and states. For example, state AMRPs are only submitted every three years and only report on a limited set of services. Although states are required to report on home health services, they are not required to examine access to home- and community-based services (HCBS) more broadly, an integral and growing part of the Medicaid program.[10]

Further, the current approach often relies on structural or process measures rather than direct measures of access. For example, in states where the majority of the Medicaid population is enrolled in managed care, the structural measures reported by MCOs (such as time and distance standards) do not directly measure whether beneficiaries are receiving needed care. Additionally, provider directories, particularly paper versions, are often outdated and list providers who may no longer be accepting new patients or participating in the network, potentially overstating provider availability.

In addition, data issues limit the usefulness of this information for identifying problems and developing solutions. For example, there are concerns with the completeness and accuracy of administrative data that are used to assess utilization of care, as well as its timeliness. Survey data, although useful for monitoring beneficiary experience, are limited by their sample size and often cannot be used to compare access across states or subpopulations. Plans may be required to report grievance and appeals data to states, but these data are not consistently collected nor are they necessarily representative of the access and quality issues experienced by beneficiaries. Additionally, there is a lack of complete and reliable beneficiary demographic data, which limits the ability to monitor access across populations or detect disparities in access to care.

Finally, by design, the system allows for state variation and does not capture core measures uniformly across states and delivery systems. Further, finding comparable measures across states is challenging because of policy, health system, and geographic differences. For example, eligibility for particular services varies across states. In addition, states may define and report services and providers differently. This limits the ability of CMS, states, and other stakeholders to make meaningful comparisons, detect access issues, and identify priorities for improvement. It also makes it difficult for researchers and program evaluators to assess the effects of the many policy choices that states make in administering the program.

CMS repeatedly has expressed interest in a more consistent approach, acknowledging the need for a more unified data-driven approach that would align methods and measures used to monitor access across delivery systems (CMS 2019a, 2015a, 2015b). Most recently, CMS has indicated that it is developing a comprehensive access strategy which may involve a range of actions, such as regulations, guidance, and technical assistance. As an initial step, the agency released a request for information (RFI) in February 2022 (CMS 2022a).[11] A forthcoming rule is expected to support access monitoring across delivery systems, and be inclusive of HCBS. Publication of the rule is anticipated in October 2022 (OMB 2021).

Goals of a New Access Monitoring System

To address the concerns articulated above, CMS should develop a new regulatory framework for a new comprehensive access monitoring system. Such a system is needed to provide CMS, states, beneficiaries, and other stakeholders with information to assess the program's value, serve as a means of accountability, help identify problems, and guide program improvement. An effective access monitoring system should allow

for actionable and meaningful comparisons across states and delivery systems. The monitoring system should prioritize methods that are timely and minimize administrative burden, build on existing data collection and reporting wherever possible, and allow for updating over time. In addition, a new system should reflect the priorities of CMS, states, and beneficiaries, and incorporate considerations of equity in assessing and improving access.

Meaningful. The data collected should include measures that are meaningful to CMS, states, and beneficiaries, reflecting the services that are important to those served by the program. Further, an examination of access should account for the characteristics and complex health needs of Medicaid beneficiaries, as well as state-level programmatic, policy, and geographic differences.

Focused on equity. An access monitoring system should collect data that can be used to assess need, detect disparities, and identify areas of improvement for historically marginalized populations. This includes collecting and analyzing data by race and ethnicity, primary language, disability, sexual orientation, gender identity, and geography.

Comparable. The system should be based on a common set of access measures that are consistent and comparable across states, delivery systems, and populations. It also should allow for some flexibility for states to add additional measures to suit their unique circumstances and priorities.

Actionable. An effective access monitoring system should yield information that is actionable for CMS, states, and plans. The measures and data collected should be used to identify areas of concern, and guide program improvement.

Timely. A monitoring system should collect and report data in a timely enough fashion to detect problems so state and federal policymakers can intervene as quickly as possible.

Efficient. Given constraints on state and federal capacity, an access monitoring system should be efficient and minimize administrative burden for CMS, states, plans, and providers. It should build on existing systems and data wherever possible and prioritize which populations and services to monitor.

Adaptable. Access monitoring should allow for modification and updates to the system over time, including dropping measures that are no longer useful and adapting to changes in available data and the service delivery system.

Key Elements of a New Access Monitoring System

To inform the Commission's work on assessing the need for a new access monitoring system, MACPAC conducted a literature review, examined state and stakeholder comments on proposed and final federal rules, and conducted stakeholder interviews with CMS, states, plans, beneficiary advocates, and researchers. The interviews were designed to gain a better understanding of the stakeholder priorities, the challenges and potential solutions to monitoring access, and the design and implementation of a new access monitoring system.[12] MACPAC also convened experts including Medicaid researchers, beneficiary advocates, and representatives from CMS, states, and plans at public meetings to discuss data availability and implementation considerations in designing a new access monitoring system.

Below are the key elements of a new access monitoring system: stakeholder engagement, access measures, data collection and analysis, public reporting and oversight, and phased implementation.

Stakeholder engagement

Stakeholders with multiple perspectives should be engaged in the design and implementation

of a new access monitoring system. Public engagement with states, beneficiaries, consumer groups, plans, providers, researchers, and policy experts is critical to selecting access measures that are meaningful, feasible to collect, and actionable. Incorporating the beneficiary voice and experience in the design and implementation of the system is particularly important to understand their lived experience, the services they use, and the barriers they face.[13] Similarly, collaborating with states in development and selection of access measures will help ensure that measures align with state priorities; complement, rather than duplicate, existing data collection efforts; and are practical and actionable. Although CMS has a primary responsibility to ensure access for Medicaid beneficiaries, states are equal partners in program design and administration and thus should be key partners in the development and implementation of a new access monitoring system.

In prior rulemaking, CMS engaged stakeholders formally through comment periods and requests for information. These formal comment mechanisms provided CMS with insight into stakeholder concerns, some of which were incorporated into regulations. For example, in response to state comments about use of uniform time and distance standards to measure network adequacy, CMS updated the requirements to allow states to develop their own quantitative standard tailored to their state (CMS 2020a). Similarly, in the final 2015 FFS rule, CMS addressed many of the comments submitted by states, researchers, and advocates in response to the proposed 2011 rule (CMS 2015b, 2011).

At times, CMS also has convened workgroups and technical expert panels, inviting key stakeholders to engage in designing and implementing a new approach to monitoring access. For example, in 2019, CMS announced plans to convene workgroups and technical expert panels with federal and state stakeholders that would focus on current requirements and identify data that could be used to conduct federal access reviews (CMS 2019a).[14] However, CMS did not explicitly include

beneficiaries or specify how the beneficiary voice would be included in these processes.

As CMS designs and implements a new access monitoring system, it should take a more expansive approach to stakeholder engagement. The opportunities for contribution should be accessible to all stakeholder groups, including beneficiaries who represent the various populations covered by Medicaid, policy experts, advocates, and researchers. Further, the perspectives and concerns raised by these stakeholder groups should be incorporated into the design of the new access monitoring system.

CMS has successfully involved multiple stakeholder groups, and specifically beneficiaries, in formal structures for engagement with Medicaid. One example is the advisory council CMS convened to establish the Adult and Child Core Sets. This council (consisting of providers, beneficiary advocates, state officials, and policy experts) reviewed the core set measures, assessing validity and feasibility of the measures and alignment with federal priorities.[15] If a similar process were used to develop access measures, it would be important also to incorporate direct input from beneficiaries and to provide assistance or resources in advance to promote their ability to contribute to the discussion (Stewart 2022).

Access measures

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.

Beginning with the access framework described in MACPAC's inaugural report in March 2011, the Commission has highlighted the need to monitor access across multiple domains (MACPAC 2017, 2011). As identified by prior research and supported by stakeholders in MACPAC-conducted interviews, access measures should reflect three key domains: provider availability and accessibility

(i.e., potential access), use of services (i.e., realized access), and beneficiary perceptions and experiences (Kenney et al. 2016, NORC 2013).[16] Gathering and analyzing data across these domains will require multiple sources of data, including claims and survey data.

Provider availability. Provider availability and accessibility measures capture potential access to providers and services, regardless of whether or not the services are used. Provider availability is a function of the presence of providers in the state or region (i.e., supply), as well as their participation in Medicaid and the Children's Health Insurance Program (CHIP) (Kenney et al. 2016, MACPAC 2011). This domain should also include other measures of availability, such as timeliness of appointments, travel time, and accessibility for individuals with language barriers and disabilities.

States use various methods to measure and monitor provider availability and accessibility, including licensure data, provider directories, claims data, secret shopper audits, and surveys. However, each of these have shortcomings. For example, provider participation can be measured using health plan directories, but these are not always current and do not consider the size of a provider's Medicaid case load. Secret shopper audits and provider surveys can measure provider accessibility, such as timeliness of appointments, but they are not used consistently across states or representative of all provider types.

The most feasible approach to improving provider availability data is to standardize the provider type definitions in the Transformed Medicaid Statistical Information System (T-MSIS) to improve consistency and identify active Medicaid providers across states. Additionally, a federal beneficiary survey could capture more consistent information on provider accessibility, such as wait times for appointments and transportation. Based on expert interviews, the Commission also considered expanding the use of secret shopper audits and provider surveys. However, given that these practices are not universal and often resource-

intensive for states and providers, the Commission did not pursue these as a necessary component of a new access monitoring system, understanding that states may continue to undertake such work for their own purposes.

Use of services. This domain measures realized access by examining use of services and in some cases, use of specific providers or settings. States typically rely on administrative data (reported by states to CMS in T-MSIS) to assess beneficiary utilization. Many states also require Medicaid managed care plans to report particular measures from the Healthcare Effectiveness Data and Information Set (HEDIS), a set of standardized performance measures.[17] All states also voluntarily report some measures in the Adult and Child Core Sets, a set of standardized health care quality measures for beneficiaries in Medicaid and CHIP.[18] However, existing measures typically focus on medical care; relatively few standardized measures are available for other types of services, particularly for LTSS (Box 1.1). Further, these measures typically focus on in-person services and do not capture telehealth services, which have expanded since the beginning of the PHE (Libersky et al. 2020). Stratifying these data by race and ethnicity and other important demographic characteristics is not required and may not be possible given the incompleteness and low quality of that information for many states (MACPAC 2022, Mathematica 2021, NCQA 2021).

T-MSIS is the most complete and consistent data source on utilization across states, and more attention to standardization would make it an even more useful source for access monitoring (MACPAC 2021b, Kenney et al. 2016). Over the past several years, significant investments have been made in T-MSIS to improve timeliness, reliability, and completeness of Medicaid data and in assessing and publishing data quality assessments of many T-MSIS measures (CMS 2021a, MACPAC 2019). Addressing the remaining quality issues would improve the availability of high-quality and timely data for access monitoring. Many researchers suggested that

BOX 1-1. Monitoring Access for Long-Term Services and Supports

Monitoring access to long-term services and supports (LTSS), particularly home- and community-based services (HCBS), is especially important given the predominant role of Medicaid in funding these services. Further, the Americans with Disabilities Act (ADA, P.L. 101-336, as amended) and subsequent Supreme Court decision *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999) require public programs such as Medicaid to ensure that people with disabilities have equal access to services and that services are provided in the community rather than institutions when community-based services are appropriate, desired by the beneficiary, and can be reasonably accommodated by the state. However, there are unique challenges to assessing access to HCBS and few established measures.

Monitoring provider availability in HCBS can be difficult because states typically contract with agencies rather than individual providers and often have no way to count the number of direct service workers providing care. Some states may require direct care workers to complete certifications, background checks, or join a registry, but these practices are not universal. In addition, provider network adequacy measures based on time and distance standards may not be applicable for providers who travel to a beneficiary's home or for self-directed care, which relies on an independent provider network (Ne'eman 2018).

Monitoring service use is challenging due to incomplete HCBS claims data in the Transformed Medicaid Statistical Information System (T-MSIS) and lack of consistency within and across states. In addition, personal care workers often do not have National Provider Identifiers and states use a variety of different procedure codes for these types of claims.[21] Dates of services and units of service are often missing and there is variation in how specific services are reported (CMS 2022d). Further, CMS does not currently report assessments of the quality of HCBS data and completeness of elements of HCBS taxonomy in T-MSIS (CMS 2021a).[22] Thus, significant expertise is required to ensure states are reporting data elements in the HCBS taxonomy correctly.

Monitoring unmet need and particular access goals for HCBS also can be a challenge. Service gaps, such as delivery of fewer HCBS hours than recommended in the treatment plan, are difficult to capture in administrative data, as recommended hours are not reported on claims. Further, many beneficiaries in need of HCBS may not be receiving any services at all given waiting lists for care.[23] Administrative data also cannot capture information on the key goals of HCBS, such as an individual's ability to live independently, see family and friends, and participate in community activities.

Beneficiary surveys could be used to address the limitations inherent in claims data. For example, CMS or states could use information from nationally accredited beneficiary surveys, including the National Core Indicators (NCI), the National Core Indicators of Aging and Disabilities (NCI-AD), and the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) to monitor access. However, these surveys are not administered in all states, often have small sample sizes, and beneficiaries may not have access to the support needed to complete these surveys.[24]

CMS and policy experts are working to establish more standardized measures of access and quality in HCBS. For example, in 2020, CMS released a request for information to solicit feedback on a set of standardized HCBS quality measures, including those appropriate for states with managed LTSS (CMS 2020c).

further standardizing T-MSIS where there is lack of clarity in definitions and high rates of missing data is needed for greater comparability across states and populations. For example, efforts could focus on standardizing definitions of service and provider categories and improved collection of encounter data from managed care plans. Assessments of T-MSIS data by CMS, the U.S. Department of Health and Human Services Office of the Inspector General, and researchers also highlight the need for more complete and reliable beneficiary demographic data, particularly on race, ethnicity, and disability status (MACPAC 2022; CMS 2022a, 2021b; OIG 2021).[19] Although CMS provides states with technical assistance to monitor and address specific data quality issues, several states and researchers noted that states likely will need additional technical assistance and resources to improve the quality of data reported to T-MSIS (CMS 2022c).

The Commission also discussed other data sources that could be used to construct access measures. For example, measures could be constructed based on chart reviews to compare treatment plans to actual utilization to identify any unmet need for sample populations. HEDIS measures and all-payer claims databases also could be used to compare access in private insurance and Medicaid. However, using these can be technically complex and would likely require many states to establish new systems.

Ideally, a monitoring system would capture key health outcomes and the appropriateness of services, although this is challenging in practice (Kenney et al. 2016). CMS may consider including some measures, particularly those already included in the Adult and Child Core Sets, in the initial set of access measures.[20] However, measures of access-related health outcomes and appropriate care are more challenging and resource-intensive to collect compared to utilization measures analyzed from claims data and may need to be developed over time. For example, determining the appropriateness of care for a child with developmental delays could require a chart review to assess whether

they received all the occupational therapy visits authorized in their treatment plan.

Beneficiary perceptions and experiences.

Beneficiaries' perceptions of their needs, barriers to care, and care experiences are important components of access. This includes connection to the health care system, timeliness of care, barriers to care and unmet needs, and culturally competent care (Kenney et al. 2016). It is also important to understand beneficiaries' perceptions of interactions with providers (including being treated with respect and without bias), beneficiary knowledge and understanding of benefits, stability of care, and perceived quality of care.

Current state activities to monitor beneficiary perceptions and experiences use data from surveys, consumer complaint hotlines, grievances and appeals, and other qualitative sources such as focus groups or interviews. However, there are comparability and generalizability limitations to these methods and collection of these data is not universal (MACPAC 2017). For example, a number of states use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey to assess access. However, these surveys only capture information about beneficiaries covered by managed care plans and data are only available from plans that voluntarily submit to the CAHPS database. Furthermore, response rates are low and the results are not representative of all Medicaid beneficiaries (AHRQ 2021b, 2019).[25] A few states conduct their own beneficiary surveys, but these are typically not comparable across states and are not generally reported to CMS (SHADAC 2021, UCLA 2021). Complaint data, including grievances and appeals, are not representative of general experience, in part because the process is complicated to navigate and may not be accessible to all beneficiaries (Myers 2018, Perkins 2016). States or plans may not consistently capture data and may not share those data with states and CMS.

In the Commission's view, access monitoring in Medicaid would be enhanced by fielding a survey of beneficiaries, much like CMS 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.

The Commission discussed whether such a survey should be state or federally administered. A state-administered survey could include a core set of questions for consistency and comparability, but also allow for customization. This could promote cross-state comparisons, while also prioritizing measures that align with state needs and complement existing efforts. Such an approach is taken with other surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS).[26] Other researchers suggested that CMS could highlight certain access measures that states should include in their state surveys to promote consistency across state. However, as state-level beneficiary surveys are not universally administered and do not use consistent and validated measures, such an approach would not address the need for gathering standardized information on beneficiary perceptions in all states (AHRQ 2021b).

A federal survey would provide consistent data across states and relieve some state administrative burden. It also could seek to address gaps in other domains of access, by including questions related to provider availability, service use, unmet need, and collect more complete demographic information. The survey should capture the experience of a wide range of beneficiaries, including children and people with disabilities, and allow for assessments among key demographic groups, such as by race and ethnicity. The survey should be designed to complement existing state survey efforts. Several researchers, including two panelists, told the Commission that the Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems (NAM CAHPS) specifically could serve as a starting point for a federal Medicaid beneficiary survey (Box 1.2).[27]

BOX 1-2. Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems

The Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems (NAM CAHPS) was the only national Medicaid beneficiary survey conducted by the Centers for Medicare & Medicaid Services (CMS). The survey design, data collection, and analysis approach could serve as a starting point for a future Medicaid beneficiary survey.

Conducted in the fall of 2014, the NAM CAHPS was designed to inform the development of standard quality measures for the adult Medicaid population and provide baseline information on the experiences of low-income adults prior to implementation of the Patient Protection and Affordable Care Act ACA, (P.L. 111-148, as amended) (NORC n.d.). The survey allowed for national and state-level estimates of demographic and health characteristics, access to care, and barriers to care for adult Medicaid beneficiaries (NORC 2015, CMS 2014). The survey also allowed for direct comparisons between populations in fee for service (FFS) and managed care. It was not intended to interfere with ongoing survey efforts by states. For states that pursued their own CAHPS surveys, CMS developed standard procedures and coordinated with states to avoid duplication with existing survey efforts and prevent sampling any enrollee more than once (CMS 2014).

BOX 1-2. continued

The NAM CAHPS had a nationwide sampling frame of more than 1.2 million adult Medicaid enrollees.[28] Ultimately, more than 270,000 beneficiaries completed the survey, averaging approximately 5,800 adult Medicaid enrollees from each state. This represented a response rate of approximately 23.6 percent. The sample population was designed to capture four key subgroups: dually eligible individuals, individuals with a disability, individuals in Medicaid managed care, and individuals in FFS. The sampling frame was constructed from each state's Medicaid Statistical Information System (MSIS) eligibility file or internal eligibility system. States were given options for how this would be done, and most chose to have CMS's contractor extract eligibility data from MSIS, which the state then validated and appended enrollees' contact information. Participation in the survey was voluntary for beneficiaries (NORC 2015).

The NAM CAHPS was administered through the mail, with telephone follow-up as necessary, to collect information related to health care use, barriers to, and quality of care. The survey also captured data on race, ethnicity, sex, primary language, and disability status (NORC 2015). CMS spent approximately $10.8 million over four years for administration and analysis of the NAM CAHPS (Costello 2021).[29]

Prioritization. Given administrative capacity and data constraints, CMS will likely need to prioritize areas of focus. For example, it could focus on services for which Medicaid is a major payer, such as primary care, pediatrics, behavioral health, maternal health, and LTSS. CMS could concentrate efforts on services for which there are known access issues, such as behavioral health and oral health services, and known disparities. In establishing a new access monitoring system, CMS should seek to balance the need to assess access for specific populations and services, and feasibility in terms of data availability and state and federal capacity. For example, examining access for particularly small populations with significant but unique issues, such as children and youth with special health care needs and children involved in the child welfare system, may be especially difficult. CMS could consider whether such populations warrant specific state attention or should be examined on a rotating basis or through alternative means, such as targeted beneficiary surveys or focus groups.

Data collection and analysis

A new access monitoring system will require clearly defined roles for CMS, states, and plans in selecting measures, collecting and analyzing data, and setting benchmarks for adequate access. In the current approach, as described above, CMS laid out broad parameters and intentionally built in flexibility for states to design their own monitoring plan and measurement standards (CMS 2016, 2015b). Current regulations do not establish thresholds, benchmarks, or explicit goals for determining adequate access. This approach allows states to focus on state-level priorities, but the lack of standardization makes it difficult to make valid comparisons across states and delivery systems.

In the Commission's view, CMS should lead the design of a new access monitoring system, including establishing specific access measures that can be collected consistently across states and delivery systems and compared against benchmarks. However, there was less agreement

among the stakeholders interviewed about whether CMS or states should be responsible for data analysis and how CMS should determine benchmarks.

Collecting data. States, plans, and CMS should share responsibility for data collection activities, taking the lead on areas for which they are best suited, for example with CMS fielding an ongoing Medicaid beneficiary survey. States and plans are positioned to and already collect most of the data required for monitoring use of services

and provider availability.[30] However, resource constraints may limit states' ability to collect and analyze additional data, as demonstrated by the challenges states have faced in preparing to report on the mandatory core set of quality measures (MACPAC 2020). Bolstering and expanding existing data collection, such as through T-MSIS, would be an important first step in addressing existing data limitations and comparability across states and would provide continuity for states and plans while potentially easing the administrative burden on states.

BOX 1-3. Supporting Assessments of Access: The Role of Health Services Research

Health services researchers can be valuable partners in state monitoring efforts by collecting and analyzing data in partnership with state agencies. They independently can conduct analyses to identify access issues, underlying barriers to care, and health disparities that can help inform policy (Wasserman et al. 2019).

In many states, researchers at public universities work under contract or through other partnerships with their state Medicaid agency to provide analytic and technical expertise. For example, the University of Alabama has partnered with the Alabama Medicaid Agency to provide technical expertise to measure time and distance to provider locations using geographic information system mapping. Wisconsin partners with the Institute for Research on Poverty (IRP) at the University of Wisconsin-Madison, which developed an administrative database to evaluate state policies and outcomes across several of the state's health and human services agencies (IRP 2022). The State-University Partnership Learning Network (SUPLN), supported by AcademyHealth, has helped facilitate the development and growth of collaborations between state government and university researchers with the goal of supporting high-quality research and data analysis and improving the health and experience of the Medicaid population (AcademyHealth n.d.).

Independent research by health services researchers can provide insight into specific access issues or populations, and often focus on the effects of particular policy changes or interventions. While for many years researchers struggled to conduct multi-state or national studies due to difficulties in accessing high quality national and state-level Medicaid administrative data, the Transformed Medicaid Statistical Information System (T-MSIS) is changing this equation. Recent improvements to the data quality of T-MSIS and changes to the process of accessing the data with the launch of the Virtual Research Data Center (VRDC) have made the data more usable and accessible to researchers. Even so, there are still the ongoing data quality and cost concerns with T-MSIS. For example, although the cost for accessing Medicare and Medicaid data may be comparable, the cost of obtaining a sufficiently large Medicaid sample for state-level analyses may still limit the ability of many researchers to independently assess access (ResDAC 2022, CMS 2022d).

Calculating measures. Stakeholders interviewed offered differing opinions regarding who should be responsible for calculating and analyzing access measures. A few stakeholders suggested CMS should be responsible for calculating access measures at the national and state levels. However, others, including the states interviewed, preferred states to take the lead with CMS providing additional guidance on the analytical methods and support for dedicated analytical staff.[31] Some researchers expressed concerns about limited state analytic capacity and suggested states contract out the data collection and analysis to universities and other research partners (Box 1.3).

Setting benchmarks. In our interviews, stakeholders commented that states should be involved in the process of determining the benchmarks so that they are feasible and meaningful, but CMS should be responsible for setting them. Several stakeholders suggested that CMS could start by calculating baseline measures for states over a multi-year period. These data could serve as minimum standards and a starting point to establish benchmarks for improved access overtime. However, others pointed out that expectations should account for factors that may affect access, such as provider shortages in certain regions or specialties, a pandemic, or other secular changes (e.g., a large increase or decrease in specific types of services).

CMS could determine benchmarks for adequate access in several ways, and there was no clear consensus from the stakeholders as to which method would be best. Policy experts and states noted that setting goals for relative improvement over time should be the focus of an access monitoring system. For example, given state variation, each state could have a different threshold, with expectations that access would not diminish or would see improvement over time against the state-specific baseline. In response to the 2015 RFI, the majority of states commented that CMS-established thresholds should both accommodate variation and be updated over

time to reflect changes in geography, state size, Medicaid populations, provider supply, and beneficiary demographics. Other states, policy experts, and beneficiary advocates interviewed said that it is important to have a national threshold for adequate access. Still others suggested a hybrid approach in which CMS could establish a minimum threshold or floor for states with the expectation for improvement over the state baseline.

Public reporting and oversight

Access monitoring can serve both a governmental oversight function and provide information directly to the public. CMS should publicly release the data collection and analytical methods, data, and results to promote transparency and accountability. For example, beneficiary advocacy groups would value having access to information in a timely and consumer friendly format in order to hold plans and states accountable for addressing access issues. States would value having information about how they compare to others. Additionally, details on the methods may help guide state data collection and improvement efforts. Health services researchers would value improved access to monitoring data to further research on access and quality in Medicaid.

Phased implementation

Changing Medicaid's approach to access monitoring with the elements described above would be a significant task. For that reason, a phased-in and iterative approach is needed to allow for sufficient time to engage stakeholders in the design and to provide states and plans ample time to establish processes to collect and analyze data.[32] CMS, research experts, and provider groups suggested that CMS and states would first assess what they already do to measure access, and then determine necessary next steps to meet short-term and long-term monitoring goals. After establishing an initial set of measures using existing data, CMS could begin to assess

the gaps and determine whether states have the necessary infrastructure in place to collect data on the selected access measures and whether improved or new data sources are needed. States also should be provided with ongoing technical assistance to support implementation of the new access monitoring system.

Commission Recommendations

Recommendation 1.1

The Centers for Medicare & Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should:

- capture potential access, realized access, and beneficiary perceptions and experiences;

- prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and

- be adaptable to reflect changes in measurement, policy priorities, and care delivery.

CMS should issue public reports and data at the state and national level in a consumer-friendly and research-ready format in a timely manner.

Rationale

The purpose of the Medicaid program is to provide access to services; states and the federal government have statutory obligations to ensure sufficient access. Yet there is insufficient information to assess whether the program is meeting this obligation. A core set of standardized access measures would allow for an assessment of access to care across states and delivery systems and represent both federal and state

priorities (MACPAC 2017, 2012). States should retain flexibility to monitor additional services, populations, and geographies that reflect their state-specific priorities.

In addition to being comparable, the core set of measures must be both timely and yield actionable information for CMS, states, and plans to detect access concerns and disparities and make improvements. To promote efficiency and reduce administrative burden, CMS should explore ways that existing data sources and data collection methods can be used.

A monitoring system should assess the full experience of Medicaid beneficiaries accessing care, including the availability of services, use of services, and experience with care. The selected measures should capture access to a range of services, including primary, preventive, and specialty care, and LTSS. The measures also should prioritize services for which Medicaid plays an outsized role and where there are known disparities or access concerns, such as oral health and behavioral health.

In addition, a monitoring system should allow for modifications to account for changes in CMS and state priorities, measurement, and care delivery (e.g., growth of services provided via telehealth, the introduction of new therapies). Finally, as the availability of data improves, or measures are no longer useful, measure sets should be updated to reflect these changes.

Data transparency and public reporting plays a critical role in ensuring accountability, identifying problems, and guiding program improvement. Reporting results in a timely, consumer-friendly, and accessible format can facilitate these efforts. Such reports should provide context for and additional information on state variation, such as geographic and programmatic differences, so that results can be interpreted accurately. In addition, to the extent possible with appropriate privacy protections, data should be available for use by outside researchers and stakeholders to assess access.

Implications

Federal spending. Increased data collection, standardization, and reporting could lead to increases in federal costs in the short term as a new approach is established. An approach that builds on what is currently in place and replaces duplicative process would help limit such increases.

States. There may be additional data collection and reporting associated with a new access monitoring system, particularly in the short term. To the extent that a new system builds on existing data collection and reporting infrastructure, the effect on states may be minimized.

Enrollees. To the degree that a new system identifies access barriers that lead to actions to change policies and practices, beneficiaries may experience improved access to services.

Plans and providers. To the extent that a new system capitalizes on existing data measures, the reporting burden on plans and providers may be minimized. Plans and providers may be affected to the extent that a new system changes reporting requirements.

Recommendation 1.2

The Centers for Medicare & Medicaid Services should involve stakeholders in the development and future modifications of a new system. The agency should actively solicit and incorporate input from key stakeholders, including, but not limited to, states, beneficiaries, consumer groups, health plans, providers, researchers, and other policy experts. The process for establishing a new access monitoring system should be public and transparent.

Rationale

Given the federal obligation to ensure access to services, CMS should take the primary role in defining the goals, requirements, and access measures for a new access monitoring system.

To ensure that the system is both meaningful and feasible, CMS should actively solicit input from states, beneficiaries, consumer groups that are representative of the people they serve, plans, providers, and other key stakeholders to design, update, and maintain a system that is meaningful for them and to secure their support. CMS also should make the process for modifying its approach to monitoring access public and transparent.

Meaningful stakeholder engagement goes beyond required public notice and comment periods in formal rulemaking, and should begin earlier in the process of developing a new approach to monitoring access. CMS should engage stakeholders through multiple avenues, such as requests for information, 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.

Implications

Federal spending. Federal rulemaking already requires public notice and comment and CMS routinely seeks input from states and other key stakeholders. Costs to CMS may increase if additional staff time is necessary to ensure the process is meaningful for beneficiaries, states, and other stakeholders.

States. States routinely engage in the rulemaking and guidance process with CMS. The additional consultation process described in the recommendation may provide additional opportunities for engagement.

Enrollees. Beneficiaries and other key stakeholders often participate in the formal rulemaking process. To the extent that there are other avenues for stakeholder engagement,

beneficiaries may have additional opportunities to provide input.

Plans and providers. Plans and providers also routinely engage in the rulemaking process, and more informal opportunities may arise in the development of a new access monitoring system.

Recommendation 1.3

The Centers for Medicare & Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.

Rationale

Beneficiary perceptions and experiences are important components of monitoring access. These cannot be captured in administrative data, and grievances and appeals information may not be aggregated, transparent, or representative. A federal survey that allows for comparisons across states, subpopulations, and delivery systems will be an important tool to capture beneficiary perceptions and experiences with care, a key area where information is currently lacking. The Medicare Current Beneficiary Survey (MCBS) serves this function for the Medicare program, providing information on health outcomes, usual source of care, and satisfaction with care that are not available in administrative data (CMS 2021c).

A beneficiary survey also can be designed to address other data gaps. For example, existing measures of provider availability, such as time and distance standards, may not provide detail regarding the timeliness of appointments, drive-time or travel time via public transportation, or accessibility for individuals with disabilities or of limited English proficiency. A survey can ask beneficiaries directly about these barriers. A survey also can be designed to gather information on service use, unmet need, and more complete demographic information.

Any survey of Medicaid beneficiaries should be inclusive of the populations enrolled in Medicaid. While the NAM CAHPS examined care for adult Medicaid beneficiaries, including those with disabilities and individuals dually eligible for Medicare and Medicaid, it did not include children who currently comprise 40 percent of Medicaid enrollees (MACPAC 2021c). CMS could consider whether certain populations, such as pregnant women or individuals of a particular race or ethnicity, are examined or oversampled on a rotating basis.

In designing a beneficiary survey, CMS should not duplicate existing state survey efforts and work with states to ensure that the data gathered meet their needs. In doing so, CMS could consider how states could add customized questions or modules.

CMS also should consider ways of ensuring the usability of these data. This could include efforts to increase survey response rates, such as providing a wide array of survey modalities (e.g., in person, by mail, online, or by telephone) and to generate sufficient sample sizes to ensure reliable sub-group analyses. Additionally, CMS should develop the survey so that responses can be linked to claims data as is done with the MCBS and release data publicly in a timely fashion to facilitate broader analyses.

In developing a Medicaid beneficiary survey, CMS could draw on the agency's 30 years of experience conducting an annual survey of Medicare beneficiaries. The MCBS includes standard information on demographic characteristics, such as age, sex, and race and ethnicity, as well as information about health conditions and access to and satisfaction with care. CMS makes these data publicly available, including the linked survey responses and person-level utilization data (CMS 2021c).[33] CMS also can draw on federal experts at the Agency for Healthcare Research and Quality and their experience with the CAHPS survey, as well as experts at the Census Bureau and the National Center for Health Statistics.

Implications

Federal spending. CMS may need additional funds to mount such a survey and federal costs would increase in the amounts provided by Congress. The cost of the contractors to design, administer, and analyze the NAM CAHPS was $10.8 million over four years. CMS staff were also dedicated to the project.

States. States could be asked to assist in the design of a federal beneficiary survey. States also may need to participate in certain validation activities when samples are drawn. For example, states could be asked to identify beneficiaries and provide address information.[34] To the extent that a federal survey replaces existing state survey efforts, states could see a reduction in costs and administrative efforts in collecting and analyzing data. However, some states may continue to field their own surveys in addition to the federal survey, in which case the cost to states may be unchanged.

Enrollees. An ongoing federal survey of beneficiaries would capture new information on unmet needs and other beneficiary experiences. Such information could be used to identify specific access barriers and result in improvements.

Plans and providers. Plans may play a role in some of the implementation pieces of the federal survey. As the survey would be directed to enrollees, it is unlikely that it would have any effect on providers.

Recommendation 1.4

The Centers for Medicare & Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.

Rationale

T-MSIS is the only federal Medicaid data source with person-level information on eligibility, demographics, service use, and spending. However, quality concerns and coding inconsistencies make state- and population-level comparisons difficult. Additional consistency in variable definitions would allow for a more accurate and complete assessment of the services people are using and the providers they are seeing.

These efforts can build on existing work to improve the accuracy and completeness of T-MSIS data, focusing on standardizing definitions of service and provider categories most important to monitoring utilization and provider availability. CMS and its contractors are already working to improve the completeness and accuracy of T-MSIS data. These efforts may improve the usability of T-MSIS data for access monitoring purposes. For example, improving the ability to identify a specific provider associated with a claim could aid in assessing provider availability. Ensuring completeness of eligibility and demographic information will allow for comparisons across key groups of interest (CMS 2022d).

CMS should pay particular attention to creating consistent definitions and methods to identify HCBS providers, given the state variation in codes used for this type of provider claim. For example, CMS could assess the quality of the HCBS data and assist states in improving collection and reporting on these measures. Other efforts could focus on working with states to improve the collection of encounter data from managed care plans, provide consistent accounting of telehealth services, and collect more complete and accurate beneficiary-provided race and ethnicity information.

Implications

Federal spending. To the extent that efforts to improve T-MSIS align with existing work and the

timing of such efforts, the additional federal costs would be minimal.

States. States are working on improving the accuracy and completeness of the data they submit to T-MSIS. To the extent that changes for access monitoring purposes align with the ongoing improvement efforts, the additional effort for states may be minimal.

Enrollees. To the degree that a new system identifies access barriers and results in changes, beneficiaries may experience improved access to services.

Plans and providers. Depending on the extent of the standardization required, plans and providers may need to update or change how they report particular data to the state.

Recommendation 1.5

To assist states in collecting and analyzing access measures, the Centers for Medicare & Medicaid Services should provide analytical support and technical assistance.

Rationale

During the course of our interviews and the Commission's discussions, the need for state technical assistance came up repeatedly. Medicaid agencies often are expected to manage a large and diverse set of responsibilities while facing staff shortages and budget constraints. This may affect their capacity to collect, analyze, report, and act on access monitoring data. As such, states will likely need technical assistance and tools to improve the quality of data reported to T-MSIS and to construct and analyze additional access measures. For example, states may benefit from additional templates and data dictionaries to calculate core access measures consistently across states. CMS could provide states with guidance and highlight successful approaches for improving the completeness of certain types of data, such as race and ethnicity data. Interviewees commented

that 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 said technical assistance from CMS would be important to help states address access issues identified through monitoring.

Implications

Federal spending. CMS routinely provides states technical and analytic support through efforts to improve T-MSIS data, as well as other initiatives. Although it is possible that the technical assistance necessary for an improved access monitoring system could be provided as part of these existing efforts, CMS would need to assess whether the current resources are sufficient or if additional funding should be requested.

States. Additional technical and analytic support from CMS could help states meet the obligation of collecting and reporting data to assess adequate access.

Beneficiaries. To the degree that technical assistance supports states to make improvements in monitoring and addressing access issues, beneficiaries may experience improved access to services.

Plans and providers. Plans and providers are unlikely to be directly affected by this recommendation.

Endnotes

[1] MACPAC uses the term pregnant women as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women.

[2] CMS has noted that these three domains of access will be included in a forthcoming access strategy and were highlighted in the recent request for information (CMS, 2022a, LLanos 2021).

[3] CMS proposed an access monitoring rule in 2011 that would have required states to conduct reviews of state-determined access measures, based on geographic location and on an established access framework, for a rotating subset of services. The 2015 rule provided states with more guidance and expanded on the 2011 proposed rule (CMS 2011).

[4] Along with the final rule, CMS issued a separate request for information (RFI) on methodology and measures that could be used to monitor and assess access in the Medicaid program (CMS 2015a).

[5] In the response to comments on the final rule, CMS recommended but did not require, that states publish the AMRPs and subsequent data collected through those plans on their websites. Approved plans submitted in 2016 are available on Medicaid.gov.

[6] States were initially required to submit their access monitoring review plan, including the first review of the sufficiency of access, by July 1, 2016. A subsequent rule delayed the submission until October 1, 2016 (CMS 2016).

[7] The 2015 final rule was issued with a comment period to determine whether further adjustments to the access review requirements would be warranted, including the scope of regular state access reviews. CMS also requested comment on whether there should be exemptions based on state program characteristics (CMS 2015b).

[8] The 2016 rule required states to develop and make publicly available time and distance network adequacy standards for specific provider types. However, in 2020, a subsequent rule rescinded these standards and instead gave states flexibility to use other quantitative standards to determine network adequacy (CMS 2020a). Other provider network adequacy requirements in the final 2016 rule remain in place.

[9] The 2020 managed care rule also requires states contracting with managed care plans for LTSS to have a quantitative network adequacy standard for LTSS providers.

[10] Medicaid home health services include skilled nursing and home health aide services as described in 42 CFR § 440.70 and are only covered if they are medically necessary on a part-time basis (e.g., therapy following a hospitalization). This is different from HCBS which are non-medical services provided on a longer-term basis.

[11] The 2022 RFI used a broad definition of access and solicited feedback on enrolling in and maintaining coverage, in addition to accessing services. Specifically, it sought information on ensuring: Medicaid and CHIP reaches eligible people; beneficiaries experience consistent coverage; beneficiaries have access to timely, high-quality, and appropriate care in all payment systems; CMS has data available to measure, monitor, and support improvement efforts related to access to services; and payment rates are sufficient (CMS 2022a).

[12] Interviewees included federal officials from CMS; state officials from Alabama, Connecticut, Georgia, Oregon, and Wyoming; research and policy experts from Baruch College Health Policy Center, Center on Budget and Policy Priorities, Kaiser Family Foundation, Lurie Institute for Disability Policy, National Opinion Research Center at the University of Chicago, State Health Access Data Assistance Center at the University of Minnesota, UCLA Center on Health Policy Research, and Urban Institute; beneficiary advocates from The Arc, National Health Law Program, Kentucky Voices for Health, NC Child: The Voice for North Carolina's Children, and Shriver Center on Poverty Law; managed care organizations and health plan associations included Centene Corporation, Molina Healthcare, and Association for Community Affiliated Plans; and provider associations included American Academy of Family Physicians and American Academy of Pediatrics.

[13] Lived experience is best understood through qualitative research in order to understand individuals' perceptions of their interactions with the health care system (de Casterle et al. 2011).

[14] A CMS official shared that initial planning for creating workgroups began in late 2019, but the workgroups were paused due to the COVID-19 pandemic.

[15] A committee continues to meet annually to provide input on measures (MACPAC 2020).

[16] A 2016 report commissioned by CMS similarly describes three access domains: 1) provider availability and accessibility, 2) beneficiary utilization, and 3) beneficiary perceptions and experiences (Kenney et al. 2016). CMS has noted that the agency is using this report as a starting point for its most recent work on monitoring access to services (CMS 2022a).

[17] HEDIS measures are developed by the National Committee on Quality Assurance (NCQA) and measure receipt of services such as certain cancer screenings and childhood immunizations using administrative data, medical chart reviews, and surveys collected from NCQA-certified health plans (MACPAC 2021d).

[18] The core sets allow states, the public, and CMS to monitor trends in performance on standardized indicators of quality of care provided to Medicaid and CHIP beneficiaries under both FFS and managed care arrangements and examine performance across states (HHS 2011, CMS 2019b). CMS has developed core sets for pediatric and adult care, health homes, maternity care, and behavioral health services. Beginning in 2024, states will be required to report on the core set for children enrolled in Medicaid and CHIP and the core set of behavioral health measures for adults enrolled in Medicaid (MACPAC 2020).

[19] T-MSIS includes questions on disability status but CMS has not assessed the extent to which states report on this information or the quality of this data.

[20] For adults and children, some access-related outcome measures are already included in the Adult and Child Core Sets (e.g. well-child visits, follow-up visits after hospitalization, preventive dental services, and hospital admissions due to ambulatory care sensitive conditions).

[21] Until recently, personal care providers were not eligible to receive National Provider Identifiers (NPIs). In 2019, CMS issued guidance to clarify which Medicaid personal care attendants (PCAs) may obtain an NPI, although the guidance does not require states to assign unique identifiers to PCAs (CMS 2019c).

[22] The HCBS taxonomy was developed by Truven Health Analytics and Mathematica Policy Research under contract with the CMS. The taxonomy maps state HCBS procedure codes to 60 service types, which are then grouped into 18 taxonomy categories (Peebles and Bohl 2013).

[23] States differ in how they structure their waiting lists, and they may include individuals who are not eligible for Medicaid.

[24] The National Core Indicators survey is now included as an option to measure quality of care in the Medicaid Adult Core Set (CMS 2019b).

[25] CAHPS surveys include surveys on patient experience with providers, condition-specific care (e.g., cancer care), health plans, and facility-based care. This includes surveys on patient experience with hospital care, nursing home care, and HCBS (AHRQ 2021a).

[26] For example, the BRFSS is an ongoing, state-specific telephone survey that collects data about health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS consists of a standardized core questionnaire, optional modules, and state-added questions and is administered by state health departments. All health departments must ask the core component questions without modification. The questionnaire is designed and approved by a working group of state coordinators and staff at the Centers for Disease Control and Prevention (CDC 2021a, 2014). Similarly, the PRAMS also has core questions that are asked by all sites (i.e., states and cities). Additional questions can be chosen from a pretested list of standard questions developed by CDC or developed by sites on their own (CDC 2021b).

[27] The NAM CAHPS is different from the CAHPS health plan surveys discussed previously. The NAM CAHPS was a national Medicaid beneficiary survey conducted by CMS in the fall of 2014.

[28] Forty-six states plus the District of Columbia were included in the sampling frame, averaging approximately 29,000 adult Medicaid enrollees from each state.

[29] This amount included the survey contract, as well as other funds for IT and additional analysis. It does not include costs for CMS staff dedicated to the project.

[30] States collect the data on utilization and enrollment that they subsequently report to CMS in a standardized format to T-MSIS.

[31] For example, in public comments and MACPAC interviews, states expressed concerns with existing CMS guidance on the AMRPs, particularly the need for additional clarity and specificity to help states calculate the measures consistently. Other stakeholders also pointed to the importance of specific guidance on how to collect and analyze data, as well as information on stratification by demographic characteristics and subpopulations. Similar comments were made in response to the 2015 RFI, with some states noting they lack the resources to collect and analyze certain data.

[32] Prior efforts to monitor access and ensure network adequacy also have taken phased approaches. For example, under FFS, the first AMRP had to be submitted within a year after the publication of the final 2015 FFS rule. Even so, states reported that the process was burdensome. In comments submitted by states in response to the final 2015 FFS rule, most expressed concerns about this timeline, citing resource constraints and lack of state capacity to collect and analyze data that may not have been previously collected by some states. Under managed care, states had two years to implement network adequacy standards (CMS 2016).

[33] The historical target sample size for the MCBS is 11,500, although the sample size can fluctuate depending on the level of funding (CMS 2021b). The fiscal year 2021 total operational budget request for the MCBS was $25.4 million (CMS 2020dc). However, the sample size for a federal Medicaid beneficiary survey may need to be larger to allow for state-level estimates. For example, the sample size for the NAM CAHPS survey of Medicaid beneficiaries was 270,000 (NORC 2015). Costs are also dependent on other factors such as how the data are collected.

[34] Based on the level of effort for the NAM CAHPS, this burden is likely to be minimal. On average, it took states nine hours to validate and append enrollee contact information to the sample file (NORC 2015).

References

AcademyHealth. n.d. State-University Partnership Learning Network. https://academyhealth.org/about/programs/state-university-partnership-learning-network.

Agency for Healthcare Research (AHRQ). 2021a. CAHPS® Surveys and tools to advance patient-centered care. Rockville, MD: AHRQ. https://www.ahrq.gov/cahps/index.html.

Agency for Healthcare Research (AHRQ). 2021b. 2021 Medicaid and children's health insurance program (CHIP) chartbook. Rockville, MD: AHRQ. https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2021-hp-chartbook.pdf.

Agency for Healthcare Research (AHRQ). 2019. Advances in survey methodology: Maximizing response rates and the representativeness of CAHPS® survey data. Rockville, MD: AHRQ. https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/survey-methods-research/summary-research-meeting.pdf.

Brennan, N., A. Oelschlaeger, C. Cox, and M. Tavenner. 2014. Leveraging the big-data revolution: CMS is expanding capabilities to spur health system transformation. *Health Affairs* 33, no.7:1195–1202. https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2014.0130.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021a. BRFSS questionnaires. Atlanta, CA: CDC. https://www.cdc.gov/brfss/questionnaires/index.htm.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021b. PRAMS questionnaires. Atlanta, CA: CDC. https://www.cdc.gov/prams/questionnaire.htm.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2014. About BRFSS. Atlanta, CA: CDC. https://www.cdc.gov/brfss/about/index.htm.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. Biden-Harris Administration announces request for information on access to care and coverage for people enrolled in Medicaid and CHIP. February 17, press release. https://www.hhs.gov/about/news/2022/02/17/biden-harris-administration-announces-request-for-information-on-access-to-care-and-coverage-for-people-enrolled-in-medicaid-and-chip.html.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. CMCS informational bulletin regarding "CMS enforcement discretion: Medicaid Access Monitoring Review Plans." March 31, 2022. https://www.medicaid.gov/federal-policy-guidance/downloads/cib03312022.pdf

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Transformed Medicaid statistical information system (T-MSIS). Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022d. CMS technical instruction: overview of data quality T-MSIS priority items. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/54044.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. Explore by Topic (Explore Single Topic View), Race and Ethnicity. Baltimore, MD: CMS.https://www.medicaid.gov/dq-atlas/downloads/snapshots/2019/Release_1/topics/TAF_DQ_Snapshot_2019_R1.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. Medicare current beneficiary survey (MCBS). Baltimore, MD: CMS. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021c. *Medicare current beneficiary survey (MCBS) 2019 methodology report.* Baltimore, MD: CMS. https://www.cms.gov/files/document/2019-mcbs-methodology-report.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. Medicaid program: Medicaid and Children's Health Insurance Program (CHIP) managed care. Final rule. *Federal Register* 85, no. 220 (November 13): 72754-72844. https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. State Medicaid & CHIP telehealth toolkit: Policy considerations for states expanding use of telehealth. https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020c. *Request for information: recommended measure set for Medicaid-funded home and community-based services.* Baltimore, MD:CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020d. *Fiscal year 2021 Centers for Medicare & Medicaid services justification of estimates for appropriations committees.* Baltimore, MD: CMS. https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/FY2021-CJ-Final.pdf.

Centers for Medicare & Medicaid (CMS), U.S. Department of Health and Human Services. 2019a. *Comprehensive strategy for monitoring access in Medicaid.* https://www.medicaid.gov/federal-policy-guidance/downloads/CIB071119.pdf/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. Center for Medicaid and CHIP Services informational bulletin regarding "2020 updates to the child and adult core health care quality measurement sets." November 19, 2019. https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

Centers for Medicare & Medicaid (CMS), U.S. Department of Health and Human Services. 2019c. Medicaid and CHIP FAQs regarding "Allowability of using National Provider Identifiers (NPIs) for Medicaid personal care attendants (PCAs)". July 2019. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/FAQs-Using-NPIs-for-Medicaid-PCAs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Medicaid program: Methods for assuring access to covered Medicaid services-exemptions for states with high managed care penetration rates and Rate Reduction Threshold. Proposed rule. *Federal Register* 83, no. 57 (March 23): 12696 - 12706. https://www.govinfo.gov/content/pkg/FR-2018-03-23/pdf/2018-05898.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Medicaid and Children's Health Insurance Program (CHIP) programs: Medicaid managed care, CHIP delivered in managed care, and revisions related to third party liability. Final rule. *Federal Register* 81, no. 88 (May 6): 27498–27901. https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015a. Medicaid program: request for information (RFI) – Data metrics and alternative process for access to care in the Medicaid program. Request for information. *Federal Register* 80, no. 211 (November 2): 67377–67381. https://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27696.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015b. Medicaid program: Methods for assuring access to covered Medicaid services. Final rule. *Federal Register* 80, no. 211 (November 2): 67576-67612. https://www.govinfo.gov/content/pkg/FR-2015-11-02/pdf/2015-27697.pdf.

Centers for Medicare & Medicaid Services (CMS), U S. Department of Health and Human Services. 2014. Center for Medicaid and CHIP Services informational bulletin regarding "Nationwide CAHPS survey of adult Medicaid enrollees." June 6, 2014. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/CIB-06-06-14.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. CMS announces new data sharing tool. November 12, 2013, press release. https://www.cms.gov/newsroom/press-releases/cms-announces-new-data-sharing-tool.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. Medicaid program: Methods for assuring access to covered Medicaid services. *Federal Register* 76, no. 88 (May 6): 26342–26362. https://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf.

Costello, A.M., Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. E-mail to MACPAC, October 24.

de Casterle, B.D., S.T.L. Verhaeghe, M.C. Kars, A. Coolbrandt, M. Stevens, M. Stubbe, N. Deweirdt, J. Vincke, and M. Grypdonck. 2011. Researching lived experience in health care: significance for care ethics. *Nursing Ethics* 18, no. 2: 232-242.

Institute for Research on Poverty, University of Wisconsin-Madison (IRP). 2022. The Wisconsin Administrative Data Core (WADC). Madison, WI: IRP. https://www.irp.wisc.edu/wadc/.

Kenney, G.M., K. Gifford, J. Wishner, V.C. Forsberg, D Pavliv. 2016. *Research report: proposed Medicaid access measurement and monitoring Plan*. Washington, DC: Urban Institute. https://www.urban.org/research/publication/proposed-medicaid-access-measurement-and-monitoring-plan.

Libersky, J., E. Soyer, T. Masaoay, et al. (2020). Changes in Medicaid telehealth policies due to COVID-19: Catalog overview and findings. MACPAC contractor report. Washington, DC: Mathematica. https://www.macpac.gov/wp-content/uploads/2020/06/Changes-in-Medicaid-Telehealth-Policies-Due-to-COVID-19-Catalog-Overview-and-Findings.pdf.

LLanos, K. 2021. Presentation before the Medicaid and CHIP Payment and Access Commission, December 9,2021, Washington, DC. https://www.macpac.gov/public_meeting/december-2021-macpac-public-meeting/.

Mathematica. 2021. Recommendations for improving the core sets of health care quality measures for Medicaid and CHIP. Draft Report for Public Comment. Washington, DC: Mathematica. https://www.mathematica.org/-/media/internet/features/2021/coreset/2022coresetreview_draftreport.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. Availability of race and ethnicity data for Medicaid beneficiaries. Washington, DC: MACPAC. https://www.macpac.gov/publication/availability-of-race-and-ethnicity-data-for-medicaid-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. Exhibit 14: Medicaid enrollment by state eligibility group and dually eligible status. In *MACStats: Medicaid and CHIP data book*. December 2021. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-enrollment-by-state-eligibility-group-and-dually-eligible-status/h.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *Update on transformed Medicaid statistical information system (T-MSIS)*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/04/Update-on-Transformed-Medicaid-Statistical-Information-System-T-MSIS.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021c. Exhibit 15: Medicaid full year equivalent enrollment by state and eligibility group. In *MACStats: Medicaid and CHIP data book.* December 2021. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-full-year-equivalent-enrollment-by-state-and-eligibility-group-2/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021d. Monitoring Managed Care Access. Washington, DC: MACPAC. https://www.macpac.gov/subtopic/monitoring-managed-care-access/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. *Report to Congress on Medicaid and CHIP*. March 2020. Washington, DC: MACPAC. https://www.macpac.gov/publication/state-readiness-to-report-mandatory-core-set-measures/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Comment letter on proposed rule: Medicaid Program; Methods for assuring access to covered Medicaid services – Exemptions for states with high managed care penetration rates and rate reduction threshold (May 11, 2018) https://www.regulations.gov/comment/CMS-2018-0031-0039.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. *Report to Congress on Medicaid and CHIP*. March 2017. Washington, DC: MACPAC. https://www.macpac.gov/publication/march-2017-report-to-congress-on-medicaid-and-chip/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2012. *Report to Congress on Medicaid and CHIP*. June 2012. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2012/06/Data-Sources-for-Monitoring-Access-to-Care-in-Medicaid-and-CHIP.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011. *Report to Congress on Medicaid and CHIP*. March 2011. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2011/03/March-2011-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

Myers, C.A. 2018. Advocates' guide to accessibility in Medicaid managed care grievances and appeals. Washington, DC: National Health Law Program. https://healthlaw.org/wp-content/uploads/2016/05/2016_05_2016_Issue_Brief_2_MMC_Regs_Grievance_Appeals.pdf.

National Committee for Quality Assurance (NCQA). 2021. Health Equity and Social Determinants of Health in HEDIS: Data for Measurement. Washington, DC: NCQA. https://www.ncqa.org/about-ncqa/health-equity/health-equity-and-social-determinants-of-health-in-hedis-data-for-measurement.

National Quality Forum (NQF). 2021. MAP task forces: Medicaid. Washington, DC: NQF. https://www.qualityforum.org/ProjectDescription.aspx?projectID=75335.

Ne'eman, Ari. Community Living Policy Center, University of California San Francisco. 2018. *Managed long-term services and supports: assessing provider network adequacy*. San Francisco, CA: CLPC. https://clpc.ucsf.edu/publications/managed-long-term-services-and-supports-assessing-provider-network-adequacy.

NORC at the University of Chicago (NORC). 2015. Methodology report: *2014-2015 nationwide CAHPS survey of adults enrolled in Medicaid between October and December, 2013*. Bethesda, MD: NORC. https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/methodology-report.pdf.

NORC at the University of Chicago (NORC). 2013. *Study brief: Recommendations for monitoring access to care among Medicaid beneficiaries at the state-level*. Bethesda, MD: NORC. https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files//139261/rpt_MedicaidAccessStudy.pdf.

NORC at the University of Chicago (NORC). n.d. Nationwide Adult Medicaid CAHPS. https://www.norc.org/Research/Projects/Pages/nationwide-adult-medicaid-cahps.aspx.

Office of Management and Budget (OMB). 2021. *Unified agenda and regulatory plan: Assuring access to Medicaid services (CMS-2442)*. https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202110&RIN=0938-AU68.

Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS). 2021. *Data on Medicaid managed care payments to providers are incomplete and inaccurate.* Washington, DC: OIG. https://oig.hhs.gov/oei/reports/OEI-02-19-00180.pdf.

Peebles, V., M. Kim, A. Bohl, N. Morales, and D. Lipson. 2017. *HCBS claims analysis chartbook: Final report.* Report to the Medicaid and CHIP Payment and Access Commission. Mathematica Policy Research: Chicago, IL. https://www.macpac.gov/publication/hcbs-claims-analysis-chartbook-final-report/

Perkins, J. 2016. Medicaid managed care final regulations grievance & appeals systems. Washington, DC: National Health Law Program. https://healthlaw.org/wp-content/uploads/2016/05/2016_05_2016_Issue_Brief_2_MMC_Regs_Grievance_Appeals.pdf

Research Data Assistance Center (ResDAC). 2022. CMS fee information for CMS research identifiable data. Minneapolis, MN: ResDAC. https://resdac.org/cms-fee-information-research-identifiable-data.

Silanskis, J. Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. E-mail to MACPAC, September 23.

State Health Access Data Assistance Center (SHADAC). 2021. State survey research activity. Minneapolis, MN: SHADAC. https://www.shadac.org/our-focus-areas/state-survey-research-activity.

Stewart, C. 2021. Presentation before the Medicaid and CHIP Payment and Access Commission, January 21, 2022, Washington, DC. https://www.macpac.gov/public_meeting/january-2022-macpac-public-meeting/.

UCLA Center for Health Policy Research. 2021. California Health Interview Survey. Los Angeles, CA: CHIS. https://healthpolicy.ucla.edu/chis/Pages/default.aspx.

U.S. Department of Health and Human Services (HHS). 2011. *2011 annual report on the quality of care for children in Medicaid and CHIP*. Washington, DC: HHS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2011_statereporttocongress.pdf.

Wasserman, J. R.C. Palmer, M.M. Gomez, R. Berzon, S. Ibrahim, and J.Z. Ayanian. 2019. Advancing health services research to eliminate health care disparities. *Etiology Science*, 109, no.1:64-69.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 8, 2022.

A New Medicaid Access Monitoring System

1.1 The Centers for Medicare & Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should:

- capture potential access, realized access, and beneficiary perceptions and experiences;

- prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and

- be adaptable to reflect changes in measurement, policy priorities, and care delivery.

CMS should issue public reports and data at the state and national level in a consumer-friendly and research-ready format in a timely manner.

1.2 The Centers for Medicare & Medicaid Services should involve stakeholders in the development and future modifications of a new system. The agency should actively solicit and incorporate input from key stakeholders, including, but not limited to, states, beneficiaries, consumer groups, health plans, providers, researchers, and other policy experts. The process for establishing a new access monitoring system should be public and transparent.

1.3 The Centers for Medicare & Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.

1.4 The Centers for Medicare & Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.

1.5 To assist states in collecting and analyzing access measures, the Centers for Medicare & Medicaid Services should provide analytical support and technical assistance.

1.1-5 Voting Results	#	Commissioner
Yes	15	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Herrera Scott, Weno
Not Present	1	Scanlon

Chapter 2:

Oversight of Managed Care Directed Payments

Oversight of Managed Care Directed Payments

Recommendations

2.1   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.

2.2   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 payment amounts publicly available in a standard format that enables analysis.

2.3   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.

2.4   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, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.

2.5   To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services involved in the review of directed payments and the review of managed care capitation rates.

Key Points

- Managed care directed payments are a large and growing share of Medicaid spending.

  - The Centers for Medicare & Medicaid Services created this new option in 2016 and approved 230 distinct arrangements in 37 states by the end of 2020.

  - Although information on spending under this new option is extremely limited, state projections indicate that total spending exceeded $25 billion in 2020.

- States use directed payment arrangements for a variety of purposes.

  - Many directed payment arrangements set base payment rates for services provided in managed care.

  - Some states use this option to increase the adoption of value-based payment methods.

  - Some states make large additional payments to providers, similar to supplemental payments in fee for service.

- More transparency is needed to understand how much is being spent and the extent to which these payments are advancing quality and access goals.

CHAPTER 2: Oversight of Managed Care Directed Payments

There are two major categories of Medicaid payments: (1) base payments for services and (2) supplemental payments, which are additional payments to providers that are typically made in a lump sum for a fixed period of time. In fee for service (FFS), states set payment levels for both types; in managed care, states pay managed care organizations (MCOs) a per-member per-month capitation rate and historically have had little control over the rates that MCOs pay providers.[1] Because the capitation rate is intended to be sufficient to cover the cost of the services specified in the MCO contract, the Centers for Medicare & Medicaid Services (CMS) does not allow states to make supplemental payments for services provided through managed care.[2]

In 2016, CMS created a new option for states to require MCOs to pay providers according to specified rates and methods, referred to as directed payments. Many states have used directed payments to set parameters for base payment rates (e.g., requiring MCOs to pay no less than the state's FFS payment rate), and some states are using this option to increase the use of value-based payment (VBP) methods in managed care. However, a few states are also using the directed payment option to make large additional payments to providers that do not have a clear link to quality or access goals, similar to supplemental payments in FFS.

Since 2016, the use of directed payments has grown substantially. As of August 2018, CMS had approved 65 distinct directed payment arrangements in 23 states (Pettersson et al. 2018).[3] By December 2020, based on MACPAC's review of directed payment approval documents (which are not publicly available), this had grown to 230 distinct arrangements in 37 states.[4] Some states are using directed payments to preserve

prior payment arrangements, and some are using directed payments to make new payments to providers.

Available information on directed payment spending is extremely limited, but according to state projections, total spending was more than $25 billion in 2020.[5] This amount is greater than fiscal year (FY) 2020 spending on each of the two largest types of FFS supplemental payments—disproportionate share hospital (DSH) and upper payment limit (UPL) payments.[6] Moreover, this estimate is an undercount given that spending information was not available for more than half of approved directed payment arrangements that we reviewed.[7]

Because directed payments are such a large and growing share of Medicaid spending, policymakers and the public have an interest in knowing more about where this money is being spent and the extent to which these payment arrangements are advancing quality and access goals for Medicaid beneficiaries. The Commission has long been concerned about the transparency and oversight of FFS supplemental payments, and so we are particularly concerned that directed payments have even less transparency.

In the Commission's view, assessment of Medicaid payment policy requires information on all types of Medicaid payments that providers receive. Because directed payments appear to account for more than half of Medicaid managed care payments to some hospitals, physicians, and other providers, lack of information about these payments severely limits our ability to understand whether Medicaid payments are consistent with statutory principles (MACPAC 2015a).

The Commission is also concerned about the potential of some directed payment arrangements to undermine the integrity of the managed care rate setting process. In general, managed care capitation rates are required to be actuarially sound, meaning that they are sufficient to cover all reasonable, appropriate, and obtainable costs under the contract, including the costs of

complying with managed care access standards. As a result, it is not always clear what additional value is obtained when states use directed payments to substantially increase payments above rates that were previously certified as actuarially sound. In interviews with state officials, CMS, and actuaries, we heard conflicting views about the extent to which actuaries should be involved in the review of directed payment arrangements, suggesting that more guidance and clarity about roles and responsibilities are needed to help ensure that actuarial soundness requirements are being met.

As a first step toward improving the transparency and oversight of directed payments, the Commission makes five recommendations, which are discussed further in this chapter:

- 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.

- 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 payment amounts publicly available in a standard format that enables analysis.

- 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.

- 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, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.

- To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services involved in the review of directed payments and the review of managed care capitation rates.

Improved transparency about directed payments can also help inform future policy development. In particular, more information about directed payment spending would help inform discussion of whether there should be any upper limits on directed payments, similar to the limits on other types of Medicaid spending. This chapter concludes with a discussion of this issue and potential areas for future work.

Background

The new directed payment option has roots in the history of supplemental payments and managed care as well as state efforts to promote quality and access in managed care.

Supplemental payments and managed care

In FFS, supplemental payments account for a large share of Medicaid payments for some providers. In FY 2020, states made $57 billion in supplemental payments to hospitals, mental health facilities, nursing facilities, and physicians, which was 36 percent of total FFS payments to these providers (MACPAC 2021a).[8]

MACPAC's prior research has found that states often use supplemental payments to offset low base payment rates in circumstances in which states have difficulty financing the non-federal share of Medicaid payments with state general funds. Medicaid is jointly financed by states and the federal government, and states have flexibility to finance the non-federal share of Medicaid payments from multiple sources, including state general funds, provider taxes, and intergovernmental transfers (IGTs) from publicly owned providers and other local government sources. In the absence of state general funds to increase base payment rates, states often collaborate with providers to increase provider contributions toward the non-federal share to implement new Medicaid supplemental payments (Marks et al. 2018).[9]

Federal rules do not allow states to make supplemental payments for services provided in managed care.[10] This limitation was historically a barrier to the expansion of comprehensive managed care in some states because providers that relied on large FFS supplemental payments could lose substantial revenue when a state transitioned from FFS to managed care. For this reason, some states excluded certain services or populations from managed care or sought demonstration waiver authority under Section 1115 of the Social Security Act to continue making supplemental payments in managed care.[11] Other states indirectly made additional payments to providers in managed care by increasing capitation rates paid to MCOs and then requiring MCOs to direct these additional funds to particular providers. These payments, known as pass-through payments, were typically not tied to the use of Medicaid services or performance on measures of quality or access.

As part of its comprehensive update to Medicaid managed care regulations in 2016, CMS required states to phase out the use of pass-through payments because of concerns that pass-through payments were too similar to supplemental payments and thus not consistent with the requirement that managed care rates be actuarially sound. Specifically, CMS noted that "because the capitation payment that states make to a managed care plan is expected to cover all reasonable, appropriate, and attainable costs associated with providing the services under the contract, the statutory provision for managed care payment does not anticipate a supplemental payment mechanism" (CMS 2016). However, because pass-through payments accounted for a large share of Medicaid payments for some providers, CMS allowed states to gradually phase out the use of pass-through payments over 10 years for hospitals and 5 years for physicians and nursing facilities (CMS 2017a).

In place of pass-through payments, the 2016 managed care rule created a new option for states to direct payments to providers under certain circumstances. To limit lump sum payments to providers based on how the payment was financed, CMS required that directed payments be based on the delivery of services covered under the managed care contract, be distributed equally to a class of providers, and not be conditioned on provider participation in IGT agreements. In addition, to address concerns that pass-through payments were not tied to quality and access goals, CMS required directed payments to advance at least one goal of the state's quality strategy and required states to measure the degree to which the payment arrangement achieves these goals. To enforce these requirements, CMS required states to seek prior approval of directed payment arrangements each year.[12]

Promoting quality and access in managed care

CMS's stated goal when creating the directed payment option was to "assist states in achieving their overall objectives for delivery system and payment reform" (CMS 2016). These include efforts to ensure access to an adequate provider network and to increase the use of VBP methods. Although MCOs generally have the flexibility to negotiate payments with providers that advance these goals, the directed payment option provides states with more control over the rates and methods used by MCOs when paying providers.

First, directed payments allow states to require MCOs to increase payment rates to providers, which may help improve provider participation. For example, MACPAC's review of the National Ambulatory Medical Care Survey found that higher Medicaid payment rates were associated with higher rates of physician acceptance of new Medicaid patients (Holgash and Heberlein 2019).

MCOs are already required to provide timely access to care, including access to an adequate network of providers, and actuaries must certify that the capitation rate is sufficient to meet this requirement.[13] In practice, we have found that MCOs often pay providers base payment rates that are similar to FFS, in part because managed care capitation rates are often initially developed based on FFS rates (Marks et al. 2018). FFS base rates are also required to meet federal access requirements (§1902(a)(30)(A) of the Social Security Act), but in many states, base FFS payment rates to hospitals and physicians are below the rate that Medicare would pay for the same service (MACPAC 2017; Zuckerman et al. 2017).

Second, directed payments allow states to require MCOs to increase the use of VBP models, including pay-for-performance incentives, shared savings arrangements, and other alternative payment models. Although a growing share of Medicaid beneficiaries is enrolled in managed care, most Medicaid payments to providers are still made using FFS payment methods that are based on the volume of care provided (HCP-LAN 2021). In contrast, VBP models reward providers for achieving quality goals and, in some cases, cost savings.

MCOs can negotiate VBP arrangements with providers without a directed payment arrangement, but requiring plans to adopt a particular model can help ensure consistency across multiple Medicaid MCOs in a state. States can also set broad VBP targets for the share of Medicaid MCO payments that should be based on value without using a directed payment arrangement (Bailit 2020; Hinton et al. 2022).

Uses of Directed Payments

Our review of approved directed payment arrangements found that states are using directed payments for a variety of purposes. Consistent with CMS's stated goals, many directed payments set parameters on base payments to providers to advance access goals, and some arrangements are intended to increase the use of VBP models in managed care. However, CMS has also approved some arrangements that appear to make large additional payments to providers that are similar to supplemental payments in FFS.

To analyze the uses of directed payments, MACPAC contracted with Mathematica to review directed payment approval documents for all states. This information is not publicly available, but CMS provided it to us for this analysis. Overall, of the 490 state directed payment arrangements that had been approved, renewed, or amended as of December 31, 2020, we identified 230 distinct arrangements that targeted the same providers using a similar payment method for one or more rating periods. Twenty-nine of these arrangements were temporary changes approved through an expedited approval pathway created during the COVID-19 pandemic; these arrangements are excluded from our analyses. The approval documents that we reviewed included the CMS standard application form (referred to as a preprint) as well as state responses to CMS questions about payment amounts, financing, and other information that is not included on the preprint.

Mathematica also interviewed state officials and stakeholders in five states (California, Florida, Massachusetts, Ohio, and Utah) to learn more about why states are using directed payments and how states are assessing the effects of directed payments on quality and access goals. In addition, the project team interviewed CMS officials and actuaries who work with multiple states.

Types of directed payments

In our review, we classified directed payments into three categories based on the distinctions that CMS uses in its current directed payment preprint form:

- **Minimum or maximum fee schedule:** a type of directed payment that sets parameters for the base payment rates that managed care plans pay for specified services. Most of these fee schedules require MCOs to pay providers no less than the FFS rate approved in the Medicaid state plan. Some states also use the Medicare fee schedule or another fee schedule established by the state to set minimum or maximum payment rates for providers.

- **Uniform rate increase:** a type of directed payment that requires MCOs to pay a uniform dollar or percentage increase in payment above negotiated base payment rates. These types of arrangements are the most similar to supplemental payments in FFS.

- **VBP:** a type of directed payment that requires MCOs to implement VBP models, such as pay-for-performance incentives, shared savings arrangements, or other alternative payment models. This category also includes arrangements that require MCOs to participate in multipayer or Medicaid-specific delivery system reforms.

FIGURE 2-1. Directed Payment Types and Projected Payment Amounts, 2020

Multiple types
n = 7 (3%)

VBP
n = 31
(15%)

Uniform rate
increase
n = 61
(30%)

Minimum or
maximum
fee schedule
n = 102
(51%)

Multiple types
$1.4 billion (5%)

Minimum or
maximum
fee schedule
$1.0 billion
(4%)

VBP $3.1
billion
(12%)

Uniform rate
increase
$20.2 billion
(79%)

Approved directed payment arrangements
N = 201

Spending for directed payment arrangements
N = 97; total spending = $25.7 billion
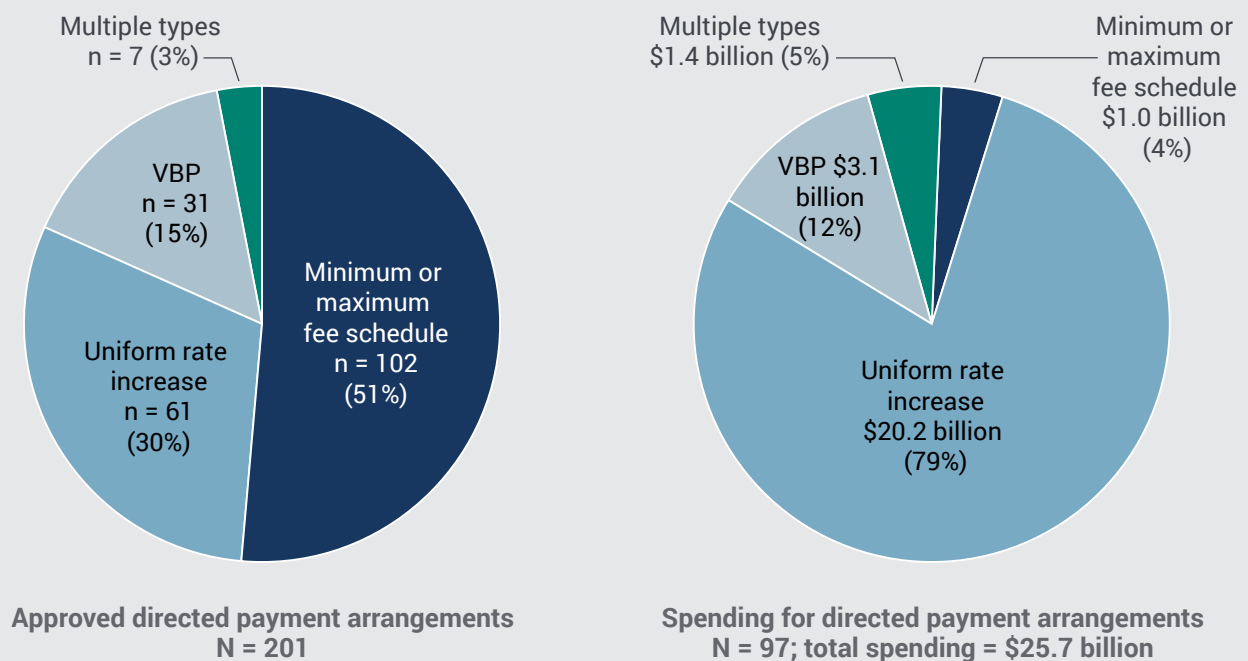
Notes: VBP is value-based payment. This analysis is based on a review of unique directed payment arrangements approved through December 31, 2020, and excludes temporary directed payments approved under the expedited COVID-19 pathway (n = 29). Prior versions of directed payment arrangements that were subsequently renewed or amended are also excluded (n = 260). Projected payment amounts are for the most recent rating period, which may differ from calendar year or fiscal year 2020. In addition, projected spending reported in directed payment approval documents may differ from actual spending. Percentages may not sum to 100 due to rounding.

Source: Mathematica, 2021, analysis for MACPAC of directed payment preprints approved through December 31, 2020.

Within each of these categories, there is wide variation in the size and scope of arrangements. For example, some uniform rate increases make incremental adjustments to base payment rates (e.g., a 10 percent increase), while others make large additional payments that are greater than the original base payment rate. Similarly, some VBP arrangements require participation in arrangements that do not increase spending, while others provide large additional pay-for-performance incentives to providers, similar to delivery system reform incentive payments (DSRIP) authorized under Section 1115 demonstrations (MACPAC 2020).

Number of directed payments and projected spending amounts

Of the 201 directed payment arrangements not related to COVID-19, approximately half were minimum or maximum fee schedules, and about one-third were uniform rate increases (Figure 2-1). However, uniform rate increases accounted for the vast majority of projected directed payment spending that was available for our review. Thirty-five states, the District of Columbia, and Puerto Rico had at least one approved directed payment arrangement, and five states (Arizona, California, Massachusetts, New York, and Washington) had 10 or more distinct arrangements.

The spending data in the approval documents we reviewed was extremely limited. Less than half of directed payment approval documents included information about projected spending amounts, and those that did so did not always present it in a consistent format.[14] Moreover, during our interviews with states, we learned that actual spending on directed payments was sometimes higher or lower than the amount projected in approval documents.

Based on the information that was available for our review, a small number of directed payments account for the vast majority of projected spending. Specifically, about 90 percent of all directed payment spending that we identified was attributable to the 35 directed payment

arrangements that were projected to increase payments to providers by more than $100 million a year. Most of these arrangements were uniform rate increases, but some were large pay-for-performance incentive payments, similar to DSRIP. The majority of these arrangements (20 of the 35 we identified) increased provider payments above the Medicare payment rate, which is generally used as the basis for setting an upper limit on FFS payments (MACPAC 2021c).

Currently, no upper limit exists on the amount of directed payments that states can make. In general, it appears that CMS has often permitted states to pay providers as high as the average rate that providers negotiate with private payers (referred to as the average commercial rate), which is often much higher than the amount Medicare would have paid for the same service. For example, in some cases, we found examples of directed payments that paid almost three times the Medicare rate for hospitals inpatient and outpatient services.

Targeting and financing of payments

The targeting and financing of directed payments varied based on the directed payment type (Table 2-1). Minimum or maximum fee schedules were often targeted to behavioral health providers; uniform rate increases were most often targeted to hospitals; and VBP arrangements were most often targeted to physicians, including those employed by academic medical centers or public hospital systems. Minimum or maximum fee schedules and VBP arrangements were often financed with state general funds, but most uniform rate increases were financed by providers through provider taxes or IGTs.

The largest directed payment arrangements are typically targeted to hospitals and financed by them. Of the 35 directed payment arrangements projected to increase payments to providers by more than $100 million a year, 30 were targeted to hospital systems and at least 27 were financed by provider taxes or IGTs.[15] During our interviews,

TABLE 2-1. Directed Payment Programs by Payment Type, Provider Type, and Funding Source, 2020

Directed payment characteristics	Minimum or maximum fee schedule		Uniform rate increase		VBP		Total	
	Number	**Share**	**Number**	**Share**	**Number**	**Share**	**Number**	**Share**
Total	**103**	**100%**	**68**	**100%**	**37**	**100%**	**201**	**100%**
Provider type								
Hospitals	19	18	30	44	9	24	58	29
Professional services at AMCs or public hospital systems	6	6	23	34	11	30	36	18
Physicians and other professional service providers	13	13	6	9	10	27	29	14
Behavioral health and substance abuse providers	39	38	8	12	9	24	56	28
Nursing facilities	14	14	7	10	3	8	21	10
Dental providers	7	7	3	4	1	3	11	5
HCBS providers	9	9	2	3	–	–	11	5
Transportation services	6	6	1	1	–	–	7	3
Other	15	15	3	4	5	14	23	11
Funding source								
State general fund	38	37	29	43	20	54	86	43
IGT or CPE	5	5	28	41	14	38	42	21
Health care-related tax	5	5	20	29	4	11	28	14
Other non-state general fund	–	–	2	3	1	3	3	1
Not specified	58	56	2	3	1	3	61	30

Notes: VBP is value-based payment. AMCs are academic medical centers. HCBS is home- and community-based services. IGT is intergovernmental transfer. CPE is certified public expenditure. This analysis is based on a review of unique directed payment arrangements approved through December 31, 2020, and excludes temporary directed payments approved under the expedited COVID-19 pathway (n = 29). Prior versions of directed payment arrangements that were subsequently renewed or amended are also excluded (n = 260). Totals do not sum because a single directed payment arrangement can target multiple provider types or have multiple funding sources.

– Dash indicates zero.

Source: Mathematica, 2021, analysis for MACPAC of directed payment arrangements approved through December 31, 2020.

stakeholders noted that the amount of available IGTs or provider taxes often determined the total amount of spending for these types of arrangements. Once this available pool of funding was determined, states then worked backward to calculate the percentage increase in provider rates.

Goals of directed payments

The stated goal of most directed payment arrangements (60 percent) was improving access to care. However, the level of detail about access goals provided in directed payment approval documents varied widely. In some cases, the goal was to ensure that providers remain in the MCO network, and in other cases, the goal was more specifically related to beneficiaries' ability to obtain care in a timely manner.

VBP directed payment arrangements were more likely to address other goals, such as increasing receipt of preventive screenings and reducing avoidable hospital use. During our interviews, several of the stakeholders expressed interest in aligning the measures used to monitor directed payment performance with those used to monitor MCO performance, but they also noted the many

operational challenges involved in adjusting MCO contracts to align these measures.

In addition to quality and access goals, stakeholders noted that directed payments were a useful tool for making FFS and managed care payment policies consistent. For example, in Massachusetts, which uses multiple delivery system models, the state has implemented several minimum fee schedules that are intended to ensure parity between managed care and FFS rates. For states transitioning new services or populations from FFS to managed care, directed payments were meant to ensure continuity of payment for providers. For example, when Florida expanded managed care to cover long-term services and supports, the state required MCOs to pay nursing facilities no less than FFS rates.

Relationship to supplemental payments

Although many directed payments are intended to adjust base payment rates, some are intended to preserve prior supplemental payments or make new additional payments to providers that are similar to FFS supplemental payments (Box 2-1).

BOX 2-1. Examples of Directed Payments with Different Relationships to Supplemental Payments

Although many states use directed payments to adjust the base payment rate that providers receive, some states have begun using this authority to make additional payments to providers that are similar to supplemental payments in fee for service (FFS). During interviews with state officials and stakeholders involved in the development of directed payments, we learned that some directed payments are intended to replace prior supplemental payments, while others are intended to make new payments to providers. Illustrative examples of these different types of arrangements are described below:

Adjusting base payment rates

- **Florida minimum payment rate for nursing facility services.** Florida requires managed care plans to pay nursing facilities no less than the Medicaid state plan rate. The state first enacted this policy in 2013 to minimize the effects of managed care expansion on nursing facilities.

BOX 2-1. continued

- **Massachusetts COVID-related rate increases.** During the COVID-19 pandemic, Massachusetts used directed payment authority to enact a number of temporary rate increases for a variety of provider types. For example, the state increased payments to personal care attendants by 10 percent, mirroring an increase that the state made in FFS.

Preserving prior supplemental payments

- **Utah uniform increase for private hospitals.** Before 2016, Utah made a pass-through payment to private hospitals financed by a provider tax. In 2018, the state transitioned this pass-through payment to a directed payment to preserve a similar level of funding for providers. In state fiscal year (SFY) 2021, total spending on this arrangement was $182 million; the state estimated that this arrangement increased payments for participating hospitals from approximately 86 percent to 156 percent of the Medicare payment rate.

- **California quality incentive program (QIP).** In 2018, California transitioned a prior pass-through payment to designated public hospitals into a $640 million pay-for-performance incentive program financed by intergovernmental transfers (IGTs) from participating public hospitals. The hospitals participating in this program also participated in the state's Public Hospital Redesign Incentives in Medi-Cal (PRIME) program, a type of delivery system reform incentive payment program authorized under the state's Section 1115 demonstration. In 2019, the state ended its PRIME program and increased total funding for QIP to $1.6 billion for the July 2019 through December 2020 rating year. The performance measures used in QIP are similar to those used in PRIME.

Making new additional payments to providers

- **Florida hospital directed payment program.** In 2021, Florida established a new directed payment arrangement to supplement Medicaid base payment rates for hospitals. These payments are financed by IGTs from local governments, many of which have authorized new local provider taxes to claim more federal funding through this program. Payment increases for participating hospitals ranged from 45 to 70 percent of base payment rates, and in total, the state made $1.8 billion in payments through this arrangement in SFY 2021.

- **Ohio Care Innovation and Community Improvement Program.** In 2018, Ohio created a new enhanced payment for physician services, 10 percent of which is tied to achievement of quality goals related to substance use, mental health, and infant mortality. The program is limited to physicians affiliated with public hospitals or the state university. Participating hospitals finance the payment through IGTs. In SFY 2021, the four participating hospital systems received $254 million from the directed payment and $36 million from a corresponding upper payment limit supplemental payment. This payment amount is equal to the difference between their Medicaid payment rate for physician services and the average commercial rate, which is approximately three times as high as the state's base payment rate and 158 percent of the Medicare payment rate, according to state estimates.

Preserving prior supplemental payments. All five states we interviewed developed one or more directed payments that were intended to preserve prior pass-through payments or supplemental payments authorized under Section 1115 demonstration authority. States were concerned that ending these prior payments would disrupt access to care because they accounted for such a large share of Medicaid payments to providers (in some cases almost half of their Medicaid managed care payments).

When transitioning prior supplemental payments to directed payments, states were able to preserve the total amount of funding, but some states reported changes in how the payments were distributed among providers. Because directed payments must be tied to Medicaid utilization, states often could not maintain the same distribution of payments when prior supplemental payments were made based on other factors, such as care provided to uninsured individuals.

New additional payments to providers. Four of the five states we studied also created new directed payment arrangements that substantially increased payments for some providers, similar to supplemental payments in FFS. In general, interviewees indicated that these directed payment arrangements were intended to improve access or quality above existing levels. However, stakeholders noted that the initial impetus for many of these arrangements came from providers who identified new sources of non-federal financing, rather than from state officials who had identified a particular quality or access problem.

For states that have maximized other types of supplemental payments to hospitals, directed payments are a tool to increase payments further. For example, in Florida, the state's new directed payment to hospitals ($1.8 billion in state fiscal year (SFY) 2021) is larger than the amount of state and federal DSH funding in the state ($383 million in FY 2021) and the limit on the hospital uncompensated care pool authorized in the state's Section 1115 demonstration ($1.5 billion).[16]

Current Oversight Process

To obtain approval for a directed payment arrangement, states must first submit a preprint to CMS for review. After the preprint is approved, states must incorporate the directed payment into their managed care contracts and rate certifications. At the time of approval, states are also required to submit a directed payment evaluation plan; at renewal, states are expected to submit their evaluation results.[17]

CMS officials with whom we spoke acknowledged that the rapid growth of directed payments in recent years has presented several oversight challenges for CMS as well as challenges for states seeking quick review and approval of their directed payment requests. As a result, CMS has made some changes to its process to better manage the volume of directed payment requests.

Preprint approval

The approval process begins with CMS review of directed payment preprint applications for compliance with regulatory requirements using a process similar to the one used to review Medicaid state plan amendments. The preprint form includes information about who is eligible for the payment, how the payment amounts are determined, and how the payment relates to the state's managed care quality strategy. CMS often follows up to request additional information before a directed payment is approved. Directed payment preprints are not automatically renewed, and in general, states must submit a new preprint every year for review.

In 2020, CMS made regulatory changes to the approval process and no longer requires states to submit a preprint for minimum fee schedules based on state plan rates, which were the most common type of directed payment arrangement in our review (accounting for about half of all directed payment arrangements). These regulations also allowed states to obtain multiyear approval of VBP directed payment arrangements (CMS 2020).[18]

In 2021, CMS revised its preprint form to request additional information to help in its review of directed payments (CMS 2021a). Most notably, the new preprint asks for projected spending information relative to an external benchmark such as costs, Medicare payments, or the average commercial rate. In addition, the preprint asks for more information about the sources of non-federal share used to finance the directed payment arrangement. Stakeholders we interviewed expressed hope that this new preprint would help streamline the review process and limit the need for CMS to request additional information during its review. These changes took effect for contract rating periods beginning on or after July 1, 2021, and thus were not available for MACPAC's review.

Capitation rate development

After a preprint is approved, states must incorporate the directed payment arrangement into their managed care contracts and rate certifications. Managed care rate certifications are reviewed by CMS and include information about the portion of the capitation rate that is attributable to directed payments.[19] In some cases, directed payments are included as an adjustment to the base capitation rate, and in other cases, the directed payment is made separately from the base capitation rate that the MCO receives (which is referred to as a separate payment term).

Overall, actuaries must certify that managed care rates are sufficient to cover the reasonable, appropriate, and attainable costs of the services provided under the contract, a standard known as actuarial soundness (42 CFR 438.4(a)). Actuarial soundness has long been the basis for federal oversight of Medicaid managed care spending, and the 2016 revisions to the Medicaid managed care rule added several new requirements for how states should document compliance with this standard (MAPAC 2022b; CMS 2016).

During our interviews, we heard conflicting views about whether current actuarial soundness

requirements have any practical effect on directed payment spending. Although actuaries certify that capitation rates are reasonable and appropriate to cover the services in the contract, they are not typically involved in assessing whether directed payment amounts are reasonable and appropriate. In practice, the actuaries with whom we spoke noted that if CMS approves a directed payment arrangement, then it is often incorporated into the managed care rate certification without changes. Moreover, because CMS has not established an upper limit on directed payment spending, no federal standard exists for actuaries to apply in their review.

Actuarial soundness requirements are also supposed to help ensure that rates are sufficient for MCOs to meet network adequacy and other access requirements in the contract. However, CMS's managed care rate development guide does not currently provide explicit guidance on how actuaries should evaluate access (CMS 2022b). In practice, actuaries noted that they typically assume that historical payment rates are adequate to ensure access to care in the absence of any evidence of penalties levied on plans for insufficient network adequacy or availability of services.

Evaluation

States are required to develop evaluation plans for directed payments at the time of their preprint submission and are generally expected to report evaluation results when the directed payment is renewed. However, in our review of the information provided by CMS, we were able to find directed payment evaluations for only 48 of the 215 directed payment arrangements that had been renewed at least once and operating for at least a year.

In interviews, state officials noted that many directed payment evaluations were not available because of various delays. Most notably, lags in data collection prevented states from reporting results in time for the one-year renewal time frame used for most directed payment arrangements.

In addition, the COVID-19 pandemic caused disruptions in care and sustained drops in use of services, complicating the task of quality measurement and delaying evaluation results for many states.

States with directed payments that built on prior VBP efforts were better positioned to report evaluation results. For example, California's quality incentive pool for public hospitals was built off the state's prior DSRIP program, and so hospitals were already prepared to report on the specified quality measures. Similarly, Utah noted that it was able to provide evaluation results for its hospital directed payment program because it used similar metrics as an existing accountable care organization initiative in the state.

States reporting evaluation results described year-over-year improvements of varying magnitude. Although many states reported modest improvements in quality, some states reported negative outcomes; even so, their directed payment arrangements were approved without changes. For example, after implementing a directed payment that more than doubled Medicaid payments to hospital-based physicians to improve access, one state reported that the Medicaid payer mix for participating providers declined and that the time to appointment for Medicaid beneficiaries increased. These results should be interpreted with caution, however. Although they may indicate that the arrangement is not meeting its access goals, the results may also indicate that the measures used may not adequately capture access.

Commission Recommendations

As a first step toward improving the transparency and oversight of directed payments, the Commission makes five recommendations in this chapter. The rationale and implications of these recommendations are described in the following sections:

Recommendation 2.1

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.

Rationale

Directed payments are a large and growing portion of Medicaid spending. Consequently, it is important for the public and policymakers to have timely access to information on what payment arrangements have been approved and the effects of these arrangements on quality and access to care for Medicaid enrollees. Making this information available is an important first step toward improving the transparency of these payments and would complement any future efforts to make more information about directed payments publicly available.

CMS already makes approval documents for many other similar types of payments publicly available on its website. For example, CMS currently posts approval documents for Medicaid state plan amendments, which describe FFS supplemental payments, and approval documents for Section 1115 demonstrations, which describe DSRIP and other supplemental payments. However, when states transition FFS supplemental payments and DSRIP into directed payments, information about these payment arrangements is no longer publicly available.

Managed care rate certifications are an important complement to directed payment approval documents because they provide information on how the directed payment arrangement is incorporated into managed care rates. Such information is also useful for informing oversight of managed care rate setting more generally. Although actuaries may use some proprietary data from health plans when developing capitation rates, the final rate certification document is intended to be a public document and is already

publicly available in some states. Prior CMS regulations have clarified that managed care spending data should be publicly available even though some stakeholders viewed this information as proprietary, and so CMS could apply a similar standard to justify making rate certification information available (CMS 2020).

Evaluation plans and results are important for understanding the objectives of the directed payment arrangement and the extent to which it is meeting its goals. Although the Commission identified weaknesses in current directed payment evaluations, making these public would still allow stakeholders to learn from state experience and provide input on how to improve the rigor of evaluations. CMS makes Section 1115 demonstration evaluation plans and results publicly available on Medicaid.gov; a similar process could be used for directed payment evaluations.

Currently, information about directed payment approvals, managed care rate certifications, and evaluation plans are only available to the public through a Freedom of Information Act request, which can be complicated and time consuming to pursue. Moreover, because states do not need to provide public notice about directed payment arrangements, some stakeholders may not even know whether there are directed payments for which they can request information. CMS already uses the Medicaid.gov website to make information about various payments available to a wide range of stakeholders in a timely manner, and so it could also use this website to make information on directed payments publicly available as soon as they are approved.

Implications

Federal spending. The Congressional Budget Office (CBO) assumes that this policy would not affect federal spending. There may be some additional administrative effort to make existing reports available in a timely manner, but this activity is not expected to increase federal spending.

States. This policy should have a limited effect on states because they are already required to provide this information to CMS.

Enrollees. This policy would not directly affect Medicaid enrollees. Over time, greater transparency of directed payment arrangements could lead to additional public input on the design of these arrangements and whether they are meeting their intended goals of improving access and quality of care for enrollees.

Plans and providers. This policy would not directly affect payments to providers or health plans, but it would make information on their payment arrangements publicly available. Over time, greater transparency could lead to modifications in state directed payment methodologies.

Recommendation 2.2

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 payment amounts publicly available in a standard format that enables analysis.

Rationale

Complete data on Medicaid payments is important to understanding whether payment amounts are consistent with federal requirements, including the federal requirement that managed care rates be reasonable and appropriate (42 CFR 438.4). This is a large and rapidly growing form of Medicaid payments to providers, but we do not have provider-level data on how billions of dollars in directed payments are being spent. The projected spending information available on directed payment preprints may not match actual spending; the aggregate information on directed payment amounts in managed care rate certifications does not provide sufficient detail needed to examine how MCOs pay particular providers.

Directed payments are now larger than DSH and UPL supplemental payments, but we have much less data on who is receiving them. Providers have long been required to submit hospital-level audits for DSH payments, and beginning in FY 2022, states will be required to submit provider-level UPL supplemental payment data. Because many states use directed payments to make additional payments to providers that are similar to supplemental payments in FFS, it is equally important to collect provider-level data on these payments.

CMS currently collects information on projected directed payment amounts in the aggregate but does not monitor the actual amount of payments made, either in the aggregate or to particular providers. Collecting data on actual spending would help CMS ensure that spending is consistent with what was approved. In addition, provider-level data would help CMS and other stakeholders understand how payments are being targeted.

This recommendation builds on the Commission's prior recommendations that the Secretary of U.S. Department of Health and Human Services collect and report data on all Medicaid payments to hospitals for all hospitals that receive them, as well as data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level (MACPAC 2016). In some circumstances, directed payments appear to account for more than half of Medicaid managed care payments to hospitals, physicians, and other providers, and so it is particularly important to collect provider-level data on these payments.

The two primary methods that CMS could use to collect provider-level data on directed payments are the Transformed Medicaid Statistical Information System (T-MSIS) and the Medicaid Budget and Expenditure System (MBES). T-MSIS is used to report Medicaid claims and encounters, but according to CMS's review of preliminary 2020 data, 10 states are missing more than 10 percent of Medicaid spending for managed care encounters (CMS 2022c). MBES is the system that CMS uses to track overall Medicaid spending and collect provider-level data on UPL payments (CMS 2021b).

However, the current provider-level UPL reporting process requires manual data entry from states, which is administratively burdensome.

In the Commission's view, the administrative burden of the data collection should be reduced where possible and should be commensurate with the size of the payment. For many smaller directed payment arrangements that adjust base payment rates, this spending may already be captured in T-MSIS, and it may not be worthwhile to distinguish the amount of funding attributable to the directed payment from the base payment rate negotiated by the MCO. However, for large directed payments that are similar to FFS supplemental payments and are not currently being reported in T-MSIS, it may be necessary to use the same process used for tracking UPL payments, even though it may be more administratively burdensome.

The Commission continues to support better collection of data related to the non-federal share of Medicaid payments, which are necessary to calculate net Medicaid payments at the provider level. However, doing so would be most effective through a broader data collection effort that is not limited to directed payments, since provider taxes and IGTs can be used to finance a wide range of Medicaid payments.

Implications

Federal spending. CBO assumes that this policy would not affect federal spending. There may be administrative effort to develop reporting standards, make required changes to information technology systems, and make the data publicly available, but these activities are not expected to result in increased spending.

States. Reporting provider-specific Medicaid payments would likely require some increased administrative effort by states to the extent that payment information would need to be compiled from different data systems. In our interviews, state officials noted that they already track actual spending on uniform rate increases at the provider level, but there may still be effort involved in providing these data to CMS in a prescribed format.

Enrollees. This policy would not have a direct effect on Medicaid enrollees.

Health plans. Depending on the approach that states and CMS use to collect data on provider-level directed payments, health plans may need to submit additional information, increasing administrative effort.

Providers. State reporting of provider-level payments would not have a direct effect on Medicaid payments to providers. Over time, however, increased transparency could lead to modifications in state payment methodologies.

Recommendation 2.3

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.

Rationale

Understanding the goals of any payment is an important first step for assessing whether it is meeting its objectives. Although CMS requires states to describe how directed payments advance at least one goal of the state's managed care quality strategy, the link between directed payments and quality and access goals is often unclear.

Most of the directed payment preprints we reviewed described improving access as the primary goal of the directed payment. However, managed care rates are already required to be sufficient to ensure access to services in a timely manner, including access to an adequate network of providers. Thus, it is not clear what improvements to access states are buying when they use directed payments to make additional payments above rates that were previously certified as actuarially sound.

Distinguishing payments needed to meet existing access standards from those intended to improve access above this level would help inform how directed payments are evaluated and incorporated into managed care rates. In particular, making this distinction would help evaluators understand what additional improvements should be expected from the directed payment and would help the state's actuaries determine what the capitation rate would be if the directed payment were discontinued in the future.

Quantifying how the directed payment compares to prior supplemental payments, including prior pass-through payments that are similar to FFS supplemental payments, is a first step toward clarifying the payment goals. For example, if the directed payment is intended to replace pass-through payments that were previously part of the actuarially sound capitation payment, then it may be reasonable for the state to attest that this payment is necessary to meet existing access standards. However, if the directed payment substantially increases payment rates above levels that actuaries previously certified as sufficient, then it may be reasonable to expect the payment to result in improvements in access and quality above existing levels. Because spending on prior pass-through payments is not publicly available, quantifying the amount of these payments in the directed payment preprint would be particularly helpful.[20]

Information on how total Medicaid payments to providers compare to external benchmarks, such as Medicare payment rates, would also be useful for understanding the goals of the directed payment. CMS's new directed payment preprint includes questions for states to describe how total payments to providers compare to Medicare after accounting for directed payments, and so we are hopeful that these data can be used in CMS's review of directed payment goals.

Requiring states to more explicitly describe the goals of their directed payment arrangements could also help inform future policy development.

For example, CMS may want to encourage states to incorporate payments needed to comply with access standards into base payment rates so that any remaining additional payments to providers can be tied to more ambitious quality and access goals, similar to the approach it has used for some DSRIP demonstrations (MACPAC 2015b).

Implications

Federal spending. CBO assumes that this policy would not affect federal spending as it would only require that CMS modify existing guidance on this topic.

States. States are already required to provide information about program goals through the current directed payment approval process. New guidance would require only that they elaborate on these goals further.

Enrollees. We do not have enough information to assess how this policy would affect Medicaid enrollees. Directed payment policies affect enrollees' access to quality care, but it is not clear how states might change their directed payment methodologies in response to federal requirements to clarify their payment goals.

Health plans. This policy would not have a direct effect on health plans. However, over time, clarifying the relationship between directed payments and network adequacy requirements may affect the extent to which health plans are involved in the development of directed payment arrangements.

Providers. This policy would not have a direct effect on providers. However, over time, distinguishing new directed payment funding from prior supplemental payment funding could lead to changes in state directed payment methodologies.

Recommendation 2.4

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,

multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.

Rationale

MACPAC's review of directed payment evaluations raised several concerns about how directed payments are being evaluated and how evaluation results are being used. Although some states have reported improvements in quality and access measures after the implementation of directed payments, information on the results of many directed payment arrangements is unknown even after multiple renewals. In addition, we identified some circumstances in which performance on quality measures declined but the payment arrangement was renewed without changes.

To make evaluations more useful for policymakers, CMS should clarify its expectations for directed payment evaluation plans. For example, CMS could provide written guidance on the types of measures that states should monitor and the timing for submitting results. It would also be helpful for CMS to clarify how evaluations will be used to inform decisions about whether directed payments are renewed and the type of information needed to support this decision making.

Allowing states to develop multiyear evaluation plans would also help improve states' ability to conduct meaningful assessments of performance. For example, given the data lag with many of the sources of data that states are using, it often takes at least a year to collect baseline information on some quality measures and another year or two to measure changes in performance. Although CMS only permits multiyear approval for VBP directed payments, we have found that many uniform rate increases have been approved for multiple years in a row, and so it is reasonable to expect multiyear evaluations of these payment arrangements as well.

Even though states are required to develop evaluation plans for all directed payments, it would be most helpful for CMS to develop evaluation

guidance for the subset of directed payments that make substantial additional payments to providers. In the Commission's view, the rigor of the evaluation should be commensurate with the level of new federal spending associated with these arrangements.

Implications

Federal spending. CBO assumes that this policy would not affect federal spending. There may be some additional administrative effort for CMS to develop guidance on this topic.

States. This recommendation would increase administrative effort for states that do not currently have rigorous evaluation plans for their directed payments. However, developing multiyear evaluation plans rather than single-year evaluation plans may reduce administrative effort for states over time.

Enrollees. This policy would not have a direct effect on enrollees. However, over time, better evaluations of directed payment arrangements may help ensure that these payments promote better access to quality care for Medicaid enrollees.

Plans and providers. More rigorous evaluation plans may require health plans and providers to provide additional information about performance on quality and access measures. However, the burden of reporting new quality measures could be minimized if directed payment evaluations are coordinated with existing quality reporting efforts, such as those used in monitoring performance of the state's managed care quality strategy.

Recommendation 2.5

To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services involved in the review of directed payments and the review of managed care capitation rates.

Rationale

The statutory requirement that managed care rates be actuarially sound is the foundation for federal oversight of managed care. However, actuaries cannot appropriately assess whether rates are reasonable without clear guidance from CMS about what they should review.

During our interviews, we heard conflicting views about the extent to which actuaries should be involved in assessing directed payments. Although there is currently no federal upper limit on the amount of directed payments that states can make, CMS officials noted that state actuaries are still responsible for determining whether directed payments are reasonable and appropriate as part of their overall review of managed care capitation rates and certification of actuarial soundness. However, the state actuaries with whom we spoke noted that there is little for them to review because they are required to include directed payments in the capitation rate when these are approved by CMS and included in the managed care contract. In addition, some stakeholders had trouble describing how directed payments should be accounted for when assessing whether rates are sufficient to ensure access to services in a timely manner.

Some of the confusion we observed may be due to the timing of the process and the multiple CMS divisions that are involved in overseeing directed payments, managed care rate certifications, and managed care contracts. Stakeholders have been appreciative of the steps that CMS has taken in recent years to streamline the approval process but still expressed frustration with the length of time it took to get approval from the CMS Division of Managed Care Policy (which is primarily responsible for reviewing the preprint), the CMS Office of the Actuary (which reviews rate certifications), and the CMS Division of Managed Care Operations (which reviews managed care contracts).

Although CMS's recent guidance has helped streamline the administrative processes for incorporating approved directed payment preprints into managed care capitation rates,

additional guidance is needed to address the more fundamental question of who is responsible for overseeing what. In the Commission's view, additional guidance about the roles and responsibilities for directed payment oversight should include:

- clarification about who is responsible for reviewing and approving directed payment amounts;

- guidance about whether managed care capitation rates should be sufficient to comply with existing access standards before or after additional payments to providers are made through directed payment arrangements; and

- instructions for states about what additional federal review is needed after CMS approves a directed payment preprint.

In the process, CMS may also be able to identify additional opportunities to reduce administrative burden and focus resources on the oversight activities that are most meaningful.

Implications

Federal spending. CBO assumes that this policy would not affect federal spending. There may be some initial administrative effort involved for CMS to clarify roles and responsibilities, but over time, better coordination could help to lower administrative effort. In addition, greater clarity about who is responsible for overseeing directed payment amounts may affect the amount of directed payments approved by CMS in the future.

States. Better coordination of federal approval processes could help to reduce administrative burden for states over time.

Enrollees. This policy would not have a direct effect on Medicaid enrollees. However, over time, more clarity about the federal oversight processes for ensuring network adequacy could help improve compliance with these requirements, which are intended to ensure that enrollees can access care in a timely manner.

Plans and providers. The policy would not have a direct effect on health plans and providers. However, over time, a more coordinated federal approval process for directed payments may help expedite directed payment reviews, which would provide greater certainty for plans and providers about future Medicaid payments.

Oversight of Directed Payment Spending

As use of directed payments continues to grow, one important question to consider is whether there should be an upper limit on directed payment spending, similar to the upper limits on other types of Medicaid payments. The rapid growth of DSH payments in the early 1990s demonstrates the potential risk that federal spending could increase dramatically if unchecked. Between 1990 and 1992, after Congress clarified that DSH payments were not subject to the UPL that applies to other FFS spending, the total amount of DSH payments increased from $1.3 billion to $17.7 billion (Holahan et al. 1998).[21]

Two approaches that could be used to set an upper limit on directed payment spending are establishing a limit based on an external benchmark or establishing a limit based on historic spending. In addition, policymakers should consider how any limit on directed payment spending relates to existing limits on spending in some managed care authorities. In the following sections, we discuss policy issues to consider with each of these approaches and areas for future analyses.

Limits based on external benchmarks

Medicaid FFS payments to hospitals, nursing facilities, and other institutional providers are limited based on a reasonable estimate of what would have been paid for the same services under Medicare payment principles. This limit is established in the aggregate for a class of

providers. As a result, some providers can be paid more than what Medicare would have paid as long as total payments to each class of providers are below the UPL (MACPAC 2021b).

In our review, we identified a number of examples of directed payments that resulted in Medicaid payments to hospitals and other institutional providers that exceeded what Medicare would have paid. As a result, establishing a limit on directed payments based on the UPL in FFS would likely result in reductions in payments for some providers.

The upper limit for Medicaid FFS payments for physician services is based on the average commercial rate (ACR), which is substantially higher than the Medicare payment rate.[22] For example, CBO's recent review of studies comparing commercial prices to Medicare estimated that on average, commercial prices for physician services were 129 percent of Medicare, and commercial prices for hospital services were 223 percent of Medicare; CBO also found considerable state variation in the differences between commercial rates and Medicare (CBO 2022). Unlike Medicare payment rates, which are publicly available and are consistent for all providers, the rates that private insurers pay are not readily available and can vary widely based on providers' ability to negotiate their payment rate.

The growing use of ACR-based directed payments for hospital-based physician services also raises additional questions about how payments to hospitals should be evaluated. We learned that some states began making additional payments to hospital-based physicians because the state had already maximized the amount of Medicaid supplemental payments that the state can make for inpatient and outpatient hospital services. Because health systems can choose how they allocate the Medicaid payments they receive, it is not clear whether some of these new directed payments ultimately increase payments to physicians or whether they are being used to support the overall finances of the hospital. In addition, it is not clear what rationale states have

for paying hospital-based physicians so much more than office-based physicians for the same service, other than the fact that hospitals are able to finance the non-federal share of the payment.

Limits based on historic spending

Another approach to limit spending for directed payments would be to set a cap on payments based on states' historic spending. Compared with an external benchmark, this approach would limit reductions in payments for providers, but it would also preserve the existing variation in directed payment spending by state. Two potential models that could be considered include (1) setting a fixed limit on total spending, similar to the approach used for DSH allotments; and (2) setting limits on a per capita basis, similar to the approach used in Section 1115 budget neutrality.

In the early 1990s, Congress established state-specific caps on the amount of federal funds that could be used to make DSH payments, which were based on state spending in 1992. Although Congress has made several incremental adjustments to federal DSH allotments since then, the states that spent the most in 1992 still have the largest allotments, and the states that spent the least in 1992 now have the smallest allotments. This approach has resulted in a wide variation in state DSH funding that has no meaningful relationship to levels of uncompensated care or other measures of need for DSH funding (MACPAC 2022c).

Most Section 1115 demonstrations limit spending on a per capita basis so that the state is at risk for the costs of individuals served by the demonstration but is not at risk for the number of individuals enrolled. This limit is determined as part of a budget neutrality calculation that uses state historic spending per person, trended forward based on the lower of the state's historical growth rate or the trend assumed in the president's budget. Over time, this approach has resulted in a wide variation in the budget neutrality limits approved for different states, so CMS has recently revised its policy to require states to rebase their

budget neutrality limits when the demonstration is renewed (MACPAC 2021d).

Relationship to other limits on overall managed care spending

Some authorities that states use to operate their managed care programs have limits on spending that could be considered when setting a limit on managed care directed payments. In 2019, 29 states operated managed care through 1915(b) waivers, which are subject to a cost-effectiveness test, and 24 states operated managed care through Section 1115 demonstration authority, which is subject to a budget neutrality limit (CMS 2022d).[23] Both the cost-effectiveness test and budget neutrality limits are based on historical state spending, trended forward for inflation. However, it appears that in some circumstances CMS allows states to increase their cost-effectiveness or budget neutrality limits to account for payment rate increases, which would undermine the ability of CMS to use cost effectiveness or budget neutrality as a tool to limit directed payment spending from uniform rate increases.[24]

In addition, it is worth noting that other types of Medicaid managed care authorities do not have any statutory or regulatory limits on spending. Because directed payments provide states with an option to make additional payments to providers without a Section 1115 demonstration, it is possible that some states may transition their managed care programs to other authorities in the future, similar to what California did in its most recent Section 1115 demonstration renewal.

Areas for future work

More information about directed payment spending is needed to examine the potential effects of each of these approaches and to consider whether statutory or regulatory actions would be required to make such changes. CMS's recent revisions to the directed payment preprint form should help improve the quality of information about aggregate directed payment spending compared with external benchmarks, and so the Commission plans to examine this new data when it is available. If CMS adopts the Commission's recommendations to collect more provider-level data and further clarify the goals of directed payments, it would help us better understand the effects of any changes on providers and beneficiaries.

Endnotes

[1] In this chapter, we use the term MCO to refer to all types of capitated managed care plans in Medicaid, including prepaid inpatient health plans and prepaid ambulatory health plans.

[2] In general, states are not allowed to make supplemental payments for Medicaid services covered in managed care contracts. However, as discussed in this chapter, states can direct MCOs to make additional payments to providers that are similar to supplemental payments in FFS. In addition, states can make disproportionate share hospital (DSH) and graduate medical education (GME) payments for services provided in managed care.

[3] A directed payment arrangement refers to each state directed payment application, technical amendment, and renewal approved by CMS. Distinct programs are defined as a series of directed payment arrangements in one state that use the same payment and provider type(s) for one or more rating period. Some newly authorized directed payments are continuations of prior arrangements that were authorized before the 2016 revisions to the Medicaid managed care rule.

[4] MACPAC contracted with Mathematica to review the 490 state directed payment arrangements that had been approved, renewed, or amended as of December 31, 2020. We identified 230 distinct arrangements, including 29 temporary COVID-19 arrangements. As of June 30, 2021, CMS has approved 557 directed payment arrangements, which by its count includes 218 new payment arrangements, 311 renewals, and 28 amendments (CMS 2022a).

5 Projected payment amounts are for the most recent rating period, which may differ from calendar year or fiscal year 2020. In addition, projected spending reported in directed payment approval documents may differ from actual spending. Total spending includes state and federal funds.

6 In FY 2020, states spent $17.9 billion on DSH payments and $24.4 billion in UPL supplemental payments (MACPAC 2021a).

7 As discussed in this chapter, not all types of directed payment arrangements are projected to increase spending.

8 Total supplemental payment spending includes DSH payments ($17.9 billion), UPL supplemental payments ($24.4 billion), and supplemental payments authorized by Section 1115 demonstrations ($14.6 billion) (MACPAC 2021a).

9 Health care providers cannot be given a direct or indirect guarantee that they will be repaid for all or a portion of the amount of taxes that they contribute. However, if a health care-related tax produces revenue that is less than 6 percent of net patient revenue, then the tax is considered to be below the safe harbor threshold, and 75 percent or more of taxpayers in a class can receive 75 percent or more of their total tax costs back from Medicaid (MACPAC 2021b).

10 States can make DSH and GME payments for services provided in managed care.

11 For example, in FY 2020, 9 states reported spending on delivery system reform incentive payment (DSRIP) or DSRIP-like programs, and 8 states reported spending on uncompensated care pools authorized under Section 1115 demonstrations (MACPAC 2022a).

12 Subsequent revisions to the managed care rule in 2020 eliminated the requirement for prior approval for minimum fee schedules based on state plan rates and allowed for multiyear approval of VBP directed payment arrangements (CMS 2020).

13 Specifically, 42 CFR 438.4(b)(3) requires actuaries to certify that rates are adequate to meet the requirements of 42 CFR 438.206 (timely access to services), 42 CFR 438.207 (network adequacy), and 42 CFR 438.208 (care coordination). States establish their own access standards to enforce this requirement, including quantitative standards for network adequacy (42 CFR 438.68).

14 For example, it was often unclear whether payment amounts reported in renewals included amounts from prior submissions or amendments to that arrangement or if the number provided reflected only the amount for the current rating period.

15 Financing information was not available for all directed payment arrangements.

16 DSH and uncompensated care pools pay for the costs of care for both Medicaid-enrolled patients and uninsured individuals, while directed payments may pay for services only to Medicaid-enrolled patients. DSH payments to individual hospitals are limited to the hospitals' uncompensated care costs for inpatient and outpatient services, but they are not affected by payments that hospitals receive for services to hospital-based physicians, such as those made by several of the directed payment arrangements that we studied.

17 Federal regulations do not explicitly require states to submit evaluation results, but CMS noted that it asks for this information during its review of directed payment renewal requests.

18 CMS's 2017 informational bulletin outlined criteria that the agency will consider when approving directed payment arrangements for multiple years; this policy was codified in regulation in 2020 (CMS 2017b; CMS 2020).

19 Section I.4.D. of CMS's Medicaid managed care rate development guide describes the documentation that states must provide about how directed payments are incorporated into the managed care capitation rate (CMS 2022b).

20 The revised directed payment preprint requests information about pass-through payment spending in the rate year under review but not about pass-through payment spending for prior rate years.

21 The growth in DSH in the early 1990s was also attributable to more flexible rules on the sources of non-federal share that states could use to finance Medicaid payments. Since then, Congress has limited provider donations and most provider taxes to no more than 6 percent of provider revenue (MACPAC 2021b).

22 Because a federal statute or regulation does not exist to establish a UPL for non-institutional providers, states

are permitted to pay these providers rates greater than Medicare in the aggregate. In sub-regulatory guidance, CMS has indicated that states can use the average payment rate from the top commercial payers as an upper limit on enhanced payments to physicians and other qualified practitioners (MACPAC 2021c).

[23] Some states use both Section 1915(b) waivers and Section 1115 demonstrations to provide managed care for different populations within their state.

[24] For example, Appendix D4 of the Section 1915(b) waiver application allows states to adjust their cost-effectiveness test to account for legislatively mandated fee schedule changes.

References

Bailit Health. 2020. *Strategies to promote value-based payment through Medicaid managed care final report*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Mananged-Care-Final-Report.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. E-mail to MACPAC staff, April 12, 2022.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. *2022–2023 Medicaid managed care rate development guide*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/managed-care/downloads/2022-2023-medicaid-rate-guide-03282022.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. DQ Atlas: Missing payment data—encounters. Baltimore, MD: CMS. https://www.medicaid.gov/dq-atlas/landing/topics/single/map?topic=g8m86&tafVersionId=24.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022d. Managed care enrollment report. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. Letter from Anne Marie Costello to state Medicaid directors regarding "Additional guidance on state directed payments in Medicaid managed care." January 8, 2021. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. Letter from Dan Tsai to state Medicaid directors regarding "New supplemental payment reporting and Medicaid disproportionate share hospital requirements under the Consolidated Appropriations Act, 2021." December 10, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/smd21006.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Medicaid program; Medicaid and Children's Health Insurance Program (CHIP) managed care. Final rule. *Federal Register* 85, no. 220 (November 13): 72754–72844. https://www.federalregister.gov/d/2020-24758.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017a. Medicaid program; the use of new or increased pass-through payments in Medicaid managed care delivery systems. Final rule. *Federal Register* 82, no. 11 (January 18): 5415–5429. https://www.federalregister.gov/d/2017-00916.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017b. CMCS informational bulletin regarding "Delivery system and provider payment initiatives under Medicaid managed care contracts." November 2, 2017. https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Medicaid and Children's Health Insurance Program (CHIP) programs; Medicaid managed care, CHIP delivered in managed care, and revisions related to third party liability. Final Rule. *Federal Register* 81, no. 88 (May 6): 27498–27901. https://www.federalregister.gov/d/2016-09581.

Congressional Budget Office (CBO). 2022. *The prices that commercial health insurers and Medicare pay for hospitals' and physicians' services*. Washington, DC: CBO. https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf.

Health Care Payment Learning & Action Network (HCP-LAN). 2021. Measuring progress: Adoption of alternative payment models in commercial, Medicaid, Medicare Advantage, and traditional Medicare programs. December 15, 2021. https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/.

Hinton, E., L. Stoylar, M. Guth, et al. 2022. *State delivery system and payment strategies aimed at improving outcomes and lowering costs in Medicaid*. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/.

Holahan, J., B.K. Bruen, and D. Liska. 1998. *The decline in Medicaid spending growth in 1996: Why did it happen?* Washington, DC: The Urban Institute. http://webarchive.urban.org/UploadedPDF/410365.pdf.

Holgash, K., and M. Heberlein. 2019. *Physician acceptance of new Medicaid patients: What matters and what doesn't*. April 10, 2019. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/.

Marks, T., K. Gifford, S. Perlin, et al. 2018. *Factors affecting the development of Medicaid hospital payment policies: Findings from structured interviews in five states*. Washington, DC: MACPAC. https://www.macpac.gov/publication/factors-affecting-the-development-of-medicaid-hospital-payment-policies-findings-from-structured-interviews-in-five-states/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. *Medicaid base and supplemental payments to hospitals.* Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022b. *Medicaid managed care capitation rate setting*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022c. Chapter 3: Annual analysis of disproportionate share hospital allotments to states. In *Report to Congress on Medicaid and CHIP*. March 2022. Washington, DC: MACPAC. https://www.macpac.gov/publication/annual-analysis-of-disproportionate-share-hospital-allotments-to-states-3/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. Exhibit 24: Medicaid supplemental payments to hospital providers by state, FY 2020 (millions) and Exhibit 25: Medicaid supplemental payments to non-hospital providers by state, FY 2020 (millions). In *MACStats: Medicaid and CHIP Data Book*. December 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *Health care-related taxes in Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/publication/health-care-related-taxes-in-medicaid/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021c. *Upper payment limit supplemental payments*. Washington, DC: MACPAC. https://www.macpac.gov/publication/upper-payment-limit-supplemental-payments/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021d. *Section 1115 demonstration budget neutrality*. Washington, DC: MACPAC. https://www.macpac.gov/publication/section-1115-demonstration-budget-neutrality/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. *Delivery system reform incentive payment (DSRIP) programs*. Washington, DC: MACPAC. https://www.macpac.gov/publication/delivery-system-reform-incentive-payment-programs/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. *Medicaid hospital payment: A comparison across states and to Medicare*. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-hospital-payment-a-comparison-across-states-and-to-medicare/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Chapter 3: Improving data as the first step to a more targeted disproportionate share hospital policy. In *Report to Congress on Medicaid and CHIP.* March 2016. Washington, DC: MACPAC. https://www.macpac. gov/publication/improving-data-as-the-first-step-to-a-more-targeted-disproportionate-share-hospital-policy/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015a. Chapter 7: A framework for evaluating Medicaid provider payment policy. In *Report to Congress on Medicaid and CHIP*. March 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/a-framework-for-evaluating-medicaid-provider-payment-policy/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015b. Chapter 1: Using Medicaid supplemental payments to drive delivery system reform. In *Report to Congress on Medicaid and CHIP*. March 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/using-medicaid-supplemental-payments-to-drive-delivery-system-reform/.

Pettersson, J., B. Mori, L. Roth, and J. Clarkson. 2018. *Approved Medicaid state directed payments: How states are using §438.6(c) "preprints" to respond to the managed care final rule.* Seattle, WA: Milliman. http://www.milliman.com/insight/2018/Approved-Medicaid-state-directed-payments-How-states-are-using-438_6c-Preprints-to-respond-to-the-managed-care-final-rule/.

Zuckerman, S., L. Skopec, and M. Epstein. 2017. *Medicaid physician fees after the ACA primary care fee bump.* Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/88836/2001180-medicaid-physician-fees-after-the-aca-primary-care-fee-bump_0.pdf.

Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 8, 2022.

Oversight of Managed Care Directed Payments

2.1   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.

2.2   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 payment amounts publicly available in a standard format that enables analysis.

2.3   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.

2.4   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, multiyear evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan.

2.5   To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare & Medicaid Services involved in the review of directed payments and the review of managed care capitation rates.

2.1-5 Voting Results	#	Commissioner
Yes	15	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Herrera Scott, Weno
Not Present	1	Scanlon

Chapter 3:

Acting to Improve Vaccine Access for Adults Enrolled in Medicaid

Acting to Improve Vaccine Access for Adults Enrolled in Medicaid

Recommendations

3.1 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.

3.2 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).

3.3 The Centers for Medicare & Medicaid Services should issue federal guidance encouraging the broad use of Medicaid providers in administering adult vaccinations.

3.4 The Secretary of the U.S. Department 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.

3.5 Congress should provide additional federal funds to improve immunization information systems (IIS). In addition, Congress should require the Secretary of the U.S. Department 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.

Key Points

- Adult Medicaid enrollees face access barriers to recommended vaccines, and as a result, vaccination rates are generally lower for Medicaid-enrolled adults than those with private insurance.

- Medicaid has more restrictive vaccine coverage than most other sources of health insurance. For many Medicaid-enrolled adults, vaccine coverage is optional or subject to cost sharing. This creates unequal access to cost-effective, preventive care.

- In addition to limited coverage, other access barriers include low provider payment, limited provider networks, and inadequate support and education for beneficiaries.

- The Commission recommends a set of complementary actions to meaningfully address access barriers and improve vaccination rates.

CHAPTER 3: Acting to Improve Vaccine Access for Adults Enrolled in Medicaid

Vaccines are an important, cost-effective tool to prevent illness, hospitalization, and death (CDC 2021a, 2020; Leidner et al. 2019; Ozawa 2016; McLaughlin et al. 2015; Roush et al. 2007). Yet adult Medicaid enrollees still face substantial access barriers to recommended vaccines. As a result, Medicaid vaccination rates are low, and adults enrolled in other forms of health insurance generally have higher vaccination rates than Medicaid enrollees (MACPAC 2022a, NCQA 2021).

In its March 2022 *Report to Congress on Medicaid and CHIP*, the Commission discussed the role of vaccines in promoting public health and described how current Medicaid coverage policies create unequal access to recommended vaccines. The March report also described vaccination rates across sources of coverage and racial and ethnic groups and offered policy considerations to improve vaccination rates in Medicaid (MACPAC 2022a).

It is the Commission's view that mandatory coverage of recommended vaccines for all Medicaid-enrolled adults is fundamental to improving vaccine access. Currently, some adults in Medicaid have limited coverage of recommended vaccines, creating unequal access to cost-effective, preventive care. The Commission also recognizes that low vaccination rates in Medicaid result from a number of other barriers, including inadequate provider payment, limited provider networks, and inadequate support and education for beneficiaries.

The Commission recommends five policy changes to address these barriers. They include the following:

- 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.

- 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).

- The Centers for Medicare & Medicaid Services should issue federal guidance encouraging the broad use of Medicaid providers in administering adult vaccinations.

- The Secretary of the U.S. Department 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.

- Congress should provide additional federal funds to improve immunization information systems (IIS). In addition, Congress should require the Secretary of the U.S. Department 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.

Each of these recommendations addresses a different barrier to vaccine access and could be adopted independently. However, because the problem of low vaccination rates in Medicaid is multifaceted, the Commission is recommending a set of complementary actions that together would meaningfully address barriers to access and improve vaccination rates.

In this chapter, the Commission provides an overview of the benefits of and need for adult vaccinations. Then we describe the barriers to vaccine access for adults enrolled in Medicaid. Last, we present the rationale for these recommendations and the implications for federal spending, states, enrollees, plans, and providers.

Overview

Low uptake of recommended adult vaccines has resulted in preventable disease, hospitalization, and death. Many vaccine-preventable diseases (VPDs) are communicable, and low vaccination rates contribute to the spread of these diseases. The Centers for Disease Control and Prevention (CDC) estimates that since 2010, between 140,000 and 710,000 influenza-related hospitalizations and 12,000 to 56,000 influenza-related deaths have occurred per year. Each year, an estimated 150,000 individuals are admitted to the hospital for pneumococcal pneumonia, and 5,000 die from the disease. Chronic hepatitis B affects between 700,000 and 1.4 million people, and human papillomavirus (HPV) causes more than 27,000 cases of cancer each year (CDC 2021a).

Low vaccine uptake leads to hospitalizations and other medical costs that could be avoided. Most recommended vaccines are cost effective; that is, the cost of vaccination is less than the eventual cost of untreated disease. One systematic review of cost-effectiveness studies for adult vaccines found that most published studies reported favorable cost-effectiveness profiles for adult vaccinations. Several vaccines (influenza; pneumococcal; tetanus; and tetanus, diphtheria, and pertussis (Tdap)) were found to be cost saving, and other vaccines (HPV and shingles) generally were found to have a cost-effectiveness ratio of $100,000 or less per quality-adjusted life-year saved (Leidner et al. 2019).

Medicaid-enrolled adults have lower vaccination rates than those with private insurance for nearly all vaccines. Vaccination rates for Tdap had the largest gap between Medicaid and private insurance. For the 2015 to 2018 period, the Tdap vaccination rate for those with private insurance was almost 13 percentage points higher than those enrolled in Medicaid (MACPAC 2022a).

When looking at vaccination rates among pregnant women for influenza and Tdap—two vaccines the Advisory Committee on Immunization Practices (ACIP) recommends for this population—the difference was particularly stark.[1] Although the influenza vaccine reduces the risk of hospitalization for pregnant women by an average of 40 percent (CDC 2021b), the influenza vaccination rate was almost 21 percentage points lower for pregnant women enrolled in Medicaid than it was for those enrolled in private insurance. For Tdap, pregnant women enrolled in Medicaid had a vaccination rate about 12 percentage points lower than those privately insured (MACPAC 2022a). It is important to note that these vaccines also provide protection for infants who are too young to be vaccinated (CDC 2021c). Given that Medicaid covers 43 percent of all births in the United States, this disparity in vaccination rates is particularly concerning (MACPAC 2021a).

Low vaccination rates may be of particular concern for people covered by Medicaid. Compared to commercially insured individuals, Medicaid enrollees may have a higher incidence of VPDs for which vaccinations were recommended based on certain risk factors. These include pneumococcal and meningococcal diseases as well as

hepatitis A and B (Krishnarajah et al. 2014). The higher incidence of these conditions among Medicaid beneficiaries compared to those with commercial insurance may reflect differences in demographics, socioeconomic status, and health status of those enrolled under each type of coverage. In addition, low vaccination rates in Medicaid have a disproportionate effect on people of color. More than half (61.6 percent) of Medicaid enrollees identify as Asian American, Black, Hispanic, or another non-white race or ethnicity (MACPAC 2021b).

Barriers to Vaccine Access

Several barriers to vaccine access exist for adults enrolled in Medicaid. Limited coverage of vaccines in Medicaid is a fundamental barrier. Specifically, for those adults eligible due to disability, pregnancy, or being parents or caretakers, vaccine coverage is optional and varies by state. Other barriers to vaccine access include low provider payment and availability and inadequate support and education for beneficiaries.

Limited and unequal coverage

Medicaid has more restrictive vaccine coverage than most other sources of health insurance. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires that private health insurance plans cover preventive services, including vaccines recommended by ACIP, without cost sharing (§ 2713 of the ACA).[2] This means that the vast majority of individuals with employer-sponsored health insurance or insurance through the exchange have coverage of vaccines recommended by ACIP without cost sharing. Medicare enrollees, including those dually eligible for both Medicare and Medicaid, receive most vaccines through Medicare Part B and Part D but may be subject to cost sharing for vaccines covered under Part D.

Within Medicaid, all adult beneficiaries do not have equal coverage of recommended vaccines. As part of the coverage expansion to the new adult group (non-disabled adults without dependents with incomes up to 138 percent of the federal poverty level), the ACA required that these beneficiaries receive benchmark or benchmark-equivalent coverage, also known as an alternative benefit plan (§ 1902(k)(1) of the Act), and that alternative benefit plans provide coverage of essential health benefits (§ 1937(b)(5) of the Act). As part of the essential health benefit, preventive services, including coverage of all ACIP-recommended vaccines, must be provided without cost sharing (42 CFR 440.347).

However, for all other adults in Medicaid not receiving coverage through an alternative benefit plan, vaccine coverage is optional, and states can determine which vaccines to cover and whether to apply cost sharing.[3] This includes adults eligible on the basis of disability, those age 65 and older, parents and caretaker relatives, and pregnant women. That is, for almost two out of every five (38.2 percent) Medicaid-enrolled adults, vaccine coverage is optional and varies by state.[4] In addition, these individuals tend to be lower income and are more likely to be people of color than those for whom vaccine coverage is required (MACPAC 2022b).[5]

For those not in the new adult group, coverage varies by state and vaccine. According to a recent survey, half of states (25) did not cover all ACIP-recommended vaccines in 2018–2019. Although the vast majority of states (48) covered at least one vaccine for influenza in addition to Tdap; measles, mumps, and rubella; varicella; and pneumococcal disease, several states did not cover the HPV (9-valent human papillomavirus), haemophilus influenzae type b (Hib), and herpes zoster (shingles) vaccines. Moreover, among the 44 Medicaid programs surveyed, 15 states had cost sharing requirements on adult vaccines, creating a barrier to access even when covered (Granade et al. 2020).

Inadequate provider payment

Inadequate provider payment for vaccines can create access barriers for Medicaid enrollees. To provide vaccines to patients, providers face costs associated with purchasing the vaccine (e.g., up-front purchase cost but deferred payment), storage (e.g., adequate refrigerator or freezer, backup power, insurance), and administration (e.g., staff time, documentation, billing). If providers are not paid adequately to purchase and administer vaccines, they may maintain only a limited supply or not offer vaccines at all. This limits beneficiary access and reduces uptake of recommended vaccines.

Research has shown a positive relationship between Medicaid payment rates and vaccination rates for children. One study found higher Medicaid payment rates were associated with increases in influenza vaccination rates among children (Yoo et al. 2010). Another study found that higher Medicaid payment for vaccine administration was positively associated with immunizations for children, suggesting that increasing Medicaid payment could increase the number of Medicaid-enrolled children getting vaccinations (Tsai 2018).

Evidence also indicates that some Medicaid providers may not be adequately paid for vaccinations. A 2014 survey of family and general internal medicine physicians found that the majority of respondents (55 percent) reported that they lost money administering vaccines to adult Medicaid beneficiaries, whereas 25 percent or less reported having lost money administering vaccines to adults covered by other public and private payers (Lindley et al. 2018).

Payment for vaccine purchase. To offer vaccines to their patients, providers must purchase vaccines from drug wholesalers or manufacturers. Providers have little control over vaccine prices, and if Medicaid payments do not adequately cover acquisition costs, this can result in a financial loss for providers. Researchers found that the median Medicaid payment amounts for vaccines were

below the reported private sector price for 7 of 13 vaccines. The greatest differences between the median Medicaid payment and the private sector price were for the varicella, HPV, and Tdap vaccines (Granade et al. 2020).

Vaccine prices are not constant and may increase over time. If states do not update the fee schedule periodically to account for these price changes, then providers may face a larger shortfall between the cost of the vaccine and the payment received from Medicaid.

Adult vaccine providers have smaller economies of scale than pediatric providers because vaccine recommendations for adults include factors other than age, and demand is less predictable (Shen 2017). Given the uncertainty of demand among adults, some providers choose not to stock all recommended vaccines, viewing it as a financial liability.

Administration payments. The average estimated cost to providers to administer adult vaccines is between $15 and $23 (Yarnoff et al. 2019). However, in 2018, the median Medicaid payment to health professionals to administer a single adult vaccination was $13.62 for an injection (Granade et al. 2020). Eight state Medicaid programs did not provide a separate payment for vaccine administration. In states that paid an administration fee, it ranged from $3.72 to $28.18. By contrast, Medicare paid an average administration fee of about $18 per injection in 2019 (MedPAC 2021). Furthermore, CMS established a higher payment rate for COVID-19 vaccine administration (approximately $40 per dose) to reflect the additional cost and resources necessary, including storage, handling, and reporting, to ensure the vaccine is administered safely and appropriately (CMS 2021). Some experts have suggested that the growth of vaccine hesitancy has led to providers spending more time counseling patients, thus increasing providers' administrative costs.

Limited provider networks

To ensure vaccine access, vaccinations should be available in a broad range of settings, beyond primary care or physicians' offices. In MACPAC interviews with stakeholders and immunization experts, many interviewees noted that adults are less likely than children to have medical homes and more likely to access the health care system through providers such as a pharmacy, an emergency room, or a specialist. While many states allow pharmacies and providers other than physicians to administer vaccines, this is not universal. A recent CDC survey found that 31 state Medicaid programs paid pharmacists to administer vaccines. Twenty-nine state Medicaid programs paid nurse practitioners and four states paid midwives to administer vaccines (Granade et al. 2021).

Pharmacies can be an important point of access for adult vaccinations, but some state policies may be limiting pharmacies' ability or willingness to participate in vaccinating Medicaid-enrolled adults. Some states and managed care organizations (MCOs) allow pharmacists to administer vaccines and bill for the same administration fee given to providers through the medical benefit, while others may pay only the dispensing fee established for prescription drugs. Pharmacies may encounter operational challenges to billing through the medical benefit if it is not part of their standard operating procedures.

Inadequate beneficiary support and education

To improve access and increase vaccine uptake, adults enrolled in Medicaid need additional outreach, support, and education. The adult vaccine schedule is complex. While some vaccines are universal for adults, the recommended schedule for most vaccines depends on factors such as age, medical conditions, and vaccine history. A recent survey suggests that even for the influenza vaccine, which is universally recommended for all individuals six months and

older, there is still confusion. Only 19.6 percent of survey respondents were aware that the influenza vaccine is recommended for all individuals six months and older, and about 62 percent were aware of the influenza vaccine but did not know the recommended age group (Lu et al. 2017). Providers play an important role in educating beneficiaries about the value of immunization and identifying which vaccinations are recommended based on the beneficiary's health status and medical history.

Given the complexity of the adult vaccine schedule and patients' limited familiarity with it, enrollees would benefit from increased outreach and reminders on upcoming vaccinations. These messages could be delivered by texts, phone calls, and paper mail. General public health campaigns could also help by increasing public awareness of recommended vaccines. Experts suggest that these efforts are most effective when they come from trusted sources in local communities.

In interviews with MACPAC, experts expressed concern about the growth in vaccine hesitancy and opposition. They noted that addressing this barrier may require additional educational efforts, particularly from providers and trusted community members.

Immunization information systems. State and local IISs can store and exchange vaccination records across payers and providers to support vaccination efforts. Providers can use these systems to verify a patient's vaccination history and identify recommended vaccines. This is particularly important for adults who are less likely to have a medical home and may receive vaccines in a variety of settings, such as from a pharmacist or specialist. The IIS can also be used by public health officials, Medicaid agencies, health plans, and providers to conduct targeted outreach and education efforts to encourage vaccinations.

One of the major challenges with IISs is that providers do not consistently report many adult immunizations. IISs were initially developed to capture childhood immunizations, and jurisdictions

have only recently started to prioritize capturing adult vaccinations. Adult vaccination data are still not captured to the same extent as childhood vaccinations. In 2020, 68 percent of adults participated in an IIS, compared to 94 percent of children younger than six years of age (CDC 2021d). In 2010, only 25 percent of adults had immunization records in an IIS. These percentages vary greatly by state and locality.

Now, all states and jurisdictions have an IIS with the functional capabilities to collect and use adult immunization data, although only 63 percent of jurisdictions reported actively and routinely (e.g., real time, daily, weekly) capturing adult vaccination data in 2020 (AIRA 2021). In 2017, only 53.4 percent of clinicians (including internists, obstetricians and gynecologists, and other specialists) and 53.2 percent of pharmacists reported documenting vaccinations in an IIS (AIRA 2020).

In interviews conducted by MACPAC, Medicaid medical directors, health plans, and immunization experts shared that IISs need considerable improvements related to interoperability, data quality, and timeliness. In particular, the lack of consistent reporting and limited data sharing across states, providers, and settings limits the role of an IIS in improving vaccination rates. These limitations have become particularly evident when tracking COVID-19 vaccinations, which are administered in both regular medical and non-traditional locations. Many states have built stopgap solutions to track COVID-19 vaccinations, but these workarounds may not be optimal for long-term data exchange for all vaccines. In a recent 2020 survey, 74 percent of IISs exchanged data with Medicaid programs, and only 20.8 percent exchanged data with other states or regions (AIM 2020, NGA 2021). This means that many state Medicaid agencies do not have access to data that could help them monitor vaccination rates and conduct targeted outreach. Stakeholders have also noted interoperability challenges with electronic health records, which prevent providers from having updated and accurate information (NGA 2021).

Commission Recommendations

Below we present five recommendations to ensure vaccine coverage for all adults enrolled in Medicaid, ensure payment adequacy, expand provider networks, and improve support and education for beneficiaries.

Recommendation 3.1

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.

Rationale

Current federal law does not ensure equal coverage of all recommended vaccines for all Medicaid-enrolled adults. Those in the new adult group have coverage without cost sharing of all vaccines recommended by ACIP. However, coverage for all other adults enrolled in Medicaid is optional, and states can determine which vaccines to cover and whether to apply cost sharing. As a result, vaccine coverage for some adults in Medicaid is often limited and often more restrictive than vaccine coverage under other sources of health insurance. Adults with optional coverage tend to have lower incomes and are more likely to be people of color (MACPAC 2022b). Current coverage policies contribute to lower vaccination rates for adults with Medicaid coverage compared to those with private insurance and may further perpetuate racial disparities in vaccination rates.

This recommendation would make vaccine coverage a mandatory benefit for adults regardless of eligibility pathway, matching existing requirements for the new adult group and most individuals with private insurance.[6] Currently, individuals with higher incomes enrolled in the new adult group have coverage of all recommended vaccines without cost sharing, while those with

lower incomes may not have coverage or may be subject to cost sharing. In addition, it would ensure coverage for those beneficiaries who may be particularly vulnerable, such as pregnant women or individuals qualifying on the basis of disability, preventing disease, hospitalization, and death. The recommendation would also ensure that all Medicaid-enrolled adults have coverage of vaccines that ACIP may recommend in the future, guaranteeing access to appropriate and necessary public health measures in any future pandemic. It would also ensure coverage of the COVID-19 vaccine without cost sharing once the requirements under the American Rescue Plan Act (ARPA, P.L. 117-2) expire one year after the public health emergency ends.

Ensuring equal coverage of all recommended vaccines for Medicaid enrollees would promote public health and reduce racial and ethnic disparities within the program. Vaccines prevent illness, hospitalization, and death, and they also reduce the spread of disease in communities. Mandating coverage of recommended vaccines would help reduce VPDs, particularly for communities of color, since they are less likely to have broad coverage of vaccines.

Expanded coverage would also address the economic costs of VPDs. One study found that VPDs cost the United States approximately $9 billion annually, and another study estimated the annual cost for influenza, alone, was $16 billion (Ozawa et al. 2016, McLaughlin et al. 2015). While there is limited research on the cost of VPDs to Medicaid specifically, researchers estimated in the first 19 months of a hepatitis A outbreak in West Virginia, related medical costs ranged from $1.4 million to $5.6 million. As of February 2021, the outbreak was still ongoing and had resulted in hospitalizations for about half of the individuals with hepatitis A and 23 reported deaths (Batdorf et al. 2021).

The Commission initially discussed including vaccines in the Medicaid Drug Rebate Program (MDRP) as a way to expand coverage of adult

vaccines. While coverage under the MDRP would essentially mandate coverage and apply a statutory rebate on vaccines, some adults could still face cost sharing barriers that do not exist for other adults in the program or with other forms of coverage. Instead, making vaccines a mandatory benefit offers consistency of coverage across populations.

Implications

Federal spending. Requiring coverage of recommended vaccines for all Medicaid-enrolled adults would increase federal spending. The Congressional Budget Office (CBO) estimates that this recommendation would increase federal spending by $250 to $750 million in the first year and $1 to $5 billion over five years, compared with the current baseline.

States. In a CDC survey, all 49 states surveyed offered some vaccine coverage for adults, and 24 states covered all ACIP-recommended vaccines. Under this policy, we would not expect any change in spending for those 24 states that already offer coverage of all ACIP-recommended vaccines. For the remaining states that currently do not cover all recommended vaccines, we would expect to see an increase in spending for those vaccines not previously covered. However, almost all of these remaining states cover 10 or more vaccines currently and would only need to add coverage for an additional 1 to 3 vaccines. Twelve state Medicaid programs cover 12 of the 13 recommended vaccines, and 10 states cover 10 or 11 vaccines (Granade et al. 2020).

Fifteen states surveyed indicate that they place cost sharing requirements on some vaccines (Granade et al. 2020). This would no longer be allowed. The effect would result in a slight increase in state spending. We do not have information on how this policy would affect spending on vaccine-preventable illnesses and hospitalizations.

Enrollees. Under this recommendation, all Medicaid beneficiaries would have coverage of ACIP-recommended vaccines. Vaccine coverage would no longer vary by eligibility category, state, and

vaccine. Those standing to gain coverage include adults eligible on the basis of disability, those age 65 and older, parents and caretaker relatives, and pregnant women. In addition, it would result in more comprehensive coverage of the HPV, Hib, and herpes zoster (shingles) vaccines (Granade et al. 2020). This recommendation would also remove confusion for beneficiaries who may be unsure about what vaccines are covered by Medicaid.

Plans. Plans would be required to offer coverage of all ACIP-recommended vaccines without cost sharing. States would estimate the expected change in utilization and build this estimate into managed care capitation rates.

Providers. The current vaccine coverage requirements in Medicaid can be confusing for providers. It can be unclear whether a Medicaid enrollee has coverage of a recommended vaccine, and as a result, this could be leading to fewer vaccinations for Medicaid beneficiaries overall. Equalizing vaccine coverage requirements across eligibility groups would remove uncertainty and allow providers to focus on whether patients need vaccines based on clinical indications rather than coverage status.

Recommendation 3.2

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).

Rationale

Throughout the Commission's work on vaccine access, low provider payment rates were commonly cited as a reason for low vaccination rates. Low Medicaid payment rates may discourage some providers from administering vaccines and thus reduce access for beneficiaries, a concern

supported by the research literature (Granade et al. 2020, Lindley et al. 2018).

Medicaid statute requires that payments are consistent with efficiency, economy, and quality of care and are sufficient to provide access to providers similar to that available to the general population in the geographic area (§ 1902(a)(30)(A) of the Social Security Act). Although states generally have flexibility in setting payment rates and determining whether these rates are sufficient for access, CMS has implemented payment regulations for certain services. For example, for outpatient prescription drugs, CMS requires states to pay providers based on the actual prices available in the marketplace (CMS 2016). Federal regulations require that the payment methodology for prescription drugs in the state plan reflect actual acquisition costs (AAC) (i.e., the agency's determination of the pharmacy providers' actual prices paid to acquire drug products) and a professional dispensing fee to cover reasonable costs associated with dispensing the drug to a Medicaid beneficiary (42 CFR 447.518(a)(2)).[7]

Because vaccines are excluded from the definition of covered outpatient drugs used for inclusion in the MDRP, these payment regulations do not apply to vaccines. However, vaccines are analogous to prescription drugs in that providers must purchase vaccines from drug wholesalers or manufacturers and have little control over the price of these products. If Medicaid payment is not sufficient to cover the acquisition cost of these vaccines, providers will experience a financial loss and may choose to not offer vaccines. Furthermore, the prices for vaccines are not constant and may increase over time. If states do not update the fee schedule periodically to account for these price changes, then providers may face a larger shortfall between the cost of the vaccine and the payment received from Medicaid. Paying at AAC would ensure that providers do not lose money on the purchase of vaccines for the Medicaid population.

Additionally, the outpatient prescription drug regulations set AAC and a professional dispensing

fee as an upper payment limit to ensure that states do not pay excessively for drugs (42 CFR 447.512(b)). Some states may be paying more than the private sector price for some vaccines. For example, the median Medicaid payment for pneumococcal vaccines and some hepatitis B vaccines was greater than the private sector price (Granade et al. 2020).[8]

This recommendation aims to ensure adequate payment for providers by addressing concerns related to both vaccine acquisition and administration payments. Consistent with federal regulations for prescription drugs, states would pay AAC to cover the cost of the vaccines and a professional fee for administering the vaccine. The professional administration fee would cover reasonable costs associated with vaccination.

Ensuring adequate payment rates could increase provider willingness to deliver vaccines, thus improving access. This recommendation would ensure payment adequacy by aligning vaccine payment methodologies with those of other prescription drugs. It would ensure that vaccine payment is comparable to prevailing market prices and not over- or underpay providers for the acquisition of vaccines. Furthermore, providers have additional costs beyond the time and labor associated with patient care such as special storage and handling requirements (e.g., refrigerator or deep freezer) and recording vaccinations into an IIS. Aligning vaccine administration payment methodology to a definition similar to that of a professional dispensing fee would help ensure that payment covers all reasonable costs for administering a vaccine.

During the Commission's deliberations, it also considered another approach to addressing concerns about payment adequacy: allowing providers to purchase vaccines at a federally contracted price similar to the approach used by CDC when it negotiates contracts with vaccine manufacturers for the Vaccines for Children and the Section 317 Immunization programs. In short, such a policy would address payment

adequacy concerns by reducing the purchase cost burden on providers. However, it could be operationally complex to implement this policy option since providers would need to receive a discount directly or indirectly from the vaccine manufacturer that is equal to the discount negotiated under the federal contract.

Ultimately, many Commissioners viewed this policy as operationally complex with an uncertain effect. However, nothing in this recommendation would prevent states from pursuing discounts or rebates with drug manufacturers to reduce the net cost of vaccines to the state. For example, Rhode Island has implemented a universal statewide purchasing program for all child and most adult vaccines. Under the program, the state has reduced costs by negotiating bulk purchasing at federal contract rates.[9]

Implications

Federal spending. Implementing payment regulations for vaccines and their administration would increase federal spending in some states. Current Medicaid regulations do not set a minimum standard for the vaccine payment or administration, a policy inconsistent with that for other prescription drugs. Based on the existing literature, several states are paying rates that cover neither the average acquisition cost for several vaccines nor the provider's cost of administration. CBO did not provide a score because it views this recommendation as an administrative action that CMS can implement under existing law.

States. Similar to federal spending, state spending would increase in some states. This policy could also increase the administrative burden on states if they need to conduct a survey to determine the average acquisition cost for vaccines and a study to determine the cost to administer vaccines.

Enrollees. By improving payment adequacy, more Medicaid-enrolled providers may choose to store and administer vaccines for Medicaid enrollees. As a result, beneficiaries may have greater access to recommended vaccines.

Plans. Plans would not be required to use the payment methodology described under these federal rules. Plans are required to make payments sufficient to ensure appropriate access. States could use the directed payment option allowable under managed care regulations to establish minimum payment requirements for managed care plans for vaccines and their administration.

Providers. This recommendation would increase payment for many providers and would provide greater certainty that they would receive adequate payment to cover their costs. Depending on a state's existing fee schedules, it is possible that some providers could be paid less for some vaccines as payment would not be allowed to exceed AAC and a professional administration fee.

Recommendation 3.3

The Centers for Medicare & Medicaid Services should issue federal guidance encouraging the broad use of Medicaid providers in administering adult vaccinations.

Rationale

Vaccine access could be improved by making vaccines available in more settings and from more providers. During MACPAC interviews, experts noted the success of allowing COVID-19 vaccination administration at multiple locations and commented that other adult vaccinations should be similarly accessible for adults.

Some states do not allow pharmacists to bill for vaccines for Medicaid-enrolled adults. A few states changed their policies to allow pharmacists to administer and bill for the COVID-19 vaccine and are considering expanding the scope of allowable services provided by pharmacists and pharmacy technicians to allow for the administration of additional vaccines. However, state scope of practice laws may limit the types of vaccinations or the populations that can receive vaccines at pharmacies, and it would require state legislation to make these changes.

During the COVID-19 pandemic, the Secretary of the U.S. Department of Health and Human Services (the Secretary, HHS) issued a PREP Act declaration that allowed a wide range of health professionals, including qualified pharmacy technicians, emergency medical technicians, physician assistants, and midwives, to administer COVID-19 vaccines.[10] Additionally, the Secretary has allowed state-licensed pharmacists, and pharmacy interns or technicians acting under supervision of such pharmacists, to administer vaccines for children age 3 through 18 and seasonal influenza vaccines to adults (ASPR 2022). States could assess how the PREP Act declaration increased vaccine access and to what extent some of these additional providers should be allowed to administer and bill for other adult vaccines.

States can use existing authority to expand the types of providers eligible to administer and bill for vaccinations, but federal guidance could encourage additional states to adopt or expand these policies. This recommendation would be strengthened if enacted with policies to ensure adequate payment; even if states allow a wider range of providers to administer vaccines, providers may not opt to participate if the payment is not adequate to cover their costs. Because Medicaid payment rules for federally qualified health centers (FQHCs) differ from those of other providers, states should also consider working with FQHCs to address potential barriers that prevent them from increasing adult vaccinations.

Implications

Federal spending. The CBO did not score this recommendation because states already have the authority to determine the types of providers able to administer and bill Medicaid for vaccines. Depending on how states respond to this guidance, federal spending could increase. The extent to which federal spending increases is challenging to predict and would depend on the extent to which states expand scope of practice and vaccination rates subsequently increase.

States. State spending would increase as vaccinations increase. States could incur some administrative burden if they need to submit state plan amendments or enroll new providers into the program.

Enrollees. Beneficiary access to vaccinations would improve if new providers begin to administer vaccines. This recommendation could address racial disparities if the expanded provider network serves a greater share of people of color or underserved geographic areas.

Plans. To the extent that there are any state laws limiting the scope of practice of certain providers from administering vaccinations, this policy could allow health plans to expand their provider networks.

Providers. Some providers may be able to expand the scope of their services to include vaccinations.

Recommendation 3.4

The Secretary of the U.S. Department 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.

Rationale

Beneficiary advocates and other experts have noted that federal and state agencies could be doing more to educate and encourage Medicaid and CHIP enrollees to become vaccinated. The COVID-19 pandemic has highlighted the need for public health infrastructure to provide education on the benefits of vaccines and conduct outreach to address growing vaccine hesitancy. Because this messaging could be directed by different federal

agencies, the Secretary should coordinate efforts to avoid duplication and identify ways for state Medicaid agencies, public health departments, and immunization programs to target outreach to Medicaid and CHIP beneficiaries.

Several agencies within HHS have functions that relate to vaccinations and could be responsible for funding and activities related to vaccine outreach and education. For example, the CDC oversees national, public awareness campaigns on the importance of vaccines. This includes combatting misinformation and providing evidence-based information to help increase vaccination rates. Recently, Congress passed the Consolidated Appropriations Act, 2022 (P.L 117-103), which required that the Secretary specifically consider pregnant and postpartum women and infants when developing these public awareness campaigns.

Coordinated federal guidance and technical assistance across HHS agencies could help states identify the options that could be used to improve beneficiary education and outreach and the various federal funding streams that may be available (e.g., 317 Immunization Program funding, federal match available for different Medicaid allowable activities). Some of the approaches used to increase vaccinations for COVID-19 could be applied to other recommended vaccines. The guidance could detail how states can partner with managed care plans and trusted, community-based organizations for targeted educational or outreach campaigns. For example, this could include how state Medicaid programs could use existing managed care contracting tools (e.g., withholds, performance improvement projects, bonuses) to achieve higher vaccination rates among adult enrollees. CMS can provide guidance and examples of how states could use existing Medicaid authorities such as Section 1115 demonstration waivers to fund these types of public health initiatives.

Implications

Federal spending. CBO did not score this recommendation because states already have the authority to implement education and outreach programs to encourage vaccinations. Depending on how states respond to this guidance, federal spending could increase. The extent to which it might increase vaccinations is challenging to predict and would depend on which programs states implement and whether they increase utilization of vaccines.

States. Federal guidance could help states identify and tailor vaccine education and outreach programs. Since guidance would be coordinated at the federal level, it would help prevent state Medicaid officials from duplicating efforts of other agencies. State spending could increase, particularly if use of other services such as non-emergency transportation also increases. But states may be able to offset some of that spending by claiming federal match on some activities that were previously funded with state-only dollars or by leveraging MCOs to provide some of these programs through non-benefit spending or value-added services.

Enrollees. Additional outreach and education could result in more beneficiaries receiving recommended vaccines. For adults, the vaccine schedule is somewhat complex and based on multiple factors including age, medical conditions, and vaccine history. For example, some vaccines such as the influenza vaccine are universal for adults, while others, such as the pneumococcal vaccine, are dependent on risk factors and age. Outreach efforts can supplement the provider's role in educating beneficiaries and help remind beneficiaries when they become eligible for a recommended vaccine. These efforts could also be tailored to address racial and other disparities if the state focuses additional resources on barriers that disproportionately affect people of color and other underserved communities.

Plans. Federal guidance is likely to include options on how states could effectively work with managed care plans to improve outreach and education on vaccines. Some of these options could include performance incentives to encourage plans to improve the vaccination rate among its members.

Providers. Providers play an important role in ensuring that beneficiaries receive recommended vaccines. Any federal guidance is likely to include options that support provider-led efforts to provide vaccine education and targeted outreach.

Recommendation 3.5

Congress should provide additional federal funds to improve immunization information systems (IIS). In addition, Congress should require the Secretary of the U.S. Department 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.

Rationale

IIS improvements will be needed for these systems to support vaccination efforts for adults; this includes both financial investments to help states and localities make system changes as well as guidance and standards to improve interoperability across providers and states. States have implemented different functional standards based on their specific priorities and resources available, and many have not achieved full functional standardization (NGA 2021). Additionally, IIS improvements would support broad public health functions and benefit all payers, not just Medicaid. This has become increasingly important as more adults receive routine vaccinations from their pharmacists and other providers outside

of a medical home. As such, Congress should allocate additional federal funding for IISs and interoperability improvements.[11]

Congress should direct the Secretary to coordinate efforts within the relevant agencies and develop and refine guidance and standards to improve IISs. Several HHS agencies have functions that relate to vaccination strategy and operations of IIS. The Office of the Assistant Secretary for Health (OASH) oversees key public health offices and programs, including the Office of Disease Prevention and Health Promotion and Office of Infectious Disease and HIV/AIDS Policy. OASH released its strategic vaccine plan, which included an objective to strengthen data infrastructure, including IISs, to track vaccine coverage and conduct surveillance of vaccine-preventable diseases. The CDC sets the functional standards for these systems, and state and local governments develop and administer them. The Office of the National Coordinator for Health Information Technology (ONC) develops requirements and standards for health information technology and interoperability between electronic health record (EHR) platforms.

Coordinating federal guidance and technical assistance across HHS agencies would help states and localities identify ways to strengthen their IIS and improve interoperability and bidirectional data exchange with other state systems and EHRs. For example, the Administration for Children and Families and CMS recently published a tool kit on data sharing for child welfare agencies and Medicaid. This tool kit outlines the benefits of data sharing and provides technical assistance regarding data exchange models and legal frameworks for sharing and accessing data, and discusses the process of how states have developed interagency agreements to support this type of exchange (HHS 2022). This guidance and technical assistance could also improve coordination between state Medicaid agencies and public health departments to identify needs and resources to improve IISs. The CDC, OASH, CMS, and ONC could work together to create tool

kits and provide technical assistance on how to successfully structure the integration of the MMIS and IIS and interoperability between provider EHRs and IISs. In addition, the Secretary could ensure that any guidance supports improved collection of race and ethnicity data by IISs. This could help states, MCOs, and providers address racial disparities in vaccinations.

Furthermore, CMS should provide guidance on the matching rates available to state Medicaid programs regarding IISs. Currently, state Medicaid programs can receive a 90 percent federal match rate for the design and development of immunization systems that are part of the state's MMIS and a 75 percent match for its ongoing maintenance.[12] In states in which the IIS is developed, owned, and operated by a public health or other non-Medicaid agency, match is available at 50 percent (HCFA 2000). CMS could provide guidance and technical assistance to help states understand what types of activities may be eligible for the enhanced matching rate as states develop an IIS or make additional improvements to integrate their MMIS and IIS.

Implications

Federal spending. This recommendation would increase federal spending by the amount provided by Congress. Federal Medicaid spending could increase for some states if they make changes to their MMIS and IIS that allow them to access a higher matching rate. Additionally, federal Medicaid spending could increase to the extent that state activities improve vaccination rates, but this is difficult to quantify.

States. This recommendation would help states to improve their IIS and take advantage of additional federal funding. It would increase state spending if states need to make system changes. However, over the long term, this could reduce state spending if the state can claim the 75 percent federal match for ongoing maintenance instead of the regular 50 percent match if the IIS is operated by a non-Medicaid agency. This policy

could be operationally complex to implement depending on the system changes that would be required to integrate the MMIS and IIS and develop interoperability with provider EHRs.

Enrollees. An improved IIS would offer providers a more complete and accurate record of a beneficiary's immunization history, which would help ensure that beneficiaries receive appropriate vaccines. It could also facilitate targeted outreach and reminders and increase the likelihood that beneficiaries receive recommended vaccines.

Plans. Plans could benefit if states make IIS improvements that allow or improve exchange of information with their providers. Plans could better target their outreach to get their enrollees vaccinated.

Providers. If the federal guidance leads to improvements in IISs, it would be easier for providers to identify which vaccines are needed for their patients, to target messaging to their patients, and to enter vaccination records into the IIS.

Next Steps

Vaccinations play a critical role in promoting public health and preventing costs to people and the health care system in terms of unnecessary illness, hospitalization, and death. Adoption of the recommendations discussed previously have the potential to improve the currently low rates of vaccination among Medicaid-enrolled adults. Expanding coverage, improving payment, and providing outreach would also address current inequities across states and Medicaid eligibility groups.

Looking ahead, the Commission will also monitor issues related to childhood vaccination. Evidence suggests that vaccination rates for routine childhood immunizations have declined since the start of the COVID-19 pandemic (Murthy et al. 2021). The Commission may consider future work that will examine these trends and better

understand the specific challenges affecting children enrolled in Medicaid and CHIP.

Endnotes

[1] MACPAC uses the term "pregnant women" as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women. Vaccine coverage may be mandated through other requirements such as the early and periodic screening, diagnostic, and treatment (EPSDT) benefit for adults 19 to 20 years old or if provided as part of pregnancy-related care (KFF 2017).

[2] This applies to all health insurance plans offered on the exchange and non-grandfathered plans.

[3] In response to the COVID-19 pandemic, Congress passed legislation to ensure that all Medicaid beneficiaries have coverage of COVID-19 vaccines during the public health emergency and for a period of time thereafter. The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) made coverage of COVID-19 vaccines and the administration of such vaccines mandatory for the period ending on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 public health emergency (§ 9811(a)(1) of ARPA). During this period, cost sharing is prohibited for COVID-19 vaccines and the administration of such vaccines (§ 9811(a)(3) of ARPA).

[4] In fiscal year 2019, approximately 51.8 million adults were enrolled in Medicaid, of which 19.5 million (37.6 percent of adults) were in the new adult group and had mandatory coverage of vaccines without cost sharing (MACPAC 2021c). An additional 12.5 million adults (24.1 percent of adults) were dually eligible for Medicare and Medicaid and would have received vaccine coverage through Medicare.

[5] Based on our analysis of 26 states with usable race and ethnicity data in the Transformed Medicaid Statistical Information System (T-MSIS) (representing 65 percent of Medicaid and CHIP enrollment nationally), white, non-Hispanic individuals account for 44 percent of the new adult group but only 36 percent of all other enrollees. Black, non-Hispanic individuals account for a smaller share of the

new adult group (19 percent) than all other enrollees (23 percent). Hispanic individuals account for 27 percent of the new adult group but 35 percent of all other enrollees.

[6] This recommendation is similar to a provision included in H.R. 5376, the Build Back Better Act, which passed the U.S. House of Representatives on November 19, 2021. At the time of this writing, the U.S. Senate has not yet acted on this legislation. The bill would extend the requirement to cover recommended vaccines without cost sharing to all adults in Medicaid except that the bill would also phase out the 1 percentage point increase in the federal medical assistance percentage (FMAP) on vaccines and their administration available under Section 4106 of the ACA. The Commission has not recommended changes in the FMAP.

[7] Medicaid managed care plans are not required to pay for ingredient costs based on AAC but must make payments sufficient to ensure appropriate access for their enrollees (CMS 2016).

[8] This may be particularly true if states are following Medicare Part B payment principles, which pay for preventive vaccines at 95 percent of average wholesale price. The Medicare Payment Advisory Commission has found that the average wholesale price-based formula exceeds other measures of acquisition cost such as wholesale acquisition cost or average sales price used to determine payment for all other Part B drugs and has recommended that Medicare payment be based on wholesale acquisition cost or average sales price to more accurately reflect the market price and providers' costs to acquire the drug (MedPAC 2021).

[9] The Rhode Island Vaccine Assessment Program (RIVAP) is funded through assessments paid by most payers (e.g., health plans and third-party administrators) and Medicaid MCOs. RIVAP purchases vaccines at a discounted bulk rate and distributes them statewide to providers at no cost. Providers bill only for the administration cost. The Vaccine for Children program funds and provides vaccines for eligible children (RIVAP 2015).

[10] The Public Readiness and Emergency Preparedness Act (PREP Act, P.L. 109-148) authorizes the Secretary of the U.S. Department of Health and Human Services (the Secretary, HHS) to issue a declaration that provides immunity from liability arising from specified efforts to combat a disease or threat. On March 10, 2020, the Secretary issued a

PREP Act declaration establishing that the COVID-19 pandemic constitutes a public health emergency warranting liability protections for the administration of medical countermeasures against COVID-19. Under subsequent amendments to the declaration, HHS has allowed a wide range of health professionals, including qualified pharmacy technicians, emergency medical technicians, and midwives, to administer COVID-19 vaccines. Additionally, the Secretary has allowed state licensed pharmacists—and pharmacy interns or technicians acting under supervision of such pharmacist—to administer childhood vaccines for children age 3 through 18 or seasonal influenza vaccines to adults. The PREP Act declaration expressly preempts any state or local law that prohibits any covered persons who satisfy the requirements from ordering or administering COVID-19 vaccines, childhood vaccines, or seasonal influenza for adults. The PREP Act declaration extends protection for covered COVID-19 countermeasures through October 1, 2024 (ASPR 2022).

[11] For example, the U.S. House of Representatives passed H.R. 550, the Immunization Infrastructure Modernization Act of 2021, on November 30, 2021. The bill directs the Secretary to award grant funding to improve state and local IISs, among other things. The Secretary would establish funding criteria with a focus on achieving standardization. This bill authorizes $400 million in federal spending. This bill has not yet been considered in the Senate.

[12] Under the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act, Title XIII of P.L. 111-5), states were eligible to receive a 90 percent match through HITECH funding to plan, design, develop, and implement systems that connect health care providers to IISs (ASTHO 2018). However, HITECH funding is not available after 2021.

References

Association of Immunization Managers (AIM). 2020. *Feasibility of using immunization information systems to assess immunization levels in Medicaid programs.* Rockville, MD: AIM. https://web.archive.org/web/20200922010021/ https://cdn.ymaws.com/www.immunizationmanagers.org/ resource/resmgr/publications/using_iis_to_assess_iz_in_ me.pdf.

American Immunization Registry Association (AIRA). 2021. *Landscape analysis: IIS adult vaccination data capture and data utilization.* Washington, DC: AIRA. https://repository. immregistries.org/files/resources/60958446cdad0/ adultlandscape_final.pdf.

American Immunization Registry Association (AIRA). 2020. *Literature review: An environmental scan on progress, challenges, and opportunities: Expanding immunization information systems for adults in the United States.* Washington, DC: AIRA. https://repository.immregistries.org/ files/resources/60395f6d24178/aira_adult_iis_literature_ review.pdf.

Association of State and Territorial Health Officials (ASTHO). 2018. *Medicaid 90/10 funding fact sheet for immunization information systems.* Arlington, VA: ASTHO. https://www. astho.org/Immunization/Documents/Medicaid-90-10- Funding-Fact-Sheet-for-Immunization-Information-Systems/.

Batdorf, S.J., M.G. Hofmeister, T.C. Surtees, et al. 2021. Estimated Medicaid costs associated with hepatitis A during an outbreak—West Virginia, 2018–2019. *Morbidity and Mortality Weekly Report* 70, no. 8. https://www.cdc.gov/ mmwr/volumes/70/wr/pdfs/mm7008a2-H.pdf.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021a. Vaccine-preventable adult diseases. Atlanta, GA: CDC. https://www. cdc.gov/vaccines/adults/vpd.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021b. Flu vaccine safety and pregnancy. Atlanta, GA: CDC. https:// www.cdc.gov/flu/highrisk/qa_vacpregnant.htm.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021c. Tdap (pertussis) vaccine and pregnancy. Atlanta, GA: CDC. https:// www.cdc.gov/vaccines/pregnancy/hcp-toolkit/tdap-vaccine-pregnancy.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021d. 2020 IISAR data participation rates. Atlanta, GA: CDC. https:// www.cdc.gov/vaccines/programs/iis/annual-report-iisar/2020-data.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2020. Estimated

influenza illnesses, medical visits, and hospitalizations averted by vaccination in the United States—2019–2020 influenza season. Atlanta, GA: CDC. https://www.cdc.gov/flu/ about/burden-averted/2019-2020.htm.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Biden-Harris administration increases Medicare payment for life-saving COVID-19 vaccine. March 15, 2021, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/ press-releases/biden-harris-administration-increases-medicare-payment-life-saving-covid-19-vaccine.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Medicaid program; covered outpatient drugs. Final rule. *Federal Register* 81, no. 20 (February 1): 5170–5357. https://www. gpo.gov/fdsys/pkg/FR-2016-02-01/pdf/2016-01274.pdf.

Granade, C., R. McCord, A. Bhatti, et al. 2021. Availability of adult vaccination services by provider type and setting. *American Journal of Preventive Medicine* 60, no. 5: 692–700. https://pubmed.ncbi.nlm.nih.gov/33632648/.

Granade, C., R. McCord, A. Bhatti, et al. 2020. State policies on access to vaccination services for low-income adults. *JAMA Network Open* 3, no. 4: e203316. https://jamanetwork. com/journals/jamanetworkopen/fullarticle/2764810.

Health Care Financing Administration (HCFA). 2000. Letter from Timothy Westmoreland to state Medicaid directors regarding "Development of immunization registries as a component of the Medicaid Management Information System (MMIS)." July 6, 2000. https://www.medicaid.gov/ federal-policy-guidance/downloads/smd070600.pdf.

Kaiser Family Foundation (KFF). 2017. *Data note: Medicaid's role in providing access to preventive care for adults.* Washington, DC: KFF. http://files.kff.org/attachment/Data-Note-Medicaids-Role-in-Providing-Access-to-Preventive-Care-for-Adults.

Krishnarajah, G., C. Carroll, J. Priest, et al. 2014. Burden of vaccine-preventable disease in adult Medicaid and commercially insured populations. *Human Vaccines & Immunotherapeutics* 10, no. 8: 2460–2467. https://www. ncbi.nlm.nih.gov/pmc/articles/PMC4896801/pdf/khvi-10-08-10929303.pdf.

Leidner, A., N. Murthy, H. Chesson, et al. 2019. Cost-effectiveness of adult vaccinations: A systematic review. *Vaccine* 37, no. 2: 226–234. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6545890/.

Lindley, M., L. Hurley, B. Beaty, et al. 2018. Vaccine financing and billing in practices serving adult patients: A follow-up survey. *Vaccine* 36, no. 8: 1093–1100. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5807000/pdf/nihms937255.pdf.

Lu, P., A. Srivastav, T. Santibanez, et al. 2017. Knowledge of influenza vaccination recommendation and early vaccination uptake during the 2015–16 season among adults aged ≥18 years—United States. *Vaccine* 35, no. 34: 4346–4354. https://www.sciencedirect.com/science/article/pii/S0264410X1730871X.

McLaughlin, J., J. McGinnis, L. Tan, A. Mercatante, and J. Fortuna. 2015. Estimated human and economic burden of four major adult vaccine-preventable diseases in the United States, 2013. *The Journal of Primary Prevention* 36, 4: 259–273. https://pubmed.ncbi.nlm.nih.gov/26032932/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. Chapter 2: Improving vaccine access. In *Report to Congress on Medicaid and CHIP*. March 2022. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-2-Vaccine-Access-for-Adults-Enrolled-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022b. MACPAC analysis of 2018 Transformed Medicaid Statistical Information System (T-MSIS) data.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. Chapter 2: Advancing maternal and infant health by extending the postpartum coverage period. In *Report to Congress on Medicaid and CHIP*. March 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/03/Chapter-2-Advancing-Maternal-and-Infant-Health-by-Extending-the-Postpartum-Coverage-Period.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. Exhibit 2: Characteristics of non-institutionalized individuals by age and source of health coverage. In *MACStats: Medicaid and CHIP data book*. December 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-2.-Characteristics-of-Non-Institutionalized-Individuals-by-Age-and-Source-of-Health-Coverage-2019.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021c. Exhibit 14: Medicaid enrollment by state, eligibility group, and dually eligible status, FY 2019 (thousands). In *MACStats: Medicaid and CHIP data book*. December 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2019-thousands.pdf.

Medicare Payment Advisory Commission (MedPAC). 2021. Chapter 7: Medicare vaccine coverage and payment. In *Report to the Congress: Medicare and the Health Care Delivery System*. June 2021. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch7_medpac_report_to_congress_sec.pdf.

Murthy, B., E. Zell, K. Kirtland, et al. 2021. Impact of the COVID-19 pandemic on administration of selected routine childhood and adolescent vaccinations—10 U.S. Jurisdictions, March–September 2020. https://www.cdc.gov/mmwr/volumes/70/wr/mm7023a2.htm?s_cid=mm7023a2_w.

National Committee for Quality Assurance (NCQA). 2021. Flu vaccinations (FVA, FVO). Washington, DC: NCQA. https://www.ncqa.org/hedis/measures/flu-vaccinations/.

National Governors Association (NGA). 2021. *Modernizing immunization information systems: Priorities and considerations for governors*. Washington, DC: NGA. https://www.nga.org/wp-content/uploads/2021/09/NGA_Modernize_ImmunInfoSystems.pdf.

Office of the Assistant Secretary for Preparedness & Response (ASPR), U.S. Department of Health and Human Services. 2022. Public readiness and emergency preparedness act. Washington, DC: ASPR. https://aspr.hhs.gov/legal/PREPact/Pages/default.aspx.

Ozawa, S., A. Portnoy, H. Getaneh, et al. 2016. Modeling the economic burden of adult vaccine-preventable diseases in the United States. *Health Affairs* 35, no. 11: 2124–2132. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0462.

Rhode Island Vaccine Assessment Program (RIVAP). 2015. RIVAP advisory FAQs. https://www.rivaccine.org/rivaccine.nsf/pages/faqs.html.

Roush, S., T. Murphy, Vaccine-Preventable Disease Table Working Group. 2007. Historical comparisons of morbidity and mortality for vaccine-preventable diseases in the United States. *JAMA Network* 298, no. 18: 2155–2163. https://jamanetwork.com/journals/jama/article-abstract/209448.

Shen, A. 2017. Provider payment for adult immunization. April 19, 2017. Washington, DC: U.S. Department of Health and Human Services, The National Vaccine Program Office. https://www2.cdc.gov/vaccines/ed/pickup/ciinc/2017/CIINC_4_19_2017.pdf.

Tsai, Y. 2018. Payments and utilization of immunization services among children enrolled in fee-for-service Medicaid. *Medical Care* 56, no. 1: 54–61. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5776675/pdf/nihms934513.pdf.

U.S. Department of Health and Human Services (HHS). 2022. Joint publication from the Administration for Children and Families and Centers for Medicare & Medicaid Services. *Toolkit: Data sharing for child welfare agencies and Medicaid.* Washington, DC: HHS. https://www.acf.hhs.gov/sites/default/files/documents/cb/data-sharing-and-medicaid-toolkit.pdf.

Yarnoff, B., D. Kim, F. Zhou, et al. 2019. Estimating the costs and income of providing vaccination to adults and children. *Medical Care* 57, no. 6: 410–416. https://journals.lww.com/lww-medicalcare/Abstract/2019/06000/Estimating_the_Costs_and_Income_of_Providing.5.aspx.

Yoo, B.K., A. Berry, M. Kasajima, and P. Szilagyi. 2010. Association between Medicaid reimbursement and child influenza rates. *Pediatrics* 126, no. 5: e998–e1010. https://publications.aap.org/pediatrics/article-abstract/126/5/e998/65295/Association-Between-Medicaid-Reimbursement-and.

Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 8, 2022.

Acting to Improve Vaccine Access for Adults Enrolled in Medicaid

3.1   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.

3.1 Voting Results	#	Commissioner
Yes	11	Allen, Bella, Brooks, Burwell, Carter, Davis, Duncan, Heaphy, Johnson, Herrera Scott, Weno
No	4	Cerise, Douglas, Gordon, Lampkin
Not Present	1	Scanlon

3.2   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).

3.2 Voting Results	#	Commissioner
Yes	11	Allen, Bella, Brooks, Burwell, Carter, Davis, Duncan, Heaphy, Johnson, Herrera Scott, Weno
No	4	Cerise, Douglas, Gordon, Lampkin
Not Present	1	Scanlon

3.3   The Centers for Medicare & Medicaid Services should issue federal guidance encouraging the broad use of Medicaid providers in administering adult vaccinations.

3.4   The Secretary of the U.S. Department 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.

3.5   Congress should provide additional federal funds to improve immunization information systems (IIS). In addition, Congress should require the Secretary of the U.S. Department 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.

3.3-5 Voting Results	#	Commissioner
Yes	15	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Herrera Scott, Weno
Not Present	1	Scanlon

Chapter 4:

Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

Recommendations

4.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health Information Technology to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health information technology adoption and interoperability.

4.2 The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health Information Technology to jointly develop a voluntary certification for behavioral health information technology.

Key Points

- Delivery systems for physical and behavioral health are often fragmented. This impedes access to care and results in inappropriate or limited use of services, poor health status, and increased costs for persons with behavioral health conditions.

- Adoption of certified health information technology (IT) is one strategy to promote integration. Health IT can improve communication between providers and allow them to electronically retrieve and transfer patient information in real-time.

- Behavioral health providers have adopted IT at lower rates compared with other providers because they were not eligible for federal incentive payments. Current barriers to adoption include the costs of technology and training, challenges related to sharing information about substance use disorder (SUD), and the lack of industry guidelines for behavioral health IT.

- Medicaid programs play a critical role in financing behavioral health services and are increasingly focusing on ways to provide behavioral health in more integrated settings.

- Additional subregulatory guidance is needed on how Medicaid and State Children's Health Insurance Program (CHIP) authorities can be used to encourage health IT adoption for behavioral health providers.

- At the federal level, the Office of the National Coordinator for Health IT (ONC) is charged with providing health IT guidance by developing informational resources that guide providers and developers when implementing health IT for specific settings of care and medical specialties.

- To help providers in the purchase of health IT and to move the market toward better products for behavioral health practice settings, the Substance Abuse and Mental Health Services Administration and ONC should jointly develop a voluntary certification for IT used in behavioral health and integrated care settings to support ongoing integration efforts.

CHAPTER 4: Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

Over the years, the Commission has discussed at length the need to improve integration of care for Medicaid beneficiaries with behavioral health conditions (MACPAC 2021a, 2018, 2017, 2016). The delivery systems for physical and behavioral health care, which encompass practitioners who treat substance use disorder (SUD), mental health conditions, or both, are not integrated with each other. Furthermore, delivery systems for mental health and SUD are also fragmented. In addition, behavioral health treatment is not well coordinated or integrated with treatment for other physical health conditions (MACPAC 2018). This fragmentation impedes access to care and may result in inappropriate or limited use of services, poor health status, and increased health care costs, particularly for persons with behavioral health and chronic health conditions.

Integrating care potentially can improve overall care and reduce spending. Integrating care is of particular concern to the Medicaid program given that its beneficiaries have higher rates of SUD and mental health conditions and have higher rates of other chronic conditions than their privately insured peers (MACPAC 2021a and 2021b). Medicaid is the largest payer of behavioral health services in the United States due to the population it covers and the services it finances.

State Medicaid agencies can play an important role in supporting the integration of care for individuals with behavioral health needs. In our June 2021 report, we focused on one barrier to integration:

the relatively low rates of electronic health records (EHR) and information technology (IT) use among behavioral health providers. The report showed most behavioral health providers were ineligible for federal incentives for EHR adoption under the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH, P.L. 111-5) and documented the low rates of use of these tools among behavioral health providers, particularly relative to the sharp uptick in EHR use among other providers as a result of HITECH (Wolf et al. 2012).

This year, the Commission focused on policy options to strengthen Medicaid's role in encouraging behavioral health providers to adopt health IT. We considered a range of strategies and sought feedback on their merits from state and federal officials, providers, IT vendors, and other experts in the field. In this chapter, we make two recommendations to promote greater use of health IT, which should improve integration of care:

- The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health IT to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability.

- The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health IT to jointly develop a voluntary certification for behavioral health IT.

Guidance on how to deploy existing authorities and federal funding opportunities would help states identify approaches for advancing the adoption and use of health IT for behavioral health providers, furthering integrated care efforts among state Medicaid agencies. In addition, the development of a voluntary certification for IT appropriate for behavioral health and integrated

care practice settings could provide a path toward comprehensive adoption of high-quality behavioral health IT tools, ensuring real-time data sharing and collaboration between behavioral health providers and virtually all hospitals and physicians.

This chapter begins by reviewing the implications of poorly integrated care for behavioral health and outlining how health IT can foster more integrated care through patient data sharing. Next, the major barriers to EHR adoption in behavioral health are described. The chapter concludes with recommendations to address Medicaid's role in supporting health IT adoption and state care integration efforts, noting that Medicaid authorities could be used to promote behavioral health IT adoption and could be deployed more effectively with improved guidance and instructions from the Centers for Medicare & Medicaid Services (CMS). We also note the need for federal actions to provide clarity regarding health IT standards and functions in EHRs to facilitate behavioral health integration (Box 4-1).

Benefits of Clinical Integration and Health Information Technology

As noted above, Medicaid beneficiaries have higher rates of mental health conditions and SUD and experience other chronic conditions at higher rates than their privately insured peers (MACPAC 2021a and 2021b).[1] Individuals with mental illness have worse health outcomes and die 32 years earlier when compared to the general population (Roberts et al. 2017, NASMHPD 2012). The COVID-19 public health emergency has underscored these vulnerabilities, as persons with mental health conditions and SUD face even greater mortality and morbidity risks due to COVID-19 (Fond et al. 2021, Das Munshi et al. 2021, Wang et al. 2020). Additionally, MACPAC has found there are significant disparities in unmet need for behavioral health services; beneficiaries with a mental illness who

identify as Black, Hispanic, or Asian American receive treatment at lower rates compared to those that identify as white (MACPAC 2021b).

Greater sharing of clinical information between behavioral and physical health providers can improve care among adults with mental illness. (Gilmer et al. 2016, NASEM 2020, PCC 2022). For example, when providers are unable to share information about their patients, gaps in knowledge may lead to conflicting treatments, such as prescribing medications with potentially dangerous or even deadly interactions with other medications (MACPAC 2018).

EHRs can foster clinical integration through data sharing, care coordination, and referral to treatment across the continuum of care (MACPAC 2021a). They can promote coordinated care by allowing clinicians to readily update patient health information and distribute that information to authorized providers working in other settings (Falconer et al. 2018). While EHRs on their own do not integrate patient care, the ability to share information among providers and between providers and patients is an important step toward this goal.

Increased provider adoption of certified health IT and certified EHR technology is one strategy to improve integration of care.[2] Certified health IT improves communication between providers and allows them to electronically retrieve and transfer patient information, often in real-time. However, the costs associated with certified EHR technology and the unique needs of behavioral health providers represent significant barriers to adoption with only 6 percent of mental health facilities and 29 percent of substance use treatment centers using an EHR, compared to more than 80 percent of hospitals (MACPAC 2021a, ONC 2017, Henry et al. 2016). Behavioral health providers are thus less likely to send and receive patient information with those providing other health services and many continue to rely on phone, paper, or fax. This can lead to missed opportunities to provide integrated services and improve quality of care for Medicaid beneficiaries.

The Commission previously has noted the benefits of certified EHR technology adoption in behavioral health integration efforts, and the extent to which health IT addresses other issues of concern. Namely, certified EHR technology facilitates:

- connections to state health information exchanges (HIE);

- participation in value-based arrangements; and

- provider data submissions that are necessary for the state to calculate quality measures in the Medicaid Adult and Child Core Sets (MACPAC 2021a, MACPAC 2020c).

Barriers to Certified Health IT Adoption Among Behavioral Health Providers

The barriers to certified health IT and certified EHR technology adoption are multifaceted but mainly fall into three areas, including the significant cost implications of EHR adoption, the unique challenge associated with SUD privacy protection outlined under 42 CFR Part 2 (Part 2), and the lack of clear guidelines to ensure that health IT tools can meet the needs required in behavioral health practice settings.[3]

BOX 4-1. Key Health Information Technology (IT) Terms

Standards: The common language and common set of expectations that enable different systems to interact with each other. Standards permit clinicians, labs, facilities, and patients to share data regardless of the application or market supplier (HIMMS 2022). The Office of the National Coordinator for Health Information Technology (ONC) is responsible for updating standards and specifications to support interoperability and different health information exchange scenarios. These standards are outlined in the Interoperable Standards Advisory (ISA) (ONC 2019a).

Function: Specific capabilities that an electronic health record (EHR) or an IT system should possess to document and share patient care. Examples include providing immediate access to health information and data; giving patients access to their health records; data storage that is amenable to federal, state, and private reporting; and clinical decision support tools (IOM 2003).

Interoperability: The ability of different information systems, devices, and applications to access, exchange, integrate, and cooperatively use data in a coordinated manner, within and across organizational and geographic boundaries, to provide timely and seamless portability of information and improve the health of individuals and populations (HIMMS 2022).

The 21st Century Cures Act (Cures Act, P.L. 114-255) also created a statutory definition for interoperability that states that health IT is interoperable when it:

- enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user;

- allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable state or federal law; and

- does not constitute information blocking.

Costs

Behavioral health providers report that the cost of purchasing, installing, and training staff is the principal barrier to certified health IT uptake (NASMHPD 2018).[4] Such costs are significant, especially for solo practitioners and those in small practices as well as for state behavioral health agencies with limited budgets (NASMHPD 2018).[5] Many hospitals and physicians received federal incentive payments for EHR adoption under the HITECH Act, and could be eligible for almost $64,000 over a six-year period per individual eligible provider, and almost $15 million over a four-year period for eligible hospitals.[6] Behavioral health providers and facilities, with the exception of physicians and some nurse practitioners, were not included in this effort.[7]

Due to narrow operating margins, behavioral health providers often have little capital available to invest in the expensive hardware, software, and training needed to use EHRs (MACPAC 2016). The COVID-19 pandemic has further strained provider finances despite increased demand for services. Furthermore, a national crisis hotline will be implemented in 2022, which may further increase demand for behavioral health services across the care continuum (NAMI 2021, Eder 2022, MACPAC 2021b). The National Council for Mental Wellbeing's April 2021 survey found that 40 percent of behavioral health organizations only can maintain their operations for a year due to financial issues (NCMW 2021).[8]

In addition to the costs of the technology itself, there are significant costs associated with training providers to meaningfully use an EHR and high demand for technical assistance. For many behavioral health providers, sharing information electronically will require major shifts in how they operate, for example, adopting new practice workflows that integrate technology (AmeriHealth Caritas 2021, Covered California 2021, NYeC 2021). Addressing the privacy-related concerns related to sharing information about SUD data protected by Part 2 also may create additional costs, as providers may need to establish how to share these records and hire legal counsel to update privacy practice notifications and disclosure and redisclosure consent documentation (OHA 2021).[9]

SUD patient information

Another key challenge for providers is segmenting, or restricting access to SUD information, while sharing the rest of the patient record. Federal health IT certification requirements were designed to support compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) and its implementing regulations (45 CFR Part 160 and Part 164, subparts A and E), which govern the use and disclosure of individually identifiable health information (i.e., information related to all health conditions, health care services, or payment) (Box 4-2).[10] HIPAA generally allows information to be shared without patient consent among providers and payers for payment, treatment, and health care operational purposes.[11] Certified health IT provides assurances that the product supports compliance with HIPAA and allows for the seamless sharing of patient records.

In contrast, SUD treatment information created, received, or acquired by Part 2-covered providers is subject to additional requirements that affect information sharing among providers. Specifically, Part 2 does not allow for the disclosure or redisclosure of protected SUD information for treatment purposes from Part 2-covered providers without written consent from the patient. This protection overrides the HIPAA information sharing provision. As such, Part 2-covered providers must obtain patient consent to disclose and redisclose such records, including for care coordination and case management.[12] To support compliance with Part 2, health IT must be able to segment Part 2-protected SUD treatment information from the rest of a patient's health record.[13] While data tagging and segmentation capabilities have been developed, they have not been widely incorporated into certified EHR technology used by many Medicaid-enrolled providers.[14]

Changes in federal privacy laws may make it easier for providers to share this information. The

Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) aligned the statutory basis for Part 2 more closely with HIPAA. Among other things, it permits providers to obtain a single patient consent for all future disclosures of SUD records for treatment, payment, and health care operations. The CARES Act allows Part 2-covered entities and business associates that receive Part 2 records to redisclose it in accordance with HIPAA. Under HIPAA and Part 2, patients have the right to request a restriction on the use of SUD records for treatment, payment, or health care operations, and the CARES Act requires Part 2-covered providers to make every reasonable effort to comply with a patient's request.[15]

Although the CARES Act takes steps to advance data sharing among SUD treatment providers, EHRs and connected information exchanges used by behavioral health providers will continue to require data segmentation capabilities because individuals still can request restrictions on use of their treatment records. Moreover, in addition to being subject to HIPAA, other sensitive health data (e.g., related to HIV/AIDS, mental health, substance use, reproductive health, and domestic violence) also may be subject to state laws or other federal laws mandating heightened disclosure or redisclosure protections (OCR 2017). For this reason, it is essential for IT in settings where behavioral health services are provided to have standards that support consent management, security labeling, and segmentation for access, exchange and use of health information at a document, section, or data element level.

Lack of clear guidelines for behavioral health IT

The HITECH Medicaid EHR adoption incentives spurred a large and active vendor market, especially for office-based practices (Gold 2016).[16] This allowed providers to choose an EHR that was affordable and met their specific clinical needs. However, there were drawbacks. Due to the extensive choice of products available, it took an

informed provider to purchase the right EHR for a specific practice. In some cases, providers chose EHRs that met their initial needs but later turned out to be insufficient for subsequent reporting needs (Gold 2016). To partially address this, the 21st Century Cures Act (Cures Act, P.L. 114-255) was passed in 2016 to give the U.S. Department of Health and Human Services (HHS) more authority in limiting the spread of EHRs and health IT that block information sharing (Lye et al. 2018).

Currently, voluntary certifications for IT exist for other practice settings (e.g., pediatric practices), but not for behavioral health. Based on a set of specifically appropriate criteria, a voluntary certification from ONC would help behavioral health providers understand what to look for in an EHR and also send a signal to the market that certain features are desirable for behavioral health practice settings (Box 4-2). As noted above, behavioral health providers need different privacy and clinical tools within their EHR compared to physical health providers, functions that may not be supported by many EHRs certified based on the current ONC health IT certification criteria. For example, these include Part 2-related segmentation capabilities and capturing standardized information about plans of care, encounter notes, or patient-directed goals. Although some currently available behavioral health IT may have some of these functions, they may not capture this information in a way that promotes interoperability and supports clinical decision making (Partnership for HITPS 2021).

Voluntary certification for behavioral health also would be useful for primary care providers, particularly as Medicaid agencies encourage integration of primary care, mental health care, and SUD treatment (NAMD 2021). Primary care providers should have some of these behavioral health functions in their EHR because of their own need to integrate and communicate effectively with behavioral health providers (Partnership for HITPS 2021). Voluntary certification would help primary care providers know how to upgrade their systems to support integrated care models.

BOX 4-2. Office of the National Coordinator for Health Information Technology (ONC) Certification Program, Voluntary Certification for Practice Settings, and Interoperability Standards Advisory (ISA)

The ONC Certification Program and ONC Interoperability Standards Advisory (ISA) includes health information technology (IT) standards and functions that support behavioral health care delivery, including those for capturing and tagging care plans and health data. Having these standards in an electronic health record (EHR) can provide patients with access to their information and make them available to transfer between providers during a transition of care.

The ONC Certification Program defines the requirements for health IT and the process by which health IT may be evaluated, tested, and certified (ONC 2022). Though providers are allowed to use any EHR they want, the Centers for Medicare & Medicaid Services (CMS) required the use of certified health IT as part of the EHR incentive payment programs under Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH, P.L. 111-5). By 2019, more than 90 percent of hospitals and clinicians eligible for EHR incentive payments used certified technology (ONC 2019b).

The ONC ISA provides the health IT industry with a single public list of standards and implementation specifications that can be used to address healthcare interoperability needs. ISA also is meant to reflect industry discussions about emerging standards and their limitations in addressing specific functions or interoperability needs (ONC 2019a).

ONC also develops implementation resources and recommends functions and standards for a voluntary certification for IT used in specific practice settings (ONC 2020e). This approach does not constitute a separate certification program for the practice setting, meaning that ONC does not review IT products and assess whether they meet voluntary certification's requirements. The ONC approach for doing so consists of three parts:

- ONC analyzes adopted and proposed certification criteria in the ONC Health IT Certification Program to ensure these standards are broadly applicable to multiple medical specialties and sites of service;

- ONC evaluates standards to determine applicability to medical specialties and sites of service as well as to the broader care continuum, including the evaluation of such standards for inclusion in the ISA; and

- ONC works in collaboration with stakeholders to support the development of resources for medical specialties and sites of service for which there is an identified need to advance effective implementation of certified health IT (ONC 2020e).

It is important to note that voluntary certification is not considered a seal of approval or endorsement from ONC. Rather, it provides a framework to help developers and providers understand expectations for high-quality tools.

Encouraging Behavioral Health Information Technology

There are a number of ways that federal Medicaid policies could address barriers to EHR adoption among behavioral health providers, including playing a larger role in financing certified EHR technology adoption and training and providing additional guidance on health IT suitability.

Medicaid authorities that can support behavioral health IT adoption and interoperability

States currently have the authority to fund EHR adoption through multiple mechanisms but lack explicit guidance from CMS on how to do so. Further guidance from CMS would help states deploy these authorities to promote EHR adoption and information sharing among behavioral health providers and with other providers.

Section 1115 demonstrations. States may be able to use Section 1115 demonstration authority to use federal funding for EHR adoption, but additional guidance is needed from CMS. For example, in describing Section 1115 demonstration opportunities to improve systems of care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED), CMS explains how states can use these authorities to support integration efforts and requires a health IT plan that supports behavioral health data sharing (CMS 2018, CMS 2017a, CMS 2017b).[17] But given that many behavioral health providers lack an interoperable EHR and the equipment necessary to exchange electronic health information, it is unclear how states can fulfill these goals (MACPAC 2021a).[18]

The second area where more clarity is needed relates to the use of demonstration authority to provide incentive payments for provider infrastructure improvements. Under the delivery system reform incentive payment (DSRIP) demonstrations, states could encourage provider investment in technology so long as it supported clinical and population health improvements over time (MACPAC 2020, MACPAC 2021b). Although CMS does not plan to approve new demonstrations of this type, states are still using Section 1115 demonstrations for delivery system reform initiatives. It would be useful for CMS to clarify the parameters for support of technology infrastructure improvements for providers who were previously ineligible for Medicaid EHR incentive payments under Section 1115 authority (WAHCA 2021).

Directed payments. CMS guidance on state directed payments within managed care notes that EHR incentive payments for providers that were ineligible for incentives through HITECH is an allowable use of directed payments (CMS 2016). In a recent review of directed payment programs, MACPAC found that only one state was using directed payments to support EHR adoption as part of its larger quality strategy for behavioral health beneficiaries (MACPAC 2022). States could benefit from further information from CMS on how states can use directed payments in Medicaid managed care for EHR adoption. Refer to *Chapter 2: Oversight of Directed Payments in Managed Care* in this report for more on state directed payments.

Medicaid Information Technology Architecture (MITA). MITA 3.0 is the current standard that states must meet to receive enhanced federal match for health IT improvements, including new initiatives to support care integration and behavioral health IT.[19, 20] CMS guidance notes that states may obtain an enhanced administrative match for the development of health technologies that can be used by Medicaid providers to coordinate care for beneficiaries with serious mental illness.[21] However, this MITA guidance, created by the Substance Abuse and Mental Health Services Administration (SAMHSA) and CMS to facilitate coordination, cooperation, and interoperability among state Medicaid and behavioral health agencies, is outdated. The

behavioral health planning tools and processes were written in 2008 when most state-run HIEs were still in development. The tools have not been updated to reflect changes in how Medicaid supports behavioral health integration efforts or the CMS and ONC interoperability and information blocking rules (MACPAC 2021b, CMS 2020, ONC 2020a, CMS 2008). States would benefit from clearer guidance on how the different federal match rates under MITA could support greater data sharing among providers.

Federal funding to support technical assistance. States may need to identify additional sources of funding to finance technical assistance for providers, since the use of Medicaid may be limited to costs associated with the purchasing of technology. As noted above, other expensive activities associated with EHR adoption include education and training, EHR developer selection and financial consultations, workflow redesign, and support for connections to an HIE. In recognition of these additional costs, Congress appropriated funds under HITECH for regional extension centers (REC) to support Medicaid and Medicare providers participating in the EHR incentive programs with technical assistance around workflow redesign and EHR developer selection. The REC program was administered by ONC. Providers that received support from RECs were more likely to meet and exceed the programs' quality benchmarks.[22] However, Medicaid funding for these centers ended when HITECH sunset at the end of fiscal year 2021.

Stakeholders have noted the importance of the SAMHSA-administered Certified Community Behavioral Health Clinic (CCBHC) expansion grants in convening working groups that shared information on EHR developers and workflow design (Hammond et al. 2021, SAMHSA 2022).[23] Guidance from CMS, ONC, and SAMHSA would be useful to states trying to blend sources of funding for technical assistance with those permissible under Medicaid.

Center for Medicare and Medicaid Innovation (CMMI) models. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) authorized CMMI to test incentive payments for behavioral health providers who accept Medicaid for the adoption and use of certified EHR technology. However, CMMI has no public plans to test such a demonstration. Although there is interest from states in exploring this opportunity, states are unclear on how to apply to use CMMI's authority in this way (NASMHPD 2018). States could benefit from information from CMS on how to apply to test EHR incentive payments under CMMI authority.

Providers need guidance on behavioral health IT products

In interviews with provider groups and IT experts, we heard that the purchase of a behavioral health EHR, particularly one that offers integrated physical and behavioral health functions, may be difficult and risky for providers, given that there are no industry guidelines (Partnership for HITPS). A voluntary certification outlining IT standards that support behavioral health clinical functions and care settings would help providers distinguish among products to find one that meets their needs.[24]

To help identify what stakeholders consider critical behavioral health clinical priorities, the associated health IT functions, and how they may align with existing standards and capabilities found in certified health IT products, we reviewed public comments on SAMHSA's proposed rule on Part 2 (SAMHSA 2020), CMS' interoperability rule (CMS 2020), and ONC's information blocking rule (ONC 2020a). Below are the findings.

Guidance on IT standards relevant for specific practice settings. One challenge for behavioral health providers is they are often unclear about which health IT products meet the needs of their practice. Other practice settings have had similar challenges. Under the 21st Century Cures Act (Cures Act, P.L. 114-255), ONC was required to recommend a series of standards and EHR functions relevant for pediatric health IT because of concerns that EHR usability jeopardized the

safety of pediatric patients (Pew 2019). Like behavioral health, pediatric health has specific privacy needs (e.g., disclosure of sexual history) as well as specific clinical functions (e.g., weight-based dosage).[25]

Through a collaborative working group process with EHR developers and pediatricians, ONC developed criteria for voluntary certification of health IT for pediatric care without having to create an entirely separate certification program for pediatric care and practice settings.[26] ONC also identified relevant certification program criteria and interoperability standards that supported pediatric practices. In addition, ONC developed information resources to support the implementation of health IT products that meet the voluntary certification's recommended criteria (ONC 2020a). A similar process could be used to develop guidance for IT used in behavioral health and integrated care practice settings.

Guidance on data segmentation standards.
Another significant challenge faced by behavioral health providers when using health IT is keeping SUD information private while sharing the rest of the patient record. Many EHR systems cannot easily identify which portions of the record contain Part 2 information, and instead identify patients as receiving SUD services, which restricts access to functionally all of that patient's data (ECRI 2019, Hammond et al. 2021, MACPAC 2018, Partnership to Amend 42 CFR Part 2 2021).[27] The experience with pediatric health IT shows that segmentation is feasible. That is, separation of a child's sexual history for pediatric health IT requires a similar permissions structure as the separation of SUD treatment information (ONC 2020d).

ONC and SAMHSA co-developed open-source SUD consent management tools in 2016, however, implementing these segmentation tools can be burdensome, and these open source segmentation tools may need further refinement before they can be used easily among providers who are not familiar with Part 2 privacy requirements (SAMHSA 2020, Netsmart 2019). Creation of a voluntary

certification for behavioral health practice settings would help providers and developers understand which IT standards support compliance with Part 2 and which can be readily implemented within behavioral health and integrated care settings.

Moving the field

The Commission considers requiring the use of IT products with Part 2 segmentation capabilities among behavioral health providers to be a long-term goal. However, this goal is not practical in the near term. It would require widespread adoption of EHRs that work for behavioral health providers, and widespread availability of IT tools that support Part 2's SUD privacy protections.

CMS has the discretion to add health IT requirements to its conditions of participation for Medicare and Medicaid participating providers. For example, CMS requires most hospitals to be able to send and receive electronic patient event notifications, which generally requires the use of certified EHR technology (CMS 2020). Similarly, additional data privacy or clinical function that supports beneficiaries with behavioral health needs could be added as condition for participation. When these IT systems are more mature, CMS could consider requiring the use of health IT that meets the voluntary certification benchmark for behavioral health. However, the Commission understands this is not feasible in the near future.

Commission Recommendations

In this report, the Commission recommends that the Secretary of HHS provide states with guidance on how to use Medicaid authority to promote EHR adoption, and that HHS develops a voluntary certification for health IT essential for the delivery of high-quality behavioral health care that also complies with state and federal privacy and security laws.

Recommendation 4.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health IT to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability.

Rationale

A variety of Medicaid authorities could be used to support EHR adoption and interoperability; however, states do not have a playbook for how to deploy these resources appropriately (DHCF 2021, DHS 2021, CMS 2018). More explicit instructions to states on how to use different Medicaid authorities to support behavioral health IT would help states advance behavioral health integration efforts.

Our findings suggest that there are multiple mechanisms that can be included in a playbook encouraging health IT adoption for behavioral health. MITA governs the rules for health IT funding, but has not updated its behavioral health guidance since 2008 (CMS 2008, MACPAC 2021a). Directed payments, Section 1115 authority, and CMMI's demonstration authority could be used to promote EHR adoption among behavioral health providers, but states may be unsure how to deploy these authorities to improve provider IT. In addition, other existing sources of federal health IT funding from SAMHSA, and future ONC funding, may need to complement Medicaid spending by funding technical assistance necessary to support EHR adoption, use, implementation and exchange. Additional guidance from CMS, SAMHSA, and ONC could outline how states can combine various funding streams to encourage behavioral health providers adopt health IT.

At a minimum, such guidance should:

- update the MITA rules governing how states can use an enhanced federal match

to promote integration of services for beneficiaries with behavioral health needs;

- address how states could use Section 1115 demonstration authority to develop an EHR incentive program, including potential ways for states to meet budget neutrality requirements;

- explain how states can use directed payments via managed care plans to promote EHR adoption for behavioral health providers, including how different types of EHR incentive payments can be classified under medical loss ratio calculations;

- discuss how states could finance the technical assistance necessary for providers to incorporate health IT into their workflows and achieve meaningful use of an EHR;

- address how states can use Medicaid, including the enhanced administrative federal match, to pay costs related to HIE services that support behavioral health data consent management and interoperable data sharing;

- address how states can combine Medicaid with other federal funding streams such as SAMHSA-administered grant opportunities to promote behavioral health EHR adoption and interoperability; and

- explain how states can use the CMMI SUPPORT Act authority to test EHR incentive payments for behavioral health providers enrolled in Medicaid.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid and State Children's Health Insurance Program (CHIP) spending. Depending on how states respond to guidance by encouraging IT adoption or encouraging greater behavioral health use of HIEs and other general connections to state IT systems, costs to the federal government could be affected. The extent to which spending would increase or decrease is difficult to predict.

States. This recommendation would give states the option to advance clinical integration goals through greater uptake of behavioral health IT. Providing guidance to state Medicaid and CHIP officials on these different Medicaid authorities would help remove technological barriers to clinical integration for patients with behavioral health needs. For these states, greater behavioral health IT funding would have other positive implications for other uses as well. This includes greater state capacity to collect data needed for the Adult and Child Core Set and to encourage behavioral health participation in value-based payment (VBP) programs.

Enrollees. To the degree that additional federal guidance supports states' ability to encourage greater use of behavioral health IT, it could enhance integration of behavioral health services by strengthening care coordination and data sharing. Greater information sharing is correlated with better patient health outcomes, which includes lower readmission rates, lower risks of medication discrepancies, reduced redundant testing, and decreased emergency department use (Boockvar et al. 2017, Vest et al. 2015, Yaraghi 2015).

Plans and providers. Providers would benefit from greater funding for EHR adoption and more funding for broader data sharing integration efforts via HIEs and coordination with home- and community-based service providers. Providers would have improved capabilities to integrate care for patients with behavioral health needs. Plans would benefit from guidance that encourage EHR adoption via directed payments because they could receive data from their behavioral health providers. This data could help inform integration efforts, support the development of VBP arrangements for behavioral health, and support submission of data on quality to states.

Recommendation 4.2

The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health IT to jointly develop a voluntary certification for behavioral health IT.

Rationale

Current behavioral health EHR products are of poor quality primarily because many do not allow for segmentation of data related to SUD protected under Part 2 (ABHW 2021, BHIT 2021, WIDHS 2019). Because such information cannot be disclosed, or redisclosed, without patient consent, behavioral health providers subject to Part 2 would benefit from systems that include Part 2 consent management tools and associated permission structures. Without such systems, behavioral health providers will be unable to electronically segment Part 2 records and share the rest of the patient's record.

This recommendation calls on ONC and SAMHSA, in collaboration with providers and EHR developers, to recommend a set of IT standards, implementation resources, provider manuals, and other resources to address behavioral health clinical and privacy functions.

The Commission discussed a more aggressive approach of requiring all behavioral health providers enrolled in Medicaid to use health IT tools that segment Part 2 protected information and meet other functions important for behavioral health and integrated care settings. The Commission ultimately decided on improving products and encouraging adoption as a first step. Advantages of this approach are that:

- it would help behavioral health providers know which EHR platform meets their needs;

- it would allow for development of robust consent management tools that support Part 2 compliance, allowing providers to keep SUD data private, and share the rest of the patient record; and

- it would not require the use of Part 2 consent management tools by other providers until these are more mature.

A voluntary certification also would provide a non-financial incentive for adoption because providers practicing in integrated care settings would know how to upgrade IT systems to support Part 2 segmentation, but can still send and receive the patient's other health data. Furthermore, a voluntary certification approach could outline a set of standards that support behavioral health provider needs, which would further promote EHR adoption. Recommended standards could support EHR functions for tele-behavioral health visits, mental health screening tools, and connecting to SUD registries or Prescription Drug Monitoring Programs (PDMPs) (Partnership for HITPS 2021).

ONC should replicate the process used when it created its recommendations for voluntary certification for health IT in pediatric care settings, which were released in 2020. Developed in collaboration with providers and EHR developers, ONC recommended a set of standards and functions aligned with ONC's interoperability and certification framework and included implementation resources for providers and EHR developers to support the customization of their EHR platform (ONC 2020b and 2020d).

Given the prevalence of SUD within the Medicaid population, IT that can support Part 2 compliance is urgently needed for all Medicaid providers. However, such tools are still in their infancy and standards that support them may require further development and testing before being considered as a Medicaid requirement. Although a voluntary certification for IT in behavioral health and integrated behavioral health practice settings is a less aggressive approach, it could provide a path to more stringent requirements when those standards are more mature.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid and CHIP spending, although ONC and SAMHSA would incur costs associated with undertaking these activities.

States. This recommendation would create a federal standard to support state efforts. That is, if a Medicaid agency decides to encourage EHR adoption for behavioral health practice settings, it could require providers to adopt an EHR that complies with the behavioral health voluntary certification.

Enrollees. In the near term, patients receiving services from a provider that upgraded their system to meet voluntary certification would benefit from the potential for greater communication regarding their care.

Plans and providers. In the near term, providers would benefit by having guidance on a set of standards and functions that support behavioral health. Behavioral health providers could work with a developer on an IT product that meets the needs of their practice setting. Physical health providers could use implementation resources to upgrade their systems to support SUD privacy protection requirements. Standards outlined under the voluntary certification could support tele-behavioral health services, crisis counseling, and connections to SUD registries and PDMPs. Plans and providers would be in a better position to provide integrated care through greater information sharing. In the long run, as behavioral health IT systems improve and mature, additional federal action could be contemplated to make the behavioral health certification benchmark mandatory. This action would further facilitate care integration efforts, especially for providers who serve patients receiving SUD treatment.

Endnotes

[1] For example, 55 percent of Medicaid beneficiaries have a serious mental illness and a serious physical health condition compared to 46 percent of privately insured patients (MACPAC 2021a). In addition, 36 percent of Medicaid beneficiaries have a serious mental illness and SUD, compared to 27 percent of privately insured patients (MACPAC 2021a).

2   In order to convey confidence that electronic health information can be easily shared between providers using different IT systems, ONC certifies IT systems to confirm that they meet a set of minimum quality standards. Non-certified health IT may store health records in a non-standardized structure, making it a challenge to transfer data between providers. Because certified IT systems meet minimum standards on core functions and data structures, they are more likely to facilitate interoperability and data exchange when compared to non-certified IT systems.

3   The regulation at 42 CFR Part 2 established patient protections and set the conditions for disclosure and redisclosure of SUD treatment and prevention records for people receiving treatment from federally assisted programs. These regulations first were promulgated in 1975 and implement statutory requirements intended to encourage individuals to seek treatment for SUDs by addressing the stigma of SUDs and concerns that individuals receiving treatment could be subject to negative consequences from unauthorized disclosure of their patient records. The Coronavirus Aid, Relief, and Economic Security (CARES, P.L. 116-136) Act requires changes to 42 CFR Part 2. Rulemaking on the CARES Act is in progress by SAMHSA and the U.S. Department of Health and Human Services Office of Civil Rights.

4   Additionally, designing and maintaining systems that comply with Part 2 requirements (including incorporating updates such as those made by the 2017 and 2018 Part 2 regulatory changes) can be costly (MACPAC 2018).

5   Even if a provider adopts certified EHR technology there are additional costs associated with sharing data with other providers. These may include technical on-boarding into an information exchange, fees charged by a state HIE, and legal counsel for interpreting HIE legal agreements.

6   Hospitals that were eligible for HITECH's incentive payments were primarily pediatric and short-term acute care hospitals. Psychiatric, long-term acute care, and rehabilitation facilities were ineligible for incentive payments.

7   Most licensed physicians were eligible for HITECH incentive payments, including psychiatrists and addiction medicine specialists.

8   The National Council for Mental Wellbeing's survey found that, overall, 67 percent of mental health and addiction treatment organizations had increased demand for services. They found this was also true for 63 percent of youth mental health and addiction treatment services (NCMW 2021).

9   In addition to 42 CFR Part 2, other privacy laws such as Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) and state behavioral health privacy laws also create additional costs for providers regarding consent around the disclosure and redisclosure of medical records.

10   Certification of health IT includes privacy and security provisions, which can help a user to comply with HIPAA. To further assess compliance with HIPAA, CMS also requires providers or health care organizations to complete a security risk analysis by the provider or health care organization.

11   In this report, we use the term HIPAA as a shorthand for both the HIPAA statute and its implementing regulations.

12   There are many reasons why a patient receiving SUD treatment may not want to disclose their treatment information. A good example is that there remains significant stigma against persons with SUD affecting housing, employment, and education (NASEM 2016). This is one reason why some patients do not want their SUD records shared or want them to be shared with some providers but not others. When patients are unable or unwilling to authorize Part 2 programs to disclose SUD treatment information, inadequate or even dangerous care, such as prescribing medications with dangerous or deadly interactions, may be the result (SAMHSA 2018, Wakeman and Friedman 2017, APA 2016, MHA 2016).

13   Segmentation capabilities support the sharing of Part 2-protected information within accordance with state and federal law (ONC 2015). Data segmentation includes capabilities to tag health care data and allow certain documents, messages, or individual data elements to be marked as sensitive, without restricting access to the entire EHR. This is typically not automated and is not a common feature within an EHR platform.

[14] For example, ONC and SAMHSA have developed the Data Segmentation for Privacy (DS4P) standard and the Consent2Share software application to manage patient consent preferences and share Part 2-protected information electronically through EHRs and HIEs. The Health Information Technology Standards Committee advising ONC called into question the maturity of the DS4P standard, suggesting that additional testing and refinements are needed (MACPAC 2018).

[15] The CARES Act also requires the Secretary of HHS to update federal regulations to align with statutory changes to SUD confidentiality standards. As of April 2022, HHS is still in the rulemaking process, and this provision has yet to be implemented.

[16] The Medicaid EHR Incentive Program is now called Promoting Interoperability and has gone through many name changes since its inception. Promoting Interoperability is now the umbrella term for most of the EHR incentive payment programs. The Medicaid component of Promoting Interoperability is administered by the states. This name change went into effect in April 2018.

[17] This demonstration opportunity requires states to increase the availability of community-based mental health care, including non-hospital-based and non-residential crisis-stabilization services, in order to receive a federal match for mental health services rendered in institutions for mental diseases.

[18] States must develop a health IT plan that describes the state's ability to leverage health IT, advance HIEs, and ensure health IT interoperability in support of the program goals. These health IT plans must address electronic care plan sharing, care coordination, and integration of behavioral and physical health (CMS 2018).

[19] States can receive an enhanced federal match for certain administrative health IT expenses under Section 1903(a)(3)(A) and (B) of the Social Security Act. This includes a 90 percent federal match for the design, development, and implementation of mechanized claims processing and information retrieval systems and a 75 percent match for maintenance and operations of these systems.

[20] For example, the enhanced federal match could be used for data-sharing capabilities between hospitals and community-based mental health providers such that when

a beneficiary is discharged from a hospital, their treatment record could be transferred to a community-based mental health provider, or if the beneficiary was being admitted to a hospital for acute care, the mental health provider could be notified easily. Such funding also can be used to promote data sharing between schools, hospitals, primary care, and specialized mental health providers (CMS 2018).

[21] SMI and SED guidance states that the enhanced federal match used to improve state IT systems could be made available to states to develop data-sharing capabilities among hospitals and community-based mental health providers such that when an SMI diagnosed beneficiary is discharged from a hospital, the treatment record could be transferred to a community-based treatment provider. Another example is if the beneficiary was being admitted to a hospital for acute care, the community-based mental health provider could be notified through an automated electronic messaging service.

[22] Regional Extension Centers (RECs) were organizations that supported provider EHR adoption during the implementation of the Medicaid EHR incentive payment program. The HITECH Act created a grant program through which ONC provided funding to organizations that provide on-the-ground technical assistance for individual and small provider practices that have historically had challenges effectively integrating health IT into provider workflows in ways that strengthen quality of care (Crabtree et al. 2011, Lynch et al. 2014). Providers who received support from RECs were significantly more likely to meet the milestones of the Promoting Interoperability program when compared to providers who did not receive support from RECs (e.g., 68 percent of participants in the REC program achieved Stage 1 meaningful use of EHRs of the incentive program by May 2014, compared to 12 percent of nonparticipants, (AIR 2016)).

[23] SAMHSA's Substance Abuse and Mental Health Block Grant allows states to use funds for EHRs but are limited by statute to five percent of funds for administrative services. States that receive funding through SAMHSA's Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) programs can use funds to support administrative activities including the costs for implementing electronic health records and other health information technology. However,

by statute, states cannot spend more than five percent of their grant on administrative expenses (SAMHSA 2022).

[24] As previously discussed, the use of certified health IT is technically voluntary for providers. However, since providers were required to use certified EHR technology to participate in the EHR incentive payment programs for both Medicare and Medicaid, use of a certified tool became the industry norm. When the Commission discusses voluntary certification for IT used for behavioral health, this means providing a list of standards and EHR functions that support clinical, security, and privacy needs of behavioral health providers.

[25] These recommendations were published in June 2020 and included implementation guidance for pediatric capabilities that developers and providers could use for pediatric-focused IT. For example, ONC recommended that pediatric-focused IT should compute weight-based drug dosages, synchronize immunization histories with registries, and segment access to sensitive information such as a child's sexual history (ONC 2020b). The recommendations also provided guidance that EHR vendors could use to design a pediatric-focused IT systems that also met the requirements of CMS' interoperability rule and ONC's information blocking rule (CMS 2020, ONC 2020a).

[26] ONC's voluntary certification of health IT for pediatric settings of care built on top prior federal efforts to improve pediatric health IT; specifically, it was built on top of the Children's EHR Format. The Children's EHR Format tried to bridge the gap between what was available in most EHRs at the time and what was needed to provider higher quality care for children. The Format was authorized by the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3), and was developed by Agency for Healthcare Research and Quality (AHRQ) in coordination with CMS (AHRQ 2022).

[27] MACPAC made several recommendations regarding clarifying key 42 CFR Part 2 provisions; however, this predates congressional action on SUD privacy requirements. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) aligned the statutory basis for Part 2 more closely with HIPAA. However, some issues related to patient consent and electronic information sharing were not directly addressed by the CARES Act and will instead be addressed through future rulemaking.

References

Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (HHS). 2022. Children's Electronic Health Record Format. Rockville, MD: AHRQ. https://digital.ahrq.gov/health-it-tools-and-resources/pediatric-resources/childrens-electronic-health-record-ehr-format.

American Institutes for Research (AIR). 2016. Evaluation of the Regional Extension Center Program. Washington, DC: AIR. https://www.healthit.gov/sites/default/files/Evaluation_of_the_Regional_Extension_Center_Program_Final_Report_4_4_16.pdf.

American Academy of Family Physicians (AAFP). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Washington, DC: AAFP. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1652.

American Psychiatric Association (APA). 2016. Comment letter on proposed rule. Confidentiality of substance use disorder patient records (April 11, 2016). https://www.regulations.gov/document/HHS-OS-2016-0005-0241.

AmeriHealth Caritas. 2021. Comment letter on proposed rule: Medicaid program; Patient Protection and Affordable Care Act; reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges; health information technology standards and implementation specifications (January 4, 2021). https://www.regulations.gov/comment/CMS-2020-0157-0167.

Association for Behavioral Health and Wellness (ABHW). 2021. Comment letter on proposed rule: Medicaid program; patient protection and Affordable Care Act; reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges; health information technology standards and implementation specifications

(January 4, 2021). https://www.regulations.gov/comment/CMS-2020-0157-0065.

Behavioral Health IT Coalition (BHIT). 2021. Comment letter to Senator Bennet and Senator Cornyn: a bold vision for America's mental well-being (October 8, 2021). http://www.bhitcoalition.org/news---events.html.

Bipartisan Policy Center. 2021. *Tackling America's mental health and addiction crisis through primary care integration: task force recommendations.* March 2021. Washington, DC: BPC. https://bipartisanpolicy.org/report/behavioral-health-2021/.

Boockvar, K., W. Ho, J. Pruskowski, et al. 2017. Effect of health information exchange on recognition of medication discrepancies is interrupted when data charges are introduced: results of a cluster-randomized controlled trial. *Journal of the American Medical Informatics Association* 24, no. 6: 1095–1101. https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/28505367/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2020. Medicare and Medicaid programs; patient protection and Affordable Care Act; interoperability and patient access for Medicare Advantage organization and Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, issuers of qualified health plans on the federally-facilitated exchanges, and health care providers. May 2020. Washington, DC: HHS. https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2018. State Medicaid Director Letter: "Opportunities to design innovative service delivery systems for adults with a serious mental illness or children with a serious emotional disturbance." Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2017a. State Medicaid Director Letter: "Strategies to address the opioid epidemic." Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2017b. CMCS Informational Bulletin: Delivery systems and provider payment initiatives under Medicaid managed care contracts. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib11022017.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2016. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid managed care, CHIP delivered in managed care, and revisions related to third party liability. May 2016. Baltimore, MD: CMS. https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2008. Behavioral health MITA: Maturity model document version 2.0. Baltimore, MD: CMS. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidInfoTechArch/Downloads/BH-MITA-MM.pdf.

Cerner. 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (May 29, 2019). Kansas City, MO: Cerner. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1212.

Covered California. 2021. Comment letter on proposed rule: Medicaid program; Patient Protection and Affordable Care Act; reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges; health information technology standards and implementation specifications (January 4, 2021). https://www.regulations.gov/comment/CMS-2020-0157-0153.

College of American Pathologists (CAP). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Washington, DC: CAP. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1856.

Crabtree, BF, P.A. Nutting, WL Miller, et al. 2011. Primary care practice transformation is hard work: insights from a 15-year developmental program of research. *Med Care* 49(Suppl): S25-S35. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043156/pdf/nihms-250809.pdf.

Das-Munshi, J., C.K. Chang, I. Bakolis et al. 2021. All-case and cause-specific mortality in people with mental disorders and intellectual disabilities, before and during the COVID-19 pandemic: cohort study. *The Lancet* 2021. https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00214-3/fulltext.

Department of Health Care Finance (DHCF), Government of the District of Columbia. 2021. Initial spending plan and narrative for enhanced funding for Medicaid home and community-based services under section 9817 of the American Rescue Plan Act of 2021. Washington, DC: DHCF. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/District%20of%20Columbia%20ARPA%20Initial%20Narrative%20and%20Spending%20Plan.pdf.

ECRI Institute (ECRI). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (May 20, 2019). https://www.regulations.gov/comment/HHS-ONC-2019-0002-1255.

Eder, S. 2022. As a crisis hotline grows, so do fears it won't be ready. *New York Times* 2022. https://www.nytimes.com/2022/03/13/us/suicide-hotline-mental-health-988.html.

Electronic Health Record Association (EHRA). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 4, 2019). Chicago, IL: EHRA. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1468

Falconer, E., D. Kho, and J. Docherty. 2018. Use of technology for care coordination initiatives for patients with mental health issues: a systematic literature review. *Neuropsychiatric Disease and Treatment* 2018, no. 14: 2337–2349. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6143125/pdf/ndt-14-2337.pdf.

Fond, G., K. Nemani, D. Etchart et al. 2021. Association between mental health disorders and mortality among patients with COVID-19 in 7 countries: a systematic review and meta-analysis. *JAMA Psychiatry.* 2021, no:78(11) 1208-1217. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2782457.

Gilmer, T., B. Henwood, M. Goode, et al. 2016. Implementation of integrated health homes and health outcomes for persons with serious mental illness in Los Angeles County. *Psychiatric Services* 67, no. 10: 1062–1067. https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201500092.

Gold, M., and C. McLauglin. 2016 Assessing HITECH implementation and lessons: 5 years after. *The Milbank Quarterly*. 94(3): 654-687. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5020152/.

Henry, J., Y. Pylypchuk, T. Searcy, and V. Patel. 2016. *Adoption of electronic health record systems among U.S. non-federal acute care hospitals: 2008–2015.* ONC data brief no. 35. Washington, DC: Office of the National Coordinator for Health Information Technology. https://www.healthit.gov/sites/default/files/briefs/2015_hospital_adoption_db_v17.pdf.

Healthcare Information and Management Systems Society (HIMMS). 2022. *Interoperability in healthcare.* Accessed on 4/20/2022. https://www.himss.org/resources/interoperability-healthcare.

Health Level Seven International (HL7 International). 2019. Comment letter on proposed rule: Confidentiality of Substance Use Disorder Patient Records (October 24, 2019). Ann Arbor, MI: HL7. https://www.regulations.gov/comment/HHS-OS-2019-0011-0461.

Institute of Medicine (IOM). 2003. *Key capabilities of an electronic health record system: letter report.* Washington, DC: The National Academies Press. https://nap.nationalacademies.org/catalog/10781/key-capabilities-of-an-electronic-health-record-system-letter-report?onpi_newsdoc073103=.

InterSystems. 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Cambridge, MA: InterSystems. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1694.

John, A., J. McGregor, I. Jones, et al. 2018. Premature mortality among people with severe mental illness – new evidence from linked primary care data. *Schizophrenia Research* 2018, no: 199:154-162. https://www.sciencedirect.com/science/article/pii/S0920996418301981?via%3Dihub.

Lynch, K., M. Kendall, K. Shanks, et al. 2014. The health IT regional extension center program: evolution and lessons for health care transformation. *Health Services Research* 49(1 Pt 2): 421-437. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3925411/pdf/hesr0049-0421.pdf.

Lye, C.T., H. Forman, J. Daniel, et al. 2018. The 21st Century Cures Act and electronic health records one year later: will patients see benefits? J*ournal of the American Medical Informatics Association* September 2018, 25(9):1218-1220. https://academic.oup.com/jamia/article/25/9/1218/5060211.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. Chapter 2: Oversight of managed care directed payments. In *Report to Congress on Medicaid and CHIP.* June 2022. Washington, DC: MACPAC. https://www.macpac.gov/publication/oversight-of-managed-care-directed-payments/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. Chapter 4: Integrating clinical care through greater use of electronic health records for behavioral health. In *Report to Congress on Medicaid and CHIP.* June 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-4-Integrating-Clinical-Care-through-Greater-Use-of-Electronic-Health-Records-for-Behavioral-Health.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. Chapter 2: Access to mental health services for adults covered by Medicaid. In *Report to Congress on Medicaid and CHIP.* June 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021c. *MACStats: Medicaid and CHIP Data Book.* December 2021. Washington, DC: MACPAC. https://www.macpac.gov/macstats/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Chapter 2: State readiness to report mandatory core set measures. In *Report to Congress on Medicaid and CHIP.* March 2020. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/03/State-Readiness-to-Report-Mandatory-Core-Set-Measures.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. *Delivery System Reform Incentive Payment (DSRIP) Programs.* April 2020. Washington, DC: MACPAC. https://www.macpac.gov/publication/delivery-system-reform-incentive-payment-programs/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Chapter 2: Substance use disorder confidentiality regulations and care integration in Medicaid and CHIP. In *Report to Congress on Medicaid and CHIP.* June 2018. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/06/Substance-Use-Disorder-Confidentiality-Regulations-and-Care-Integration-in-Medicaid-and-CHIP.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. Chapter 2: Medicaid and the opioid epidemic. In *Report to Congress on Medicaid and CHIP.* June 2017. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Chapter 4: Integration of behavioral and physical health services in Medicaid. In *Report to Congress on Medicaid and CHIP.* March 2016. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf.

Mental Health American (MHA). 2016. Comment letter on proposed rule: Confidentiality of substance use disorder patient records (April 12, 2016). https://www.regulations.gov/document/HHS-OS-2016-0005-0273.

Momen, N.C., O. Plana-Ripoll, E. Agerbo et al. 2022. Mortality associated with mental disorders and comorbid general medical conditions. *JAMA Psychiatry* 2022 Mar. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2790723.

National Alliance on Mental Illness (NAMI). 2022. *As launch of 988 mental health crisis number looms, NAMI poll finds broad support for the system and fees to fund it, opposition to police response to mental health crises.* Arlington, VA: NAMI. https://www.nami.org/Press-Media/Press-Releases/2021/As-Launch-of-988-Mental-Health-Crisis-Number-Looms-NAMI-Poll-Finds-Broad-Support-for-the-System-and.

National Alliance on Mental Illness (NAMI). 2020. *Mental health care matters.* Arlington, VA: NAMI. https://www.nami.org/NAMI/media/NAMI-Media/Infographics/NAMI_MentalHealthCareMatters_2020_FINAL.pdf.

National Academy of Sciences, Engineering, and Medicine (NASEM). 2020. *Caring for people with mental health and substance use disorders in primary care settings: proceedings of a workshop.* Washington, DC: The National Academies Press. https://doi.org/10.17226/25927.

National Academy of Sciences, Engineering, and Medicine (NASEM). 2016. *Ending discrimination against people with mental and substance use disorders.* Washington, DC: The National Academies Press. https://nap.nationalacademies.org/catalog/23442/ending-discrimination-against-people-with-mental-and-substance-use-disorders.

National Association of Medicaid Directors (NAMD). 2021. Comment letter to U.S. Senate Committee on Finance's request for information on behavioral health care. (November 12, 2021). Washington, DC: NAMD.

National Association of State Mental Health Program Directors (NASMHPD). 2018. Comment letter to Center for Medicare and Medicaid Innovation: Section 6001 of the SUPPORT Act, payment on incentives to behavioral health providers to adopt EHRs (December 10, 2018).

National Association of State Mental Health Program Directors (NASMHPD). 2012. *Reclaiming lost decades: The role of state behavioral health agencies in accelerating the integration of behavioral healthcare and primary care to improve the health of people with serious mental illness.* Alexandria, VA: NASMHPD. https://www.nasmhpd.org/sites/default/files/Reclaiming%20Lost%20Decades%20Full%20Report.pdf.

National Association for Community Health Centers (NACHC). 2021. Health information technology a home run

for NACHC. October 2021. Washington, DC: NACHC. https://blog.nachc.org/health-informatics-team-hit-a-home-run-for-nachc/.

National Council for Mental Wellbeing (NCMW). 2021. New report: 40% of mental health and addiction treatment organizations will survive less than a year without additional financial support. March 2021. Washington, DC: NACHC. https://www.thenationalcouncil.org/news/new-report-40-of-mental-health-and-addiction-treatment-organizations-will-survive-less-than-a-year-without-additional-financial-support/.

New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services, State of New Jersey. 2021. *State of New Jersey home and community-based services enhanced FMAP spending plan.* Trenton, NJ: DHS. https://nj.gov/humanservices/assets/slices/NJHCBSspending.pdf.

New York eHealth Collaborative (NYeC). 2021. Comment letter on proposed rule: Medicaid program; Patient Protection and Affordable Care Act; reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges; health information technology standards and implementation specifications (January 4, 2021). https://www.regulations.gov/comment/CMS-2020-0157-0219.

Netsmart. 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Overland Park, KS: Netsmart. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1509.

NextGen Healthcare (NextGen). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Horsham, PA: NextGen. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1711.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2022. *ONC Health IT Certification Overview.*

Updated on March 31, 2022. Washington, DC: HHS. https://www.healthit.gov/sites/default/files/PUBLICHealthITCertificationProgramOverview.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020a. *21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program.* May 2020. Washington, DC: HHS. https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020b. Pediatric health information technology: Pediatric healthcare provider informational resource. Washington, DC: HHS. https://www.healthit.gov/sites/default/files/page/2020-12/Pediatric_HealthIT_Provider_IR_Print_508.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020c. Strategy on reducing regulatory and administrative burden relating to the use of health IT and EHRs. Feb 2020. Washington, DC: HHS. https://www.healthit.gov/sites/default/files/page/2020-02/BurdenReport_0.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020d. Pediatric health information technology: Developer informational resource. Washington, DC: HHS. https://www.healthit.gov/sites/default/files/page/2020-06/Pediatric-Health-IT-Developer-IR-06102020.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020e. ONC approach and stakeholder opportunities for advancing health IT across the care continuum. Washington, DC: HHS. http://www.healthit.gov/sites/default/files/page/2020-07/Care%20Continuum%20Tipsheet.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2019. *Health IT standards.* June 2019. Washington, DC: HHS. https://www.healthit.gov/topic/standards-technology/health-it-standards.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2019b.

2015 edition market readiness for hospitals and clinicians. March 2019. Washington, DC: HHS. https://www.healthit.gov/data/quickstats/2015-edition-market-readiness-hospitals-and-clinicians.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2017. Non-federal acute care hospital electronic health record adoption. Health IT Quick-Stat #47. September 2017. Washington, DC: HHS. https://www.healthit.gov/data/quickstats/non-federal-acute-care-hospital-electronic-health-record-adoption.

Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services. 2015a. Percent of U.S. hospitals with capability to electronically query patient health information from outside their organization or system. Health IT Quick-Stat #25. Washington, DC: ONC. https://www.healthit.gov/data/quickstats/hospital-capability-electronically-query.

Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services. 2015. 2015 Edition health information technology (Health IT) certification criteria, 2015 Edition Base Electronic Health Record (EHR) definition, and ONC Health IT Certification Program modifications. Final rule. *Federal Register* 80, no. 200 (October 16): 62601–62759. https://www.federalregister.gov/documents/2015/10/16/2015-25597/2015-edition-health-information-technology-health-it-certification-criteria-2015-edition-base.

Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services. 2013. Certification guidance for EHR technology developers serving health care providers ineligible for Medicare and Medicaid EHR incentive payment. Washington, DC: ONC. https://www.healthit.gov/sites/default/files/generalcertexchangeguidance_final_9-9-13.pdf.

Office for Civil Rights (OCR), U.S. Department of Health and Human Services (HHS). 2017. *Does HIPAA provide extra protections for mental health information compared with other health information.* Washington, DC: HHS. https://www.hhs.gov/hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html.

Oregon Health Authority (OHA). 2021. Health Information Exchange (HIE) Onboarding Program development Q&A. Salem, OR: OHA. https://www.oregon.gov/oha/HPA/OHIT/Pages/HIE-Onboarding-QA.aspx.

Partnership for Health IT Patient Safety (Partnership for HITPS). 2021. Optimizing health IT for safe integration of behavioral health and primary care. https://d84vr99712pyz.cloudfront.net/p/pdf/hit-partnership/partnership_whitepaper_behavioralhealth_v2.pdf.

The Partnership to Amend 42 CFR Part 2. 2021. Comment letter to MACPAC: Considerations related to 42 CFR part 2 (November 3, 2021).

The Pew Charitable Trusts. 2019. *Poor usability of electronic health records can lead to drug errors, jeopardizing pediatric patients: challenges can stem from product design, clinician use, and customization.* Philadelphia, PA: PEW. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2019/04/poor-usability-of-electronic-health-records-can-lead-to-drug-errors-jeopardizing-pediatric-patients.

Plana-Ripoll, O., P.C.B. Pedersen, P.E. Agerbo et al. 2019. A comprehensive analysis of mortality-related health metrics associated with mental disorders: a nationwide, register-based cohort study. *The Lancet* 2019, no: 394(10211):1827-1835. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32316-5/fulltext.

Plana-Ripoll, O., K.L. Musliner, S. Dalsgaard et al. 2020. Nature and prevalence of combinations of mental disorders and their association with excess mortality in a population-based cohort study. *World Psychiatry* 2020 Oct, no:19(3):339-349. https://pubmed.ncbi.nlm.nih.gov/32931098/.

Primary care collaborative (PCC). 2022. *Benefits of integration of behavioral health.* https://www.pcpcc.org/content/benefits-integration-behavioral-health.

Roberts, L.W., A.K. Louie, A.P.S. Guerrero, et al. 2017. Premature mortality among people with mental illness: Advocacy in academic psychiatry. *Academic Psychiatry* 2017, no. 41, 441–446. https://link.springer.com/content/pdf/10.1007/s40596-017-0738-9.pdf.

State of Washington Health Care Authority (WAHCA). 2021. Comment letter to MACPAC: Electronic health record incentive payments to behavioral health providers (March 30, 2021).

State of Washington Department of Health (WADOH). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (2019). Olympia, WA: WADOH. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1680.

State of Wisconsin Department of Health (WIDHS). 2019. Comment letter on proposed rule: 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (2019). Madison, WI: WIDHS. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1276.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2022. *Substance abuse and mental health block grants.* Rockville, MD: SAMHSA. https://www.samhsa.gov/grants/block-grants.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2021. *Disclosure of substance use disorder patient records: how do I exchange Part 2 data?* Rockville, MD: SAMHSA. https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2020. Final Rule: Confidentiality of substance use disorder patient records. Rockville, MD: SAMHSA. F*ederal Register* 85, no. 42986: 42986-43039 https://www.federalregister.gov/documents/2020/07/15/2020-14675/confidentiality-of-substance-use-disorder-patient-records.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2018. SAMHSA listening session transcript, 42 CFR part 2, January 31, 2018, Rockville, MD. https://www.samhsa.gov/sites/default/files/42cfrpart2listeningsession-securitylist.pdf.

U.S. Department of Defense (DoD). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Washington, DC: DoD. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1924.

Vest, J., L. Kern, M. Silver, et al. 2015. The potential for community-based health information exchange systems

to reduce hospital readmissions. *Journal of the American Medical Informatics Association* 22, no. 2: 435–442. https://pubmed.ncbi.nlm.nih.gov/25100447/.

Virginia Hospital & Healthcare Association (VHHA). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Richmond, VA: VHHA. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1867.

Wakeman, S. and P. Friedman. 2017 Outdated privacy law limits effective substance use disorder treatment: The case against 42 CFR Part 2. *Health Affairs Blog*, March 1. https://www.healthaffairs.org/do/10.1377/hblog20170301.058969/full/.

Wang, Q., D.C. Kaelber, R. Xu, et al. 2021. COVID-19 risk and outcomes in patients with substance use disorders: analysis from electronic health records in the United States. *Molecular Psychiatry* 2020, no. 26:30-39. https://www.nature.com/articles/s41380-020-00880-7.

WellSky. 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Kenexa, KS, DC: WellSky. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1650.

Wolf, L., J. Harvell, and A. Jha. 2012. Hospitals ineligible for federal meaningful-use incentives have dismally low rates of adoption of electronic health records. *Health Affairs* 31, no 3: 505-513. https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0351.

Yaraghi, N. 2015. An empirical analysis of the financial benefits of health information exchange in emergency departments. *Journal of the American Medical Informatics Association* 22(6):1169-72. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7784316/pdf/ocv068.pdf.

Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 8, 2022.

Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

4.1   The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health Information Technology to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health information technology adoption and interoperability.

4.2   The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health Information Technology to jointly develop a voluntary certification for behavioral health information technology.

4.1-2 Voting Results	#	Commissioner
Yes	15	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Herrera Scott, Weno
Not Present	1	Scanlon

Raising the Bar: Requiring State Integrated Care Strategies

Raising the Bar: Requiring State Integrated Care Strategies

Recommendation

5.1 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, 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.

Key Points

- The 12.2 million individuals dually eligible for Medicaid and Medicare often experience fragmented care and poor health outcomes when their benefits are not coordinated. Integrating care has the potential to improve care for beneficiaries, eliminate incentives for cost shifting, and reduce spending that may arise from duplication of services or poor care coordination. However, enrollment in integrated models was just over 1 million in 2020.

- States are at different stages of integrating care for their dually eligible populations, and the availability of integrated models and the level of integration offered in those models varies. Some states have achieved high levels of integration, while others offer only minimal or no integrated coverage options.

- State officials point to a number of barriers to integration. These include competing priorities, lack of Medicare expertise, limited staff capacity to manage integrated care initiatives relative to other responsibilities, and limited experience with enrolling dually eligible beneficiaries in Medicaid managed care.

- While the Commission appreciates these dynamics, it continues to press for action to increase enrollment in integrated models, expand the availability of these models, and achieve higher levels of integration. To provide the impetus for action for all states, we recommend that all states be required to develop a strategy to integrate care for dually eligible beneficiaries. We also discuss the key components to be included in such a strategy.

- Given the level of effort and specialized expertise needed to integrate care, we also recommend that Congress provide additional federal funding to support states in developing their strategies.

CHAPTER 5: Raising the Bar: Requiring State Integrated Care Strategies

Integrating Medicaid and Medicare coverage for individuals enrolled in both programs, known as dually eligible beneficiaries, has the potential to improve care and reduce federal and state spending. As noted in the Commission's prior work, dually eligible beneficiaries often experience fragmented care and poor health outcomes due to poor coordination of services between the two programs (MACPAC 2020a and 2020b). Moreover, dually eligible beneficiaries account for about one-third of total costs to the federal government and the states in each program, although they represent just 14 percent of Medicaid beneficiaries and 19 percent of Medicare beneficiaries (MACPAC and MedPAC 2022).

Of the 12.2 million individuals who were dually eligible in 2019, 71 percent were eligible for full Medicaid benefits, and the remainder were eligible only for Medicaid assistance with Medicare premiums and sometimes cost sharing (MACPAC and MedPAC 2022). These groups are known as full-benefit and partial-benefit dually eligible beneficiaries, respectively.

Integrated care efforts tend to focus on full-benefit dually eligible beneficiaries because they have Medicaid benefits to integrate with Medicare (MACPAC and MedPAC 2022). However, just over 1 million full-benefit dually eligible beneficiaries were enrolled in integrated care in 2020 (CMS 2020a).[1]

The Commission's long-term vision is for all dually eligible beneficiaries to be enrolled in an integrated model. To that end, the Commission's work has focused on three key goals: increasing enrollment in integrated products, making integrated products more widely available, and promoting greater integration in existing products.

In our June 2020 and 2021 reports to Congress, we focused on enhancing state capacity to integrate care by recommending additional federal assistance. We also analyzed ways that states could advance integration through contracts with Medicare Advantage (MA) dual eligible special needs plans (D-SNPs) by highlighting existing strategies available to states and describing how state Medicaid program characteristics and local markets may affect state choices.

Over the past year, we consulted with experts on how to further advance integration. In September 2021, we convened a roundtable discussion with states to hear directly about the status of their integration efforts. We focused on states in the early stages of integration to better understand the challenges they face. We also talked with health plans and beneficiary advocates to obtain their perspective on how to raise the bar on integrating care for dually eligible beneficiaries. We heard that integration strategies should focus on ensuring that beneficiary needs are met and that states need more guidance and financial support to stand up integrated models.

Raising the bar on integration will not be successful with a one-size-fits-all approach. States are at different stages of integrating Medicaid and Medicare coverage for dually eligible beneficiaries (Appendix 5A). Some offer fully integrated coverage, while others do not yet have integrated options available. In our conversations with state officials, we heard about some of the different factors—limited state resources, competing priorities for state leadership, and limited experience with enrolling dually eligible beneficiaries in Medicaid managed care—that may make it difficult for states to take steps toward integration. For example, experience enrolling people who are likely to become dually eligible (e.g., older adults and individuals with disabilities) into Medicaid managed care is necessary for states to take advantage of certain strategies, such as default enrollment into D-SNPs.[2]

In the Commission's view, federal policy must both recognize this variation across states but also provide an impetus for further action. In this chapter, we propose an incremental approach that starts by requiring all states to develop a strategy to integrate care for dually eligible beneficiaries. While states will take different paths and make progress at different rates, fully integrated coverage in all states for this population should be the eventual goal. The Commission views a federal requirement that states develop a clear, detailed integrated care strategy as an important step in raising expectations. This step may be particularly useful in spurring action among states that to date have not made progress toward integration. Given the level of effort and specialized expertise needed to integrate care for this population, we also recommend additional federal funding to support states in developing their strategies.

In this chapter, the Commission recommends the following:

- 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, 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.

Finally, we present the rationale for this recommendation and its expected effects on federal spending and on stakeholders, including states, beneficiaries, health plans, and providers.

It is important to note that in addition to support for development of a strategy to integrate care, states will likely need additional resources to set up and operate integrated models. This was the focus of our June 2020 recommendation, which we once again call to the attention of Congress.

Continuum of Integration

States can adopt a number of models to integrate care that exist on a continuum of integration, with some models offering limited integration and others offering fully integrated coverage (Appendix 5A). Use of these models varies widely across states, including the level of integration offered via D-SNPs (Figure 5-1).

Fully integrated models are not available in all states (Appendix 5A).[3] We define fully integrated care as an approach that is intended to align the delivery, payment, and administration of Medicaid and Medicare services (MACPAC 2020b). Ideally, this would involve a single entity covering all Medicaid and Medicare benefits for full-benefit dually eligible beneficiaries (Box 5-1).

D-SNPs are a type of MA plan that limits enrollment to dually eligible beneficiaries. Most D-SNPs offer minimal levels of integration and are referred to as coordination-only D-SNPs because they only coordinate Medicaid services rather than covering them. D-SNPs serve more beneficiaries than other integrated models, with 3.8 million enrollees as of February 2022 (CMS 2022a).[4] They are present in 45 states and the District of Columbia (CMS 2022b). State contracts with D-SNPs must meet minimum requirements for coordination of Medicaid benefits (42 CFR 422.107(c) and (d)). Although the regulations include some minimal coordination between the D-SNP and the state, they do not result in fully integrated coverage (MedPAC 2019).

FIGURE 5-1. Dual Eligible Special Needs Plan Integration Levels by State
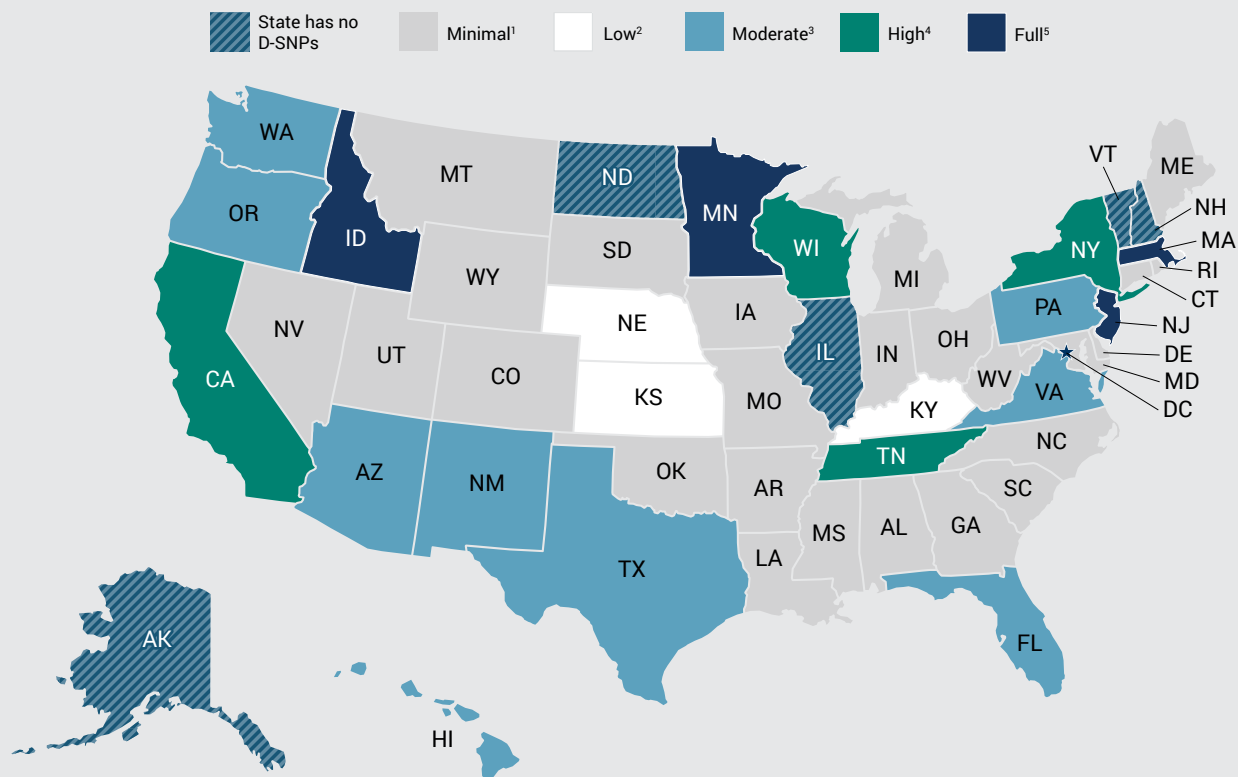
Notes: D-SNP is dual eligible special needs plan. Exclusively aligned enrollment occurs when D-SNP enrollment is limited to full-benefit dually eligible beneficiaries who receive their Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan under the same parent company. This map depicts only the level of integration available in the state based on the presence of D-SNPs, including highly integrated dual eligible special needs plans (HIDE SNPs) and fully integrated dual eligible special needs plans (FIDE SNPs), as described in the following notes. It does not reflect the presence of other integrated models, such as Medicare-Medicaid Plans established under the Financial Alignment Initiative and available in 9 states or Programs of All-Inclusive Care for the Elderly that are available in 30 states (NPA 2022). California has one FIDE SNP that operates with exclusively aligned enrollment, but the FIDE SNP is not available statewide. The other D-SNPs in California are minimally integrated coordination-only D-SNPs. The District of Columbia has one HIDE SNP in 2022 that is capitated to cover all Medicaid benefits but does not restrict enrollment to full-benefit dually eligible individuals. In 2023, the HIDE SNP operating in the District of Columbia will use separate plan benefit packages to serve full- and partial-benefit dually eligible individuals and will have exclusively aligned enrollment for full-benefit dually eligible individuals.

[1] A state with a minimal level of integration is a state that has coordination-only D-SNPs but no HIDE SNPs or FIDE SNPs.

[2] A state with a low level of integration is a state that has at least some HIDE SNPs but has not yet taken active steps to use those D-SNPs to design an integrated care initiative. HIDE SNP status has been achieved because D-SNP parent companies offer Medicaid managed care plans in overlapping service areas.

[3] A state with a moderate level of integration is a state that has HIDE SNPs or FIDE SNPs or both and has worked with the D-SNPs in the state to increase integration through strategies such as selective contracting, in which states contract only with D-SNPs that meet certain state requirements. D-SNPs in the state do not operate with exclusively aligned enrollment.

[4] A state with a high level of integration is a state that has some FIDE SNPs that operate with exclusively aligned enrollment but also has non-integrated or less-integrated D-SNPs.

[5] A state with full integration means all D-SNPs in the state are either FIDE SNPs or HIDE SNPs that operate with exclusively aligned enrollment.

Sources: Mathematica analysis, 2021, for MACPAC. CMS 2022b.

BOX 5-1. Key Features of a Fully Integrated Program

Coverage of all Medicaid and Medicare benefits. A fully integrated program should cover all Medicaid and Medicare benefits for full-benefit dually eligible beneficiaries under one entity with one set of member materials.

Care coordination. Care coordinators and care teams should establish individualized care plans to meet the unique needs of dually eligible beneficiaries enrolled in fully integrated care.

Beneficiary protections and input. A fully integrated model should offer protections to beneficiaries, such as through an ombudsman, and also establish a mechanism for beneficiary input. The Medicare-Medicaid Plans under the Financial Alignment Initiative incorporated both of these elements.

Financial alignment. In a fully integrated model, a single entity should receive a single payment to cover both Medicaid and Medicare services.

Highly integrated dual eligible special needs plans (HIDE SNPs) and fully integrated dual eligible special needs plans (FIDE SNPs) provide higher levels of integration because they are required to cover some Medicaid benefits. They are present in 20 states and the District of Columbia (Appendix 5A). HIDE SNPs offer more coordination with Medicaid than coordination-only D-SNPs because they are required to cover long-term services and supports (LTSS) or behavioral health or both. HIDE SNPs are present in 16 states and the District of Columbia.

FIDE SNPs offer fully integrated coverage and are typically responsible for all Medicaid and Medicare benefits. They are required to cover LTSS; they may also cover behavioral health unless the benefit is carved out by the state. FIDE SNPs may operate with exclusively aligned enrollment, which occurs when enrollment is limited to full-benefit dually eligible beneficiaries who receive their Medicaid benefits through the FIDE SNP. FIDE SNPs are present in 12 states.

Other models that offer fully integrated coverage include Medicare-Medicaid Plans (MMPs) and managed fee for service (FFS) under the Financial Alignment Initiative (FAI) as well as the Program of All-Inclusive Care for the Elderly (PACE). MMPs operate under a three-way contract with the Centers for Medicare & Medicaid Services (CMS), the state, and the plan to provide all Medicaid and Medicare benefits. Under the FAI, nine states are operating capitated model demonstrations in which MMPs cover all Medicare and Medicaid benefits, except Medicaid benefits that the state has carved out, with enrollment of over 400,000 dually eligible beneficiaries (ICRC 2022).[5]

Under managed FFS, the state contracts with an organization to manage all Medicaid and Medicare services on an FFS basis. One state, Washington, operates a managed FFS demonstration under the FAI, which covers all Medicaid and Medicare benefits and enrolls about 11,000 dually eligible beneficiaries (Box 5-2) (WA HCA 2022).

In PACE, a provider organization contracts with CMS and the state to provide all Medicaid and Medicare benefits for individuals age 55 and older who qualify for a nursing facility level of care but reside in the community. Almost all PACE beneficiaries—90 percent—are dually eligible for Medicaid and Medicare (NPA 2022). PACE is available in 30 states with about 60,000 enrollees (NPA 2022).

BOX 5-2. Example of an Integration Approach for States with Medicaid Fee for Service

Given that many states enroll dually eligible individuals in Medicaid fee for service (FFS) (21 states and the District of Columbia as of 2018), it is important to consider integration approaches that do not rely on a Medicaid managed care infrastructure (Appendix 5A). Use of such models could enable more states to further advance integration and reach additional beneficiaries. In 2019, most dually eligible individuals were enrolled in either Medicaid FFS (42 percent) or Medicaid FFS with a limited-benefit Medicaid managed care plan (20 percent) (MACPAC and MedPAC 2022).

A managed FFS model could be used to promote better coordination of Medicaid and Medicare benefits, similar to the model used in Washington. Under this model, a designated entity contracts with the state to coordinate all Medicaid and Medicare services on an FFS basis. Washington operates a managed FFS model through the Financial Alignment Initiative demonstration and uses Medicaid health homes for care coordination. Medicaid health homes coordinate physical and behavioral health and long-term services and supports for Medicaid beneficiaries with chronic illnesses and can be created through a state plan amendment (CMS 2021a). Washington contracts with the health homes lead entities, who in turn contract with a network of providers to deliver mandated core health home services, including comprehensive care management and care coordination, to dually eligible beneficiaries in the demonstration (Archibald et al. 2019). Under the demonstration authority, the state is eligible to receive a portion of the Medicare savings that are generated through this model by preventing avoidable hospitalizations or other high-cost services.

Barriers to Integration

Because states differ in their health care markets and reliance on managed care and have varying priorities, they are at different places on the continuum of integration. Some states have been offering integrated coverage for decades and have achieved high levels of integration, while others offer only minimal or no integrated coverage options. To shed light on state integration efforts and the factors affecting state decisions, MACPAC convened a roundtable in September 2021. States selected to participate in the roundtable had already demonstrated an interest in integrating care but had minimal to moderate levels of integration. Attendees included state staff from six states with minimal levels of integration (Delaware, Louisiana, Maine, Mississippi, Missouri, and North Carolina), one state with a low level of integration (Kansas), and one state with a moderate level of integration (Washington).

At the roundtable, states identified several barriers to integration and how federal policy might address those barriers. These include lack of capacity to focus on integrated care initiatives relative to their other responsibilities. In addition, states noted that many lack experience enrolling the dually eligible population into Medicaid managed care, the delivery system on which most integrated care models are built.

Lack of state capacity

Most roundtable participants agreed that lack of state capacity to take on integrated care is a major challenge, and federal support is needed to help overcome this barrier. They identified several specific constraints, including competing priorities for state leadership, lack of Medicare expertise, and limited staff capacity to manage integrated care initiatives.

Competing priorities. State officials talked about how competing responsibilities and limited bandwidth to focus on integrated care inhibits progress. Standing up an integrated care model is a resource-intensive project that can be affected by other agency priorities, which change frequently. For example, in the time it takes to develop an integrated care strategy, new and unforeseen events such as the COVID-19 pandemic may cause agency priorities to shift and delay efforts to move forward on integrated care. Securing leadership support may be difficult given that integrated care does not necessarily lead to timely or direct reductions in spending, and evaluations of other Medicaid outcomes have had mixed results. Given these competing priorities, leadership commitment to integrated care is crucial to progress.

Lack of Medicare expertise. In addition, states told us that most state Medicaid agency staff have no experience with Medicare requirements. Staff must have expertise to work with D-SNPs, particularly knowledge of Medicare policies, including benefits covered, eligibility requirements, and application requirements. In addition, state leadership may not be familiar with MA or the coverage offered under a D-SNP, making it difficult to advance integrated models that are built on D-SNPs or to establish state contracts with D-SNPs.

Limited staff capacity to manage integrated care initiatives. We heard from roundtable participants that states typically do not have staff who are exclusively dedicated to work on integrating care for dually eligible beneficiaries. In many states, the staff tasked with overseeing D-SNP contracts juggle a range of other responsibilities, from administering multiple home- and community-based services (HCBS) waivers to responding to the COVID-19 pandemic.

States that have achieved higher levels of integration noted the importance of dedicated staff to identify opportunities for integration, serve as project managers, develop internal buy-in among Medicaid and sister agency staff, and move programs forward. One state official described

having a core group of staff from different state agencies who were invested in raising the bar on integration and contributed by drafting decision papers and working on contracts with D-SNPs. States also noted that having someone dedicated to learning about the Medicare program was necessary to make progress on integrated care. Another state noted that staff leads can also help by bringing integrated care considerations, such as data exchange capabilities with Medicare, into agencywide decisions about information technology.

Lack of experience with Medicaid managed care

Many states do not have experience with Medicaid managed care for the dually eligible population, either because the state has managed care but does not enroll the dually eligible population or does not have managed care at all. States told us that opposition to managed care from providers and beneficiary advocates can make it difficult to design an integrated care model that relies on Medicaid managed care. For example, one state official said that the nursing facility industry was opposed to changes in the long-standing approach of providing LTSS through FFS because a switch to managed care could result in disruptions to care for beneficiaries.

States and the federal government may need to explore new and innovative ways to achieve some of the goals of integration, such as care coordination, through FFS models. Exploring opportunities to integrate care outside of managed care could enable some states to reach beneficiaries who have expressed a preference for coverage through FFS or who are statutorily exempt from mandatory Medicaid managed care enrollment, such as American Indian and Alaska Native individuals.[6]

Why an Integrated Care Strategy is Needed

Given the varied approaches to integrating care, every state should be able to devise a strategy to provide integrated coverage that is compatible with its population, delivery system, and geography. Developing a strategy, with support from the federal government, is a feasible first step for all states to raise the bar on integrated care. States could design the transition to enrollment in integrated coverage to occur gradually, for example, by phasing it in geographically, but the goal of the strategy should be for the majority of full-benefit dually eligible beneficiaries to be enrolled in an integrated model. Stakeholders we spoke with expressed support for requiring states to develop a strategy, particularly if it does not include rigid goals for a particular level of integrated care by a certain date. Stakeholders viewed this approach as giving states a place to start, particularly states that may be uncertain as to how to proceed.

The federal government's role would be to guide the high-level design of state strategies by requiring certain elements that are informed by a decade of FAI demonstrations and to create an expectation that states should move toward integration, even if their paths forward may differ. We envision that states would have two years to develop their strategy and would be required to review and update the strategy periodically. These updates could coincide with attaining certain milestones, such as executing a contract with a D-SNP, to be determined by the Secretary of the U.S. Department of Health and Human Services (the Secretary).

Given the lack of Medicare expertise among many state staff, technical assistance and financial support from the federal government would be necessary for most states. In the Commission's view, providing states with additional resources to finance the development of an integrated care strategy would advance integrated care efforts and set states up for success. Similarly, federal resources were made available for states

interested in the FAI in 2011, when CMS granted 15 states up to $1 million each to develop new care models for dually eligible beneficiaries (CMS 2011). States used those funds to develop proposals to participate in the demonstration as well as to hire dedicated staff, engage external contractors, and support data analytics. New resources could help states overcome existing capacity limits, as noted previously, as they develop their strategies.

The process of developing the strategy should include provisions for stakeholder engagement and public transparency. States should consult with key stakeholders, including beneficiaries, providers, and health plans. They should also be required to submit the integrated care strategy for public comment as is now required for the Medicaid managed care quality strategy (42 CFR 438.340).[7] CMS should clearly articulate in rulemaking which stakeholders should be involved in developing and reviewing the strategy. For example, for the managed care quality strategy, states must obtain input from their medical care advisory committee (42 CFR 431.12). States are also required to obtain input from beneficiaries and consult with tribes. The strategy should also be made available on the state Medicaid agency's website.

The integrated care strategy should also be structured to promote health equity for dually eligible beneficiaries and ensure the approach to integration addresses the needs of diverse subpopulations of beneficiaries. Compared with Medicare beneficiaries who are not dually eligible, dually eligible beneficiaries have worse health outcomes. For example, they are more likely to report being in poor health (13 percent compared with 4 percent) or to be institutionalized (13 percent compared with 3 percent) (MACPAC and MedPAC 2022). In addition, dually eligible beneficiaries are more than two times more likely to be hospitalized for complications from COVID-19 (CMS 2021b). They may also have more limited access to primary care physicians; one-third of U.S. counties with the highest density of dually eligible beneficiaries are designated as health professional

shortage areas by the Health Resources and Services Administration (Xu et al. 2021).

Integrating care can also serve as a catalyst to address disparities through improved care coordination and identification of unmet need or barriers to accessing appropriate services. Dually eligible beneficiaries are more likely to be disabled than non-dual Medicare beneficiaries (MACPAC and MedPAC 2022). They are also more likely than non-dual Medicare beneficiaries to be Black (21 percent and 9 percent, respectively) or Hispanic (17 percent and 6 percent, respectively) (MACPAC and MedPAC 2022).[8]

Components of an Integrated Care Strategy

In the following sections, we list the high-level components that should be required for a strategy to integrate care for dually eligible beneficiaries and provide examples of different ways states could tailor their strategies for each. Some of these components align with those included in a recent final rule that CMS published on May 9, 2022 (CMS 2022c). For example, the strategy would include a mechanism for beneficiary input, such as the enrollee advisory committee that CMS has required that all D-SNPs establish (CMS 2022c).

Much of the following discussion centers around managed care but is also applicable to FFS; if not, we have noted that.

Integration approach

The integrated care strategy should specify the approach a state is considering and whether it will leverage a managed care or FFS delivery system. Given their current environment, states may choose different approaches to further advance integration. For example, states that enroll dually eligible beneficiaries in Medicaid managed care may choose to focus on leveraging their contracts with D-SNPs, eventually moving to HIDE SNPs

and FIDE SNPs to further advance integration. Others might be more interested in pursuing integration through managed FFS, Medicaid health homes, accountable care organizations, or other shared savings models. For example, Washington uses Medicaid health homes as the vehicle for integration with Medicare FFS (Box 5-2).

The integrated care strategy should include provisions to ensure care coordination for dually eligible beneficiaries, regardless of delivery system. Care coordination typically involves a person or team that helps a beneficiary manage care transitions, access and coordinate Medicaid and Medicare benefits, and address social needs. An integrated program should involve care coordinators and an interdisciplinary care team to establish person-centered care plans to meet the unique needs of dually eligible individuals, such as those who are part of the MMPs. In the Commission's view, comprehensive care coordination is an essential component of an integrated model.

CMS should provide technical assistance to states, including templates or examples of potential approaches to integration, such as leveraging D-SNPs or FFS approaches, to support their decision making in developing an integrated care strategy (Rizer et al. 2020).

Eligibility and benefits covered

The integrated care strategy should specify who will be eligible to enroll in integrated models, with a goal of expanding eligibility to more dually eligible beneficiaries in the state over time. The strategy should focus on full-benefit dually eligible beneficiaries because this group stands to benefit the most from integrated coverage. However, it should also consider the needs of partial-benefit dually eligible beneficiaries and seek to avoid disruptions in their coverage. For example, partial-benefit dually eligible beneficiaries may benefit from the additional supplemental benefits offered by D-SNPs that are not available in other MA plans.[9] CMS's recent final rule focused on changes

affecting full-benefit dually eligible beneficiaries enrolled in D-SNPs but also made provisions for partial-benefit dually eligible beneficiaries, allowing them to stay enrolled in D-SNPs with certain modifications, such as separate plan benefit packages (CMS 2022c).

The integrated care strategy should specify the subpopulations of dually eligible beneficiaries who will be eligible to enroll and how coverage will be tailored to their different needs and circumstances. Dually eligible beneficiaries are a diverse group, including individuals who qualified for Medicare based on their age and may be relatively healthy and others who are younger and qualified for Medicare because of a disability. These groups may look for different types of benefits from their coverage, based on their different circumstances and characteristics.

The strategy should also consider how to improve integration for groups that have been mostly excluded from integrated models that rely on managed care. For example, relatively few states provide coverage through managed care to people with intellectual or developmental disabilities (Barth et al. 2020). Individuals with intellectual or developmental disabilities rely on a broad array of services, often from birth to end of life. States have been hesitant to transition to managed care because of the potential to disrupt care for this high-cost, high-need population. This has been of particular concern for LTSS users. In other cases, individuals who are statutorily exempt from mandatory enrollment in Medicaid managed care, such as American Indian or Alaska Native individuals, are often left out of integrated options in states that rely on managed care. To the extent that states pursue an integrated approach through managed care, such as an integrated D-SNP model, the state should also consider how to improve integration for these groups outside of managed care.

The integrated care strategy should specify which Medicaid benefits will be covered and which,

if any, will be carved out. Many states provide Medicaid coverage through managed care, but certain Medicaid benefits may be carved out of comprehensive managed care and provided through FFS or limited benefit plans. These carve outs tend to carry over into integrated care arrangements as well. Carve outs may affect the level of integration that can be achieved by contracting with a D-SNP, as all Medicaid benefits may not be covered. The strategy should move toward full integration of all Medicaid benefits to the extent practicable while allowing for a narrow set of benefit carve outs when needed, recognizing the operational challenges for states in integrating previously carved-out benefits (Holladay et al. 2019). For example, under current law, CMS allows limited Medicaid LTSS and behavioral health services carve outs in HIDE SNPs and FIDE SNPs (CMS 2020b).

If the integration approach involves D-SNPs, the integrated care strategy should also detail the state's expectation for the provision of non-medical MA supplemental benefits for dually eligible beneficiaries. For example, D-SNPs may offer services such as adult day care services, transportation for non-medical needs, pest control, and indoor air quality equipment and service (CMS 2019). States can require D-SNPs to offer these services to complement Medicaid benefits and reduce duplication across the programs (MACPAC 2021a).

Enrollment strategy

The integrated care strategy should describe the state's approach to enrollment.[10] For states with Medicaid managed care, automated enrollment processes, such as passive enrollment in the MMPs and default enrollment in D-SNPs, can increase enrollment and retention in integrated programs.[11] For example, in the FAI, passive enrollment led to higher enrollment in MMPs (MACPAC 2019). However, some stakeholders have raised concerns over how the passive enrollment process may limit the ability of dually

eligible individuals to review accessible materials, understand their options, and make an informed choice (Brill et al. 2021).

States can use other enrollment strategies to further advance integration and promote retention. For example, states can require exclusively aligned enrollment, limiting enrollment in a D-SNP to full-benefit dually eligible beneficiaries who receive their Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan under the same parent company. Under this strategy, one organization is responsible for both Medicaid and Medicare benefits for all its members, maximizing the potential for integration.

Stakeholders have also suggested improvements to the enrollment process, such as improving information provided to dually eligible beneficiaries about their integrated care options and allowing beneficiaries to maintain access to existing providers when enrolling in integrated care for a certain period of time (Brill et al. 2021).[12]

Further, the strategy should describe how the state will conduct outreach to eligible beneficiaries. In the past, low enrollment in integrated care has been associated with a lack of understanding of the benefits of integrated care and a desire to maintain existing providers. At our roundtable, state staff noted that outreach with beneficiaries, providers, and other key stakeholders to help them understand the value of integration is key to bolstering enrollment and obtaining buy-in from beneficiaries.

Outreach strategies should also consider how to provide outreach to a diverse group of dually eligible beneficiaries in a culturally competent manner. For example, states should describe how they will conduct outreach to dually eligible beneficiaries with limited English proficiency.

States may also wish to include a strategy to work with entities such as the state health insurance assistance programs (SHIPs) to ensure they are appropriately trained to advise clients about

integrated care options. SHIPs are present in every state, receive federal funding to provide one-on-one assistance to Medicare beneficiaries, and are a resource for dually eligible beneficiaries during the enrollment process.[13]

Finally, states should also describe how they will conduct outreach to providers to improve participation in integrated care. For example, many beneficiaries opted out of the FAI, in some cases with encouragement from providers, to stay with an existing provider who was not participating. Eliciting input from providers enabled one state that participated in our roundtable to better understand provider preferences and incorporate them into the integrated care initiative.

Beneficiary protections and input

The integrated care strategy should contain key beneficiary protections, such as those offered through an ombudsman, a unified appeals and grievance process when possible, care coordination, and an advisory mechanism for beneficiaries to provide input into the design and ongoing operation of the integrated care program.

States, plans, and beneficiary advocates we interviewed viewed an ombudsman program as a critical element of an integrated care strategy. An ombudsman program gives beneficiaries a dedicated point of contact to learn about their coverage and to get help with problems that may arise, such as filing appeals related to coverage denials. For example, states could look to the FAI that required an ombudsman for each demonstration. In the FAI, states could leverage an existing ombudsman program, such as a long-term care ombudsman (the approach taken in Virginia), or contract with a non-profit organization (the approach taken in California) (Archibald et al. 2021).

Depending on the integration approach, the strategy should consider a unified appeals and grievance process. Appeal and grievance processes are an important beneficiary protection in Medicaid and in Medicare. They give

beneficiaries a formal opportunity to question coverage decisions or express dissatisfaction with a health plan or a provider. Given that the processes vary in each program, creating confusion for beneficiaries and providers, these should be integrated into a single process when possible. The FAI requires integration of the Medicaid and Medicare appeals and grievance processes at the health plan level, which is the first level of appeal.[14] Certain D-SNPs with exclusively aligned enrollment must also have a unified process, and CMS expanded the number of D-SNPs subject to this requirement in the recent final rule (Stringer and Tourtellotte 2020, CMS 2022c).

Finally, the strategy should establish a meaningful mechanism to obtain input from beneficiaries on their experiences in integrated care. We heard interest from states in ensuring that integrated care models are designed with beneficiary preferences and needs in mind. The strategy should provide opportunities for input and engagement by key subgroups, such as HCBS users, and should represent the diversity of dually eligible beneficiaries. Beneficiaries should provide input on issues of access to care, care coordination, and health equity, among other topics.

Beneficiary input should be collected routinely by health plans. The advisory mechanism could be modeled after the approach in the FAI. Each FAI MMP is required to set up an enrollee advisory committee or recruit MMP enrollees to governing boards to ensure that the plans obtain enrollee input on the program (ATI Advisory 2021, CMS 2022c). Membership is made up of beneficiaries, family members, and other caregivers that reflect the enrolled population (CMS 2022c).

States could also set up beneficiary advisory committees to provide input to the state directly. For example, as part of its FAI demonstration, Massachusetts established the One Care Implementation Council. At least half the membership of the One Care Implementation Council is made up of beneficiaries (CMS 2022c).

Data analytics

The integrated care strategy should describe how the state will exchange data with Medicare and how states will learn how to use Medicare data, such as the Medicare Modernization Act file. The Medicare Modernization Act file enables states to identify dually eligible beneficiaries and Medicaid beneficiaries who will become dually eligible based on an exchange of demographic data between states and CMS.

State processes and infrastructure for successfully exchanging data with Medicare are critical to coordination of Medicaid and Medicare benefits in a D-SNP model. For example, we heard from one state that the state's health information exchange has been one of the most important factors enabling that state to take steps toward integrated care. The health information exchange allows D-SNPs and Medicaid health homes in the state to store and share data regarding hospital admissions, discharges, and transfers for dually eligible beneficiaries.

The data analytics section of the strategy should also identify the data-sharing arrangements states will need to have in place with D-SNPs to use D-SNP contracting strategies, such as default enrollment (42 CFR 422.107).[15] The strategy should consider whether states will use their contracting authority to require D-SNPs to submit data or reports to states for oversight of operations and quality of care. For example, requiring D-SNPs to submit encounter data or data on prescription drugs covered under Medicare Part D can help the state obtain a comprehensive picture of which services enrollees are using and identify areas for improvement, such as the need for added care coordination. Several states told us they meet monthly with their D-SNPs and their Medicaid managed care plans to discuss data issues and foster relationships as well as promote coordination across plan types. State staff said these meetings allow the state and the plan to get on the same page before the D-SNP begins submitting reports to the state, saving time later.

The strategy should also describe how the state will share data with other state agencies in cases in which another agency may administer a Medicaid benefit. For example, in South Dakota, LTSS is administered by the Department of Human Services, while the Medicaid program is part of the Department of Social Services.

Finally, the strategy should describe how the state would collect and use beneficiary demographic data, such as age, gender, disability, social determinants of health, race and ethnicity, or residence in an urban or rural area, that may reflect the disparate needs of different subpopulations. Collection of this data could inform measurements of quality and beneficiary experience in integrated care. Improved collection of demographic data can also help the state better target efforts to improve health equity and identify and address potential disparities. For example, to maximize COVID-19 vaccinations among dually eligible beneficiaries and to address access barriers and vaccine hesitancy, CMS has encouraged plans serving dually eligible beneficiaries to collect data on COVID-19 testing, hospitalization, and outcomes, stratified by gender, race, ethnicity, preferred language, disability status, and other demographics (CMS 2021c).

Quality measurement

The integrated care strategy should include a plan for how states will measure the quality of the care that dually eligible beneficiaries receive in the integrated care program. States could draw on efforts already underway to develop standard quality measures for populations with complex care needs (BPC 2021, Bossley and Imbeah 2020).

Quality measurement could be based on the model of care (MOC) that is statutorily required for every SNP (§ 1859(f)(7) of the Social Security Act). This tool ensures that the plan has identified the needs of its enrollees and is addressing them through its care management practices (CMS 2021d). All SNPs are required to have a MOC approved by the National Committee for Quality Assurance. The

MOC provides the basic framework that the SNP will use to meet the needs of its enrollees (CMS 2021d). The Secretary sets the standards for how the MOC is scored by the National Committee for Quality Assurance, including clinical and non-clinical elements. The MOC is scored in four areas: description of the population served, care coordination, provider network, and MOC quality measurement and performance improvement. Each of the four areas contain detailed measurement requirements. For example, the description of the population standard includes specific characteristics of the population, such as age, gender and ethnicity profiles, incidence and prevalence of major diseases, and other barriers that the target population faces (NCQA 2021). The care coordination standard includes a health risk assessment, an individualized care plan, and an interdisciplinary care team (NCQA 2021).

Further, quality measurement should go beyond clinical measures and include LTSS quality measures that address the experience of beneficiaries receiving HCBS. For example, one of the key goals of HCBS is to allow individuals to live independently in the community, see their family and friends, and participate in activities that would be unavailable to them in an institution. LTSS quality measures should consider how to measure these social outcomes as well as whether beneficiaries are receiving the level of care and direct service hours they need. For example, in 2020, CMS released a request for information to solicit feedback on a set of standardized HCBS quality measures (CMS 2020c). These proposed quality measures were intended as a resource for states with managed LTSS plans. Many of the measures proposed by CMS are drawn from questions in nationally accredited beneficiary surveys of LTSS users. These surveys include the National Core Indicators, the National Core Indicators of Aging and Disabilities, and the HCBS Consumer Assessment of Healthcare Providers and Systems. States could consider how to use these surveys to measure quality for LTSS users in integrated care programs.

Commission Recommendation

The Commission recommends that states develop a strategy to integrate care for their dually eligible beneficiaries. The Commission also recommends that states be given federal support to do so.

Recommendation 5.1

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 as needed, to be determined 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.

Rationale

The Commission recommends that all states develop a strategy to integrate care as a framework for raising the bar on integration. Many states need a place to start, and requiring that they develop a strategy is an important step to ensure that the time and resources are dedicated to improving delivery models for this population.[16]

The Commission also recommends additional federal funding to enhance state capacity to integrate care. Such resources could be used to finance the administrative costs of designing a strategy, hire new staff with Medicare expertise, or train existing state staff in Medicare. This recommendation is consistent with the recommendation in our June 2020 report but goes a step further by specifically linking federal funding to the development of an integrated care strategy.

Implications

Federal spending. This recommendation would increase federal spending by the amount of the additional funding provided to states. In the long run, greater adoption of integrated models and increased enrollment could affect spending due to increased coordination and reduced use of duplicative services, although the extent to which strategy development leads to such outcomes may not be quantifiable.

States. States would have to dedicate staff and other resources to develop the strategy. The federal support provided would potentially increase state Medicare expertise, reducing one of the barriers of moving to an integrated care model.

Enrollees. There is no direct effect on beneficiaries, although they may be asked for input as the state works through the process of developing an integrated care strategy. Ultimately, the effect on beneficiaries will depend upon which actions states take. To the extent this recommendation leads to greater availability of integrated care and more enrollment in integrated programs, beneficiaries could experience more coordinated care.

Plans and providers. There is no direct effect on plans and providers, although they may be asked for input on strategy development.

Looking Ahead

We plan to continue our work on integrated care for dually eligible beneficiaries in the coming year. This could include a focus on the beneficiary experience in integrated care. In addition, we will continue to reinforce support for states and will monitor potential changes to integrated coverage as a result of publication of the final rule, including the implications of transitioning MMPs to D-SNPs.

Endnotes

[1]   The Centers for Medicare & Medicaid Services defines enrollment in integrated care as enrollment in fully integrated dual eligible special needs plans and other integrated dual eligible special needs plans whose enrollees are also enrolled in affiliated Medicaid managed care plans that generally cover substantial behavioral health services or long-term services and supports or both. Other models included in the 2020 enrollment figure are Washington's managed fee-for-service program, Medicare-Medicaid Plans, and the Program of All-Inclusive Care for the Elderly (CMS 2020a).

[2]   States that enroll dually eligible beneficiaries in Medicaid managed care can allow or require D-SNPs to use default enrollment, a process under which the state identifies Medicaid beneficiaries who are becoming eligible for Medicare and enrolls them into a D-SNP under the same parent company as their current Medicaid managed care plan.

[3]   In 2022, MMPs are present in 9 states and FIDE SNPs are available in 12 states. In three states, both MMPs and FIDE SNPs are available. One state, Washington, has a managed FFS model. Programs of All-Inclusive Care for the Elderly (PACE) are available in 30 states (NPA 2022). PACE offers fully integrated coverage but because of its smaller reach relative to other integrated care models, it is not a focus of this chapter.

[4]   This total does not include 285,000 dually eligible beneficiaries enrolled in D-SNPs in Puerto Rico (CMS 2022a).

[5]   On May 9, 2022, CMS published a final rule in which the agency described a planned approach for converting MMPs to integrated D-SNPs. This approach is informed by comments received on the notice of proposed rulemaking that CMS published on January 12, 2022. MMP demonstrations are scheduled to end between December 31, 2022, and December 31, 2023. In the final rule, CMS offers states interested in converting their MMPs into integrated D-SNPs the opportunity to extend their demonstrations through 2025 under certain conditions and in order to smooth the transition, with a transition plan to be submitted to CMS by October 1, 2022. For states that do not choose to convert MMPs to integrated D-SNPs, CMS plans to work with them on reaching an appropriate MMP conclusion by December 31, 2023. CMS also applies many MMP policies to D-SNPs, such as the requirement that the plan establish an enrollee advisory committee (CMS 2022c).

[6]   States may not use a state plan amendment to require American Indian and Alaska Native (AIAN) individuals to enroll in managed care unless the entity is an Indian health entity (i.e., an entity operated by the Indian Health Service, a tribe, or an urban Indian organization) (§ 1932(a)(2)(C) of the Social Security Act). AIAN individuals may choose to enroll in a managed care plan. In some states, AIAN individuals represent a large share of overall Medicaid enrollment. For example, in Alaska and South Dakota, more than 30 percent of Medicaid enrollees are AIAN individuals. For more, see MACPAC's issue brief *Medicaid's Role in Health Care for American Indians and Alaska Natives* (MACPAC 2021b).

[7]   States contracting with a managed care organization or a prepaid inpatient health plan are required to develop and adopt a quality strategy with input from beneficiaries and stakeholders (42 CFR 438.340). Minimum requirements for this strategy include "procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the managed care organization and prepaid inpatient health plan contracts, and to individuals with special health care needs" and "procedures that identify the race, ethnicity, and primary language spoken of each Medicaid enrollee."

[8]   In 2019, most individuals dually eligible for Medicaid and Medicare benefits were female (59 percent) and white (54 percent) and lived in an urban area (79 percent). Dually eligible beneficiaries were more likely to be white (54 percent) than non-dual Medicaid beneficiaries who were eligible on the basis of a disability (46 percent) but less likely than non-dual Medicare beneficiaries (82 percent) (MACPAC and MedPAC 2022).

[9]   Compared with regular MA plans, D-SNPs may allocate more rebate dollars to benefits given that Medicaid already provides assistance with Medicare cost sharing for dually eligible beneficiaries. D-SNPs may also be more likely to offer supplemental benefits targeted to the needs of dually eligible beneficiaries, such as adult day care services, home-based palliative care, in-home support services, caregiver supports, medically approved non-opioid pain management, home and bath safety devices and modifications, transportation, and coverage for over-the-counter medications and items (MACPAC 2021a). D-SNPs may also offer benefits such as

home-delivered meals, pest control services, non-medical transportation, indoor air quality equipment, and structural home modifications (CMS 2019).

[10] Some of these strategies, such as automated enrollment into a managed care plan, are not relevant in FFS.

[11] Under the FAI, states could passively enroll dually eligible beneficiaries into MMPs at the beginning of the calendar year. States can allow or require D-SNPs to use default enrollment, a process under which the state identifies Medicaid beneficiaries who are becoming eligible for Medicare and enrolls them into a D-SNP under the same parent company as their current Medicaid managed care plan.

[12] Based on focus groups with beneficiaries, Brill and coauthors (2021) recommended that states allow beneficiaries to maintain a relationship with existing providers for up to one year to avoid disruptions in care, such as delays in access to medications as a result of a transition to a new pharmacy. While the MMPs allowed a 90-day transition, focus group participants considered this insufficient to avoid disruptions (Brill et al. 2021).

[13] SHIPs are run by volunteer counselors who provide advice to Medicare beneficiaries about their Medicare coverage options. SHIPs receive federal funding administered by the Administration for Community Living.

[14] Most of the time, an appeal is resolved at the health plan level, but if not, beneficiaries can pursue higher levels of appeal, ultimately reaching legal review by a state or federal court.

[15] To implement default enrollment, states would need to put in place systems to share data with D-SNPs about Medicaid beneficiaries becoming eligible for Medicare and about the status of their Medicaid redeterminations upon becoming eligible for Medicare. States would need to do this in a timely manner to allow D-SNPs to notify Medicaid beneficiaries of their upcoming enrollment into a D-SNP within 60 days of becoming eligible for Medicare.

[16] MACPAC's recommendation requests that Congress authorize the Secretary to require that all states develop a strategy. It is unclear if the authority already exists for the Secretary to establish this requirement or whether additional authority would be needed.

References

Archibald, N., D. Perra, A. Tourtellotte, and K. Lim. 2021. *State approaches to developing and operating ombudsman programs for demonstrations under the Financial Alignment Initiative*. Hamilton, NJ: Center for Health Care Strategies. https://www.integratedcareresourcecenter.com/sites/default/files/Ombudsman%20Programs%20brief.pdf.

Archibald, N., K. Moses, and L. Rava. 2019. *Using health homes to integrate care for dually eligible individuals: Washington state's experiences*. Hamilton, NJ: Center for Health Care Strategies. https://www.chcs.org/media/Washington-case-study_Final.pdf.

ATI Advisory. 2021. *Enhancing Medicare-Medicaid integration: Bringing elements of the Financial Alignment Initiative into dual-eligible special needs plans*. Washington, DC: ATI Advisory. https://atiadvisory.com/enhancing-medicare-medicaid-integration-bringing-elements-of-the-fai-into-d-snps/.

Barth, S., S. Lewis, and T. Simmons. 2020. *Medicaid services for people with intellectual or developmental disabilities—evolution of addressing service needs and preferences*. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-services-for-people-with-intellectual-or-developmental-disabilities-evolution-of-addressing-service-needs-and-preferences/.

Bipartisan Policy Center (BPC). 2021. *Guaranteeing integrated care for dual eligible individuals*. Washington, DC: BPC. https://bipartisanpolicy.org/report/integrated-care/.

Bossley, H., and K. Imbeah. 2020. *Measuring complexity: Moving toward standardized quality measures for the field of complex care*. Camden, NJ: National Center for Complex Health and Social Needs. https://www.nationalcomplex.care/wp-content/uploads/2020/05/Quality-measures-report_final.pdf.

Brill, R., B. Gleason, J. Curbera, et al. 2021. *Listening to dually eligible individuals: Person-centered enrollment strategies for integrated care.* Washington, DC: Community Catalyst. https://www.healthinnovation.org/Person-Centered-Enrollment-Strategies-for-Integrated-Care.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. *SNP comprehensive report 2022 02.* Baltimore, MD: CMS. https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldata special-needs/snp-comprehensive-report-2022-02.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. *Integration status for contract year 2022 D-SNPs.* Baltimore, MD: CMS. https://www.cms.gov/files/document/smacdsnpintegrationstatusesdatacy2022.xlsx.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Medicare program; Contract year 2023 policy and technical changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and regulatory revisions in response to the COVID-19 Public Health Emergency; Additional policy and regulatory revisions in response to the COVID-19 Public Health Emergency. Final Rule. *Federal Register* 87, no. 89 (May 9): 27704—27902. https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. *Medicaid Health Homes: An overview*. Fact Sheet. Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. *Medicare COVID-19 data snapshot overview*. Baltimore, MD: CMS. https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Medicare program: Contract year 2023 policy and technical changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. Final Rule. *Federal Register* 87, no. 89 (May 9): 27704—27902. https://www.federalregister.gov/documents/2022/01/12/2022-00117/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021d. *Model of care (MOC)*. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *Medicare-Medicaid Coordination Office: FY 2020 Report to Congress*. Baltimore, MD: CMS. https://www.cms.gov/files/document/reporttocongressmmco.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. Memo from Sharon Donovan regarding "Additional guidance on CY 2021 Medicare-Medicaid integration requirements for dual eligible special needs plans (D-SNPs)." January 17, 2020. https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020c. Request for information: Recommended measure set for Medicaid-funded home and community-based services. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Memo from Kathryn Coleman regarding "Implementing supplemental benefits for chronically ill enrollees." April 24, 2019. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. *15 states win contracts to develop new ways to coordinate care for people with Medicare and Medicaid*. April 14, 2011, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/fact-sheets/15-states-win-contracts-develop-new-ways-coordinate-care-people-medicare-and-medicaid.

Holladay, S., E. Bayer, I. Dave, et al. 2019. *Financial Alignment Initiative: Michigan MI Health Link first evaluation report*. Waltham, MA: RTI International. https://www.michigan.gov/documents/mdhhs/MI_FAI_EvalReport1_666833_7.pdf.

Integrated Care Resource Center (ICRC). 2022. *Monthly enrollment in Medicare-Medicaid plans by plan and by state, January 2021 to January 2022*. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/sites/default/files/MMP_Enroll_by_State_Jan_2022.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. Chapter 6: Improving integration for dually eligible beneficiaries: Strategies for state contracts with dual eligible special needs plans. In *Report to Congress on Medicaid and CHIP*. June 2021. Washington, DC: MACPAC. https://www.macpac.gov/publication/improving-integration-for-dually-eligible-beneficiaries-strategies-for-state-contracts-with-dual-eligible-special-needs-plans/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *Medicaid's role in health care for American Indians and Alaska Natives.* Washington, DC: MACPAC. https://www.macpac.gov/publication/16275/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Chapter 2: Integrating care for dually eligible beneficiaries: Policy issues and options. In *Report to Congress on Medicaid and CHIP*. June 2020. Washington, DC: MACPAC. https://www.macpac.gov/publication/chapter-2-integrating-care-for-dually-eligible-beneficiaries-policy-issues-and-options/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Chapter 1: Integrating care for dually eligible beneficiaries: Background and context. In *Report to Congress on Medicaid and CHIP*. June 2020. Washington, DC: MACPAC. https://www.macpac.gov/publication/chapter-1-integrating-care-for-dually-eligible-beneficiaries-background-and-context/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. The complex art of making it simple: Factors affecting enrollment in integrated care demonstrations for dually eligible beneficiaries. Washington, DC: MACPAC. https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC) and Medicare Payment Advisory Commission (MedPAC). 2022. *Data Book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

Medicare Payment Advisory Commission (MedPAC). 2019. Chapter 12: Promoting integration in dual-eligible special needs plans. In *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun19_medpac_reporttocongress_sec-pdf/.

National Committee for Quality Assurance (NCQA). 2021. *Model of care scoring guidelines for contract year 2023*. Washington, DC: NCQA. https://snpmoc.ncqa.org/resources-for-snps/scoring-guidelines/.

National PACE Association (NPA). 2022. *PACE by the numbers*. Alexandria, VA: NPA. https://www.npaonline.org/policy-and-advocacy/pace-facts-and-trends-0.

Rizer, A., A. Abdnor, and A. Mir. 2020. *HCBS—just one piece of the puzzle*. Washington, DC: ATI Advisory. https://atiadvisory.com/hcbs-just-one-piece-of-the-puzzle/.

Stringer, R., and A. Tourtellotte. 2020. *Integrated appeal and grievance process for integrated D-SNPs with "exclusively aligned" enrollment*. Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/sites/default/files/Appeal_and_Grievance_Fact_Sheet_0.pdf.

Washington Health Care Authority (WA HCA). 2022. *Washington State's fee-for-service dual eligible demonstration quarterly report*. Olympia, WA: WA HCA. https://www.hca.wa.gov/assets/billers-and-providers/HH-duals-demonstration-summary.pdf.

Xu, W., S. Retchin, and P. Buerhaus. 2021. Dual-eligible beneficiaries and inadequate access to primary care providers. *The American Journal of Managed Care* 27, no. 5: 212–216. https://www.ajmc.com/view/dual-eligible-beneficiaries-and-inadequate-access-to-primary-care-providers.

Commission Vote on Recommendation

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on March 4, 2022.

Raising the Bar: Requiring State Integrated Care Strategies

5.1 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, 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.

5.1 Voting Results	#	Commissioner
Yes	16	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Scanlon, Herrera Scott, Weno

APPENDIX 5A: State Use of Integrated Models

States use multiple models to serve dually eligible beneficiaries (Table 5A-1). Examples of fully integrated models include a Medicare-Medicaid Plan under the Financial Alignment Initiative, a managed fee-for-service model under the Financial Alignment Initiative, a Medicare Advantage fully integrated dual eligible special needs plan (FIDE SNP), and a Program of All-Inclusive Care for the Elderly.[1]

Most dual eligible special needs plans (D-SNPs) offer minimal levels of integration and are referred to as coordination-only D-SNPs because they are only required to coordinate Medicaid services, not cover them. Highly integrated dual eligible special needs plans (HIDE SNPs) must cover behavioral health services or long-term services and supports.

TABLE 5A-1. Landscape of Integrated Care for Dually Eligible Beneficiaries by State, January 2022

| State | MMP | PACE | D-SNP | | | Medicaid managed care for dually eligible beneficiaries?[1] |
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Total	**9**	**30**	**35**	**17**	**12**	**29**
Alabama	–	Yes	Yes	–	–	–
Alaska	–	–	–	–	–	–
Arizona	–	–	–	Yes	Yes	Yes
Arkansas[2]	–	Yes	Yes	–	–	Yes
California[3]	Yes	Yes	Yes	–	Yes	Yes
Colorado[3]	–	Yes	Yes	–	–	Yes
Connecticut	–	–	Yes	–	–	–
Delaware	–	Yes	Yes	–	–	Yes
District of Columbia	–	–	–	Yes	–	No
Florida	–	Yes	Yes	Yes	Yes	Yes
Georgia	–	–	Yes	–	–	No
Hawaii	–	–	–	Yes	–	Yes
Idaho	–	–	–	–	Yes	Yes
Illinois	Yes	–	–	–	–	Yes
Indiana	–	Yes	Yes	–	–	No
Iowa	–	Yes	Yes	–	–	Yes
Kansas	–	Yes	–	Yes	–	Yes
Kentucky	–	–	Yes	Yes	–	Yes
Louisiana[4]	–	Yes	Yes	–	–	–
Maine	–	–	Yes	–	–	–

TABLE 5A-1. (continued)

| State | MMP | PACE | D-SNP | | | Medicaid managed care for dually eligible beneficiaries?[1] |
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Total	**9**	**30**	**35**	**17**	**12**	**29**
Maryland	–	Yes	Yes	–	–	No
Massachusetts[5]	Yes	Yes	–	–	Yes	Yes
Michigan	Yes	Yes	Yes	–	–	Yes
Minnesota[6]	–	–	–	Yes	Yes	Yes
Mississippi	–	–	Yes	–	–	No
Missouri	–	–	Yes	–	–	No
Montana	–	–	Yes	–	–	–
Nebraska	–	Yes	Yes	Yes	–	Yes
Nevada	–	–	Yes	–	–	No
New Hampshire	–	–	–	–	–	Yes
New Jersey	–	Yes	–	–	Yes	Yes
New Mexico	–	Yes	–	Yes	–	Yes
New York[3]	Yes	Yes	Yes	Yes	Yes	Yes
North Carolina[7]	–	Yes	Yes	–	–	–
North Dakota	–	Yes	–	–	–	No
Ohio	Yes	Yes	Yes	–	–	Yes
Oklahoma	–	Yes	Yes	–	–	–
Oregon[9]	–	Yes	Yes	Yes	–	Yes
Pennsylvania	–	Yes	Yes	Yes	Yes	Yes
Rhode Island[8]	Yes	Yes	Yes	–	–	–
South Carolina	Yes	Yes	Yes	–	–	No
South Dakota	–	–	Yes	–	–	–
Tennessee	–	Yes	Yes	Yes	Yes	Yes
Texas[3]	Yes	Yes	Yes	Yes	–	Yes
Utah[3]	–	–	Yes	–	–	Yes
Vermont	–	–	–	–	–	Yes
Virginia	–	Yes	Yes	Yes	Yes	Yes
Washington[4]	–	Yes	Yes	Yes	–	No

TABLE 5A-1. (continued)

| State | MMP | PACE | D-SNP | | | Medicaid managed care for dually eligible beneficiaries?[1] |
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Total	**9**	**30**	**35**	**17**	**12**	**29**
West Virginia	–	–	Yes	–	–	No
Wisconsin[9]	–	Yes	–	Yes	Yes	Yes
Wyoming	–	–	Yes	–	–	–

Notes: D-SNP is dual eligible special needs plan; 45 states and the District of Columbia have D-SNPs. FIDE SNP is fully integrated dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. MMP is Medicare-Medicaid Plan. PACE is Program of All-Inclusive Care for the Elderly. Integrated care programs may not be available statewide. Washington operates a managed fee-for-service model under the Financial Alignment Initiative. Minnesota operates an alternative model focused on administrative alignment under the Financial Alignment Initiative.

– Dash indicates state does not have the factor listed or it is not applicable to the state.

[1] Medicaid managed care for dually eligible beneficiaries is as of 2018. States that offer Medicaid managed care but do not enroll dually eligible beneficiaries in Medicaid managed care are marked as "no". States without Medicaid managed care programs are marked with a dash.

[2] In 2019, Arkansas implemented the mandatory Provider-Led Arkansas Shared Savings Entity (PASSE) program for certain individuals with developmental disabilities or who use certain behavioral health services. Medicaid enrollees who qualify because of specific developmental disabilities or use of behavioral health services, including dually eligible beneficiaries who qualify, must enroll in a PASSE plan. The program provides comprehensive coverage for individuals with developmental disabilities.

[3] These states enroll dually eligible beneficiaries into certain Medicaid managed care programs on a mandatory basis and into other managed care programs on a voluntary basis.

[4] Louisiana and Washington operate behavioral health organization models that enroll full-benefit dually eligible beneficiaries, but we included only comprehensive managed care programs in this table. Washington also operates a demonstration under the Financial Alignment Initiative that provides fully integrated coverage to dually eligible beneficiaries through a managed fee-for-service approach that relies on Medicaid health homes.

[5] Dually eligible beneficiaries can receive Medicaid benefits through Senior Care Options FIDE SNPs or One Care Medicare-Medicaid Plans, but the state does not have a separate Medicaid managed care program serving dually eligible beneficiaries.

[6] Minnesota requires dually eligible beneficiaries and individuals eligible through the aged, blind, and disabled pathways who are age 65 and older to enroll in their Minnesota Senior Care Plus program unless those individuals enroll in the state's fully integrated D-SNP programs (Minnesota Senior Health Options and Special Needs Basic Care Plus).

[7] North Carolina implemented a new Medicaid managed care program in 2019, but as of 2022, dually eligible beneficiaries are not yet covered through that program.

[8] Rhode Island ended its Medicaid managed care program in September 2018.

[9] These states enroll dually eligible beneficiaries into a Medicaid managed care program on a voluntary basis.

Source: Mathematica analysis, 2021, under contract with MACPAC. CMS 2022b. NPA 2022.

States can also be characterized by the level of integration in D-SNPs. In Table 5A-2, we designate integration levels as follows:

- Minimal: State has coordination-only D-SNPs but no HIDE SNPs or FIDE SNPs.

- Low: State has some HIDE SNPs but has not yet taken active steps to use them to design an integrated care initiative. HIDE SNP status has been achieved because D-SNP parent companies offer Medicaid managed care plans in overlapping service areas.

- Moderate: State has either HIDE SNPs or FIDE SNPs (or both) and has worked with the

D-SNPs in the state to increase integration through strategies such as selective contracting (meaning that the state contracts only with D-SNPs meeting certain state requirements). D-SNPs in the state do not operate with exclusively aligned enrollment.

- High: State has some FIDE SNPs operating with exclusively aligned enrollment but also has non-integrated or less-integrated D-SNPs.

- Full: All D-SNPs in the state are either FIDE or HIDE SNPs that operate with exclusively aligned enrollment.

TABLE 5A-2. Dual Eligible Special Needs Plan Integration Levels by State, January 2022

State	D-SNP integration level				
	Minimal	**Low**	**Moderate**	**High**	**Full**
Total	**25**	**3**	**9**	**4**	**5**
Alabama	Yes	–	–	–	–
Alaska	–	–	–	–	–
Arizona	–	–	Yes	–	–
Arkansas	Yes	–	–	–	–
California[1]	–	–	–	Yes	–
Colorado	Yes	–	–	–	–
Connecticut	Yes	–	–	–	–
Delaware	Yes	–	–	–	–
District of Columbia[2]	–	–	–	–	Yes
Florida	–	–	Yes	–	–
Georgia	Yes	–	–	–	–
Hawaii	–	–	Yes	–	–
Idaho	–	–	–	–	Yes
Illinois	–	–	–	–	–
Indiana	Yes	–	–	–	–
Iowa	Yes	–	–	–	–

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TABLE 5A-2. (continued)

State	D-SNP integration level				
	Minimal	**Low**	**Moderate**	**High**	**Full**
Total	**25**	**3**	**9**	**4**	**5**
Kansas	–	Yes	–	–	–
Kentucky	–	Yes	–	–	–
Louisiana	Yes	–	–	–	–
Maine	Yes	–	–	–	–
Maryland	Yes	–	–	–	–
Massachusetts	–	–	–	–	Yes
Michigan	Yes	–	–	–	–
Minnesota	–	–	–	–	Yes
Mississippi	Yes	–	–	–	–
Missouri	Yes	–	–	–	–
Montana	Yes	–	–	–	–
Nebraska	–	Yes	–	–	–
Nevada	Yes	–	–	–	–
New Hampshire	–	–	–	–	–
New Jersey	–	–	–	–	Yes
New Mexico	–	–	Yes	–	–
New York	–	–	–	Yes	–
North Carolina	Yes	–	–	–	–
North Dakota	–	–	–	–	–
Ohio	Yes	–	–	–	–
Oklahoma	Yes	–	–	–	–
Oregon	–	–	Yes	–	–
Pennsylvania	–	–	Yes	–	–
Rhode Island	Yes	–	–	–	–
South Carolina	Yes	–	–	–	–
South Dakota	Yes	–	–	–	–
Tennessee	–	–	–	Yes	–
Texas	–	–	Yes	–	–
Utah	Yes	–	–	–	–
Vermont	–	–	–	–	–

TABLE 5A-2. (continued)

State	D-SNP integration level				
	Minimal	**Low**	**Moderate**	**High**	**Full**
Total	**25**	**3**	**9**	**4**	**5**
Virginia	–	–	Yes	–	–
Washington	–	–	Yes	–	–
West Virginia	Yes	–	–	–	–
Wisconsin	–	–	–	Yes	–
Wyoming	Yes	–	–	–	–

Notes: D-SNP is dual eligible special needs plan. Several states do not have D-SNPs, including Alaska, Illinois, New Hampshire, North Dakota, and Vermont.

[1] California has one fully integrated dual eligible special needs plan (FIDE SNP) that operates with exclusively aligned enrollment, but the FIDE SNP is not available statewide. The other D-SNPs in the state are minimally integrated coordination-only D-SNPs.

[2] The District of Columbia has one highly integrated dual eligible special needs plan (HIDE SNP) in 2022 that is capitated to cover all Medicaid benefits but does not restrict enrollment to full-benefit dually eligible individuals. In 2023, the HIDE SNP operating in the District of Columbia will use separate plan benefit packages to serve full- and partial-benefit dually eligible individuals and will have exclusively aligned enrollment for full-benefit dually eligible individuals.

Sources: Mathematica analysis, 2021, under contract with MACPAC. CMS 2022b.

Chapter 6:

Medicaid's Role in Advancing Health Equity

Medicaid's Role in Advancing Health Equity

Key Points

- Medicaid can and should play an active role in advancing health equity, in particular addressing racial disparities in health care and health outcomes. More than half of all adults enrolled in Medicaid and more than two-thirds of children enrolled in Medicaid and the State Children's Health Insurance Program (CHIP) identify as Black, Hispanic, Asian American and Pacific Islander, American Indian and Alaska Native, or multiracial.

- Disparities in access and outcomes among Medicaid beneficiaries of color are the product of decades-long inequities, stemming from structural racism and explicit and implicit bias in health care delivery, and will require sustained institutional changes to overcome.

- There is also the need to address inequities and disparities experienced by Medicaid beneficiaries who are too often marginalized for other reasons. These include, for example, their age, disability status, sex, gender identity, sexual orientation, and geography as well as the intersection of these identities with race and ethnicity.

- While Medicaid alone cannot remedy societal health inequities, changes in its policies and processes have the potential to reduce disparities and inequities in access, outcomes, and the experience of care for its beneficiaries. The Centers for Medicare & Medicaid Services has committed to advancing racial health equity with the goal to improve measurement of health disparities for a core set of metrics and ultimately close the disparities in access, quality, and outcomes.

- States are taking a variety of approaches in their actions to address health equity. These include the following:

  - improving the collection and reporting of race and ethnicity data to ensure greater consistency, granularity, and completeness;

  - building and sustaining leadership and infrastructure within the state Medicaid agency to prioritize health equity;

  - engaging beneficiaries in the design, implementation, and assessment of policies;

  - examining application and renewal processes to reduce systemic barriers that prevent beneficiaries of color from gaining and keeping coverage;

  - using delivery system levers, including managed care contracting, payment approaches, and quality strategies, to address inequities and reduce gaps in access and outcomes; and

  - developing a workforce that is representative of the beneficiaries it serves and also provides care with cultural competence.

- The Commission has committed to embedding a health equity lens across all its work. The Commission will continue to examine federal and state efforts in Medicaid and CHIP to promote equity and address racial disparities in health care and health outcomes.

CHAPTER 6: Medicaid's Role in Advancing Health Equity

Medicaid can and should play an active role in advancing health equity, in particular addressing racial disparities in health care and health outcomes. More than 57 percent of adults enrolled in Medicaid and more than 67 percent of children enrolled in Medicaid and the State Children's Health Insurance Program (CHIP) identify as American Indian and Alaska Native (AIAN), Asian American and Pacific Islander (AAPI), Black, Hispanic, or multiracial (MACPAC 2022a).[1]

Health disparities have long existed between Medicaid beneficiaries of color and their white counterparts. In the historic 1985 *Report of the Secretary's Task Force on Black & Minority Health*, then Secretary of the U.S. Department of Health and Human Services (HHS) Margaret Heckler noted that since the beginning of federal record keeping, "there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole," and she called for efforts across the federal health department to reduce these gaps. Though the report did not focus specifically on Medicaid, it acknowledged the program's role in providing health insurance coverage to low-income individuals of color and its potential to help address certain disparities (HHS 1985). Since then, HHS and the Centers for Medicare & Medicaid Services (CMS) have continued their work to identify and reduce racial and ethnic health disparities, including among Medicaid beneficiaries. In 2020, the COVID-19 pandemic and racial justice protests underscored the importance of this work and created a new sense of urgency to address inequities in health care systems, programs, and policies, including Medicaid.

Medicaid alone cannot remedy societal health inequities or their causes, but its policies can be leveraged to reduce disparities and inequities in access to care, health care experiences, and health outcomes among the people it serves. Disparities in access to care and health outcomes among Medicaid beneficiaries of color are the product of decades-long inequities, stemming from structural racism and explicit and implicit bias in health care delivery, and will require sustained institutional changes to overcome. Correcting these inequities through Medicaid will require intentional efforts involving beneficiaries, federal agencies, states, managed care organizations (MCOs), providers, and other stakeholders all at the table to identify policy levers, change program policy and operations, evaluate progress, and make needed course corrections.

Action is needed at both the federal and state levels to address longstanding disparities and set priorities for health equity. At the federal level, HHS and CMS have made commitments to these efforts, but specific action steps are still under development. State Medicaid programs have also shared their intentions and initial steps to promote health equity, and many are examining their programs and policies to better serve beneficiaries of color.

MACPAC has committed to examining how it can best contribute to combating structural racism and addressing racial disparities in health care and health outcomes by embedding a health equity lens across all of its work. Over the past two years, the Commission recommended extending postpartum coverage from 60 days to a full year to address the unacceptably high rates of maternal morbidity and mortality, changing estate recovery policies to mitigate their disparate effects on the most vulnerable, and strengthening the role of Medicaid in serving both child and adult beneficiaries with behavioral health needs (MACPAC 2021a, 2021b, 2021c, 2020a). We have also expanded our analyses of disparities in access and barriers to care for beneficiaries of color in other publications, including our *Access in Brief* series (MACPAC 2022b).

This chapter focuses on advancing health equity on the basis of race and ethnicity. It represents the Commission's most substantial statement to

date on how Medicaid policy can be reshaped to focus on health equity. It draws from the research literature; interviews with consumer advocacy groups, state officials, researchers, and other stakeholders; and the Commission's discussions to describe opportunities to promote racial and ethnic health equity in Medicaid.

We recognize the need to address inequities and disparities experienced by beneficiaries who are too often marginalized for other reasons, such as their age, disability, sex, gender identity, sexual orientation, and geography. For example, rural residents have worse health outcomes and higher death rates than their urban counterparts. Individuals living in rural areas report poorer physical and mental health and have higher rates of smoking, obesity, and physical inactivity (MACPAC 2021d). Children and youth with special health care needs are more likely to have Medicaid coverage, yet compared with those with private coverage in 2016, children and youth with special health needs were less likely to have had a medical or dental visit in the past 12 months (MACPAC 2018). MACPAC is currently analyzing some of these populations and plans to share this work in future reports to Congress and other publications.

The chapter begins with an overview of key concepts related to health equity. Next, we describe the demographics of Medicaid beneficiaries of color and the disparities in access and outcomes they face. Turning to policy, the chapter then discusses the current and past efforts at the federal level to address health equity, followed by a section outlining some key areas for Medicaid policy development to advance health equity. These include the following:

- collection and reporting of race and ethnicity data;

- the role of state leadership in prioritizing a health equity agenda;

- beneficiary engagement in the policymaking process;

- enrollment, redetermination, and renewal processes;

- delivery system levers, including managed care contracting, payment approaches, and quality strategies; and

- development of a diverse and culturally competent workforce.

The chapter concludes with the next steps for MACPAC's health equity-focused work.

Key Concepts

Before describing past policy initiatives and future opportunities, we define several key concepts frequently used in discussions of health equity.

Health equity

Health equity is commonly defined as a concept in which "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (Braveman et al. 2017). It is important to note: "equity" and "equality" are often incorrectly used interchangeably. Equality means that everyone is given the same resources or opportunities, whereas equity acknowledges the differences in individual circumstances and allocates resources with the ultimate goal of having equal outcomes (Braveman et al. 2017). Medicaid health equity efforts focus on improving health care for Medicaid beneficiaries from historically marginalized groups.

Structural versus interpersonal racism

Structural racism is defined as "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing,

education, employment, health care, and criminal justice" (Bailey et al. 2017). Structural racism is expressed as a set of institutional, multifaceted, and systemic laws and policies that has cascading effects across institutions. These laws and policies result in more favorable outcomes for white communities and disadvantage communities of color. Race has been a central factor in shaping the policies, discourse, design, and implementation of the Medicaid program and shaping the public perceptions of it (Michener 2022).

Interpersonal racism, by contrast, is seen in biases and discriminatory behaviors of individuals. It may be overt or implicit bias, the latter being defined as "unconscious or unacknowledged preferences that can affect a person's beliefs or behaviors, and in particular, an unconscious favoritism toward or prejudice against people of a certain race, gender, or group that influences one's own actions or perceptions" (O'Kane et al. 2021). In a Medicaid context, interpersonal racism may affect the experiences of Medicaid beneficiaries at enrollment and renewal, in accessing care, and while interacting with the overall health care system (Nguyen et al. 2022).

Health disparities versus inequities

The Centers for Disease Control and Prevention identifies health disparities as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (CDC 2020a). Such disparities may result from implicit and explicit bias on the part of providers, lower concentration of providers and health care facilities in neighborhoods where people of color reside, transportation barriers, lack of provider willingness to accept Medicaid patients, and lack of culturally competent care or outreach strategies, including insufficient interpretation and translation services for those with limited English proficiency (ASPE 2022, 2021a, 2021b, 2021c). Complete and accurate data can both identify and shed light on disparities in care and outcomes

between Medicaid beneficiaries of color and their white counterparts, across different subgroups, and between those covered by Medicaid and other sources of insurance.

Although the term "health disparities" focuses on differences between groups, a focus on health inequities concentrates on identifying and addressing the root causes of these unjust differences, such as structural racism in the health care system (Everette 2021). An analysis of use of non-emergency transportation might first look to see whether there are differences in use between white and Black beneficiaries. If found, policy solutions might consider how the historical segregation of Black neighborhoods and resulting lack of public transportation affects the ability of beneficiaries living in those neighborhoods to access the care they need (Everette 2021).

Intersectionality

Intersectionality, a term coined by legal scholar Kimberlé Crenshaw, describes how race, socioeconomic status, age, gender identity, and other individual characteristics intersect and overlap (Crenshaw 1989). Other characteristics include sexual orientation, disability status, and geographic residence. Intersectionality provides a framework for considering how Medicaid beneficiaries who have multiple identities experience the health care system differently, including having worse health outcomes, compared with those who do not share similar identities or have not been affected by systems of oppression (e.g., racism, sexism). For example, higher rates of COVID-19-related morbidity and mortality among Black and Hispanic individuals may occur because they are more likely to be essential workers in lower-paying jobs that cannot be done from home. Once infected, they are also more likely to encounter unequal treatment from providers due to implicit bias compared with white individuals (CDC 2021a). Adults with disabilities from underserved racial and ethnic groups are more likely to report having poorer health outcomes generally, compared with people without disabilities

in the same racial and ethnic groups and with white, non-Hispanic people with disabilities (Magana et al. 2016, Gulley et al. 2014, CDC 2008).

Social determinants of health

Discussion of health equity and the effects of structural racism often turn to the social determinants of health (SDOH), defined as "the conditions in the places where people live, learn, work, and play that affect health and quality of life" (CDC 2021b).[2] They include, for example, a person's economic stability, level of education, housing status, and physical and social environment (CDC 2021b). Due to unjust laws and policies as the result of structural racism, people of color are more likely to live in impoverished communities with degraded environmental conditions and lack of healthy food options, work in low-wage occupations that do not offer employer-sponsored health insurance, and be predisposed to poorer health outcomes. Medicaid predominantly serves low-income people of color, often with high levels of health-related social needs (Yearby et al. 2022). It is important to note that health-related social needs are of concern for all Medicaid beneficiaries, who, by definition, have low incomes and are more likely to live in communities with substandard housing and experience other challenges to health.

Disparities among Medicaid Beneficiaries

More than half of the adults and two-thirds of children enrolled in Medicaid and CHIP are individuals of color. In 2019, adult Medicaid beneficiaries were more likely than the total adult population of the United States to identify as Hispanic (23.1 percent compared with 18.5 percent, respectively) or Black, non-Hispanic (22.5 percent compared with 12.4 percent, respectively). Similarly, in 2019, a disproportionate percentage of child beneficiaries identified as Hispanic compared with the total U.S. child population (37.5 percent compared with 25.6 percent, respectively) or Black,

non-Hispanic (20.8 percent compared with 12.7 percent, respectively) (MACPAC 2022a).[3]

In 2020, most of the 7 million adults and children who were uninsured but eligible for Medicaid and CHIP were people of color: 40 percent were Hispanic and 16 percent were Black, non-Hispanic (Orgera et al. 2021).[4] In addition, many non-elderly adults of color remain uninsured because they live in states that have not expanded Medicaid coverage to the new adult group; this includes 1,338,400 who are Hispanic, 957,000 who are Black, and 173,000 who are AIAN individuals (ASPE 2022, 2021a, 2021b).[5] Black people are more than twice as likely as those who are white or Hispanic to fall into the coverage gap (Cross-Call 2020).

Having Medicaid coverage improves access to screening and preventive care, permits earlier diagnosis of chronic conditions, and improves mental health outcomes (MACPAC 2021e). However, disparities in health outcomes and access between beneficiaries of color and their white counterparts remain. For example, although Medicaid coverage decreases maternal mortality for Black women, they are 79 percent more likely to experience severe maternal morbidity and mortality than their white counterparts. AIAN, AAPI, and Hispanic pregnant women also have increased odds of having such poor outcomes compared with white women (MACPAC 2020b).[6] In 2020, Medicaid beneficiaries who identified as Black, Hispanic, and Asian American experienced higher rates of infection, hospitalization, and death due to COVID-19 compared with those who are white (Thielke et al. 2021). Moreover, one study of Medicaid beneficiaries enrolled in managed care found that Black, Hispanic, and AAPI beneficiaries report having worse patient experiences than white beneficiaries (Nguyen et al. 2022). Disparities persist for children of color as well; one study found that they were less likely to have reported good health outcomes, less likely to have had a usual source of care, and more likely to have delayed or forgone care compared with white children (CAHMI 2014).

There are also racial disparities in use of services. A prior MACPAC analysis found that from 2015 to 2018, Hispanic adults were significantly more likely to report unmet or delayed care due to cost than white adults. Black and Hispanic Medicaid beneficiaries were less likely than white beneficiaries to have received primary care or mental health care in the prior 12-month period. Hispanic and AIAN children were significantly less likely than white children to have had a well-child checkup in the past 12 months. Health screening rates among adult Medicaid beneficiaries also differed by race and ethnicity. For example, beneficiaries who identified as Asian American, Black, or Hispanic were less likely to have ever had a colonoscopy or receive a cervical cancer screening test in the last three years (MACPAC 2022b).

Federal Health Equity Actions

For more than three decades, federal health agencies have focused on reducing health disparities, with the more recent goal of advancing racial health equity (Box 6-1). In 2021, HHS and CMS renewed their commitment to advancing racial health equity, although specific Medicaid efforts remain nascent. Broad HHS activities include, for example, the creation of a COVID-19 health equity task force, under the auspices of the HHS Office of Minority Health. This task force made recommendations that, if enacted, could benefit Medicaid beneficiaries of color, such as by ensuring the continuity of Medicaid coverage after release from incarceration, reducing the closure of health care facilities that primarily serve Medicaid beneficiaries, and assessing payment parity for behavioral health providers (OMH 2021).

In November 2021, CMS announced a strategic vision to apply a health equity lens across all of its programs to achieve equitable outcomes through high-quality, affordable, person-centered care (Brooks-LaSure and Tsai 2021). For example, the Center for Medicare and Medicaid Innovation (CMMI) announced it will embed equity in its work by including models with more providers serving populations that have low and moderate income, are racially diverse, and are from rural regions. CMMI will also focus on increasing the number of beneficiaries from underserved communities who receive care through value-based payment models (Brooks-LaSure et al. 2021). To inform these new activities, CMMI will use key learnings from the Accountable Health Communities Model, which tested different approaches for meeting the health-related social needs of Medicare and Medicaid beneficiaries, such as screening, referral, and community navigation services (CMS 2022a).[7]

CMS leadership has also committed to a strategic plan based on six pillars; the first pillar is advancing health equity and addressing the underlying issues that result in health disparities. This will be accomplished by working with states to improve measurement of health disparities for a core set of metrics and closing the gap in disparities in access, quality, and outcomes (Brooks-LaSure and Tsai 2021). In April 2022, CMS released its framework for health equity, which outlines five priorities for the agency's efforts over the next decade to achieve health equity and eliminate disparities:

- expand the collection, reporting, and analysis of standardized data;

- assess causes of disparities within CMS programs and address inequities in policies and operations to close gaps;

- build capacity of health care organizations and the workforce to reduce health and health care disparities;

- advance language access, health literacy, and the provision of culturally tailored services; and

- increase all forms of accessibility to health care services and coverage (CMS 2022b).

The CMS Office of Minority Health is examining policies and programs to mitigate unintended consequences that affect underserved

communities and the safety-net providers who serve them. The CMS Office of Minority Health has convened an advisory council on equity with leaders from across the agency, including the Center for Medicaid and CHIP Services (CMCS) and Medicare-Medicaid Coordination Office, to operationalize equity priorities across all programs and policies. It developed a technical assistance program for states and organizations working to advance health equity (CMS 2021a). The CMS Office of Minority Health is also partnering with CMCS to conduct an equity assessment pilot on quality of care in the postpartum period among pregnant women covered by Medicaid and CHIP (CMS 2021b).

CMCS has identified three key priority areas for Medicaid and CHIP.

- improve measurement of racial and ethnic disparities to uncover inequities;

- identify promising practices for expanding access to coverage and care for historically marginalized populations; and

- address SDOH (CMS 2022b).

CMCS has also identified objectives for quality improvement initiatives focused on underserved Medicaid beneficiaries. These objectives are to:

- disseminate information about promising practices in reducing health disparities in Medicaid and CHIP to public and private stakeholders, state partners, community-based organizations, and underserved communities;

- identify vulnerabilities and areas of opportunity in Medicaid and CHIP for quality improvement and reducing health disparities among enrollees; and

- identify and collaborate with states and external organizations to develop partnerships to reduce health disparities in Medicaid and CHIP (CMS 2021c).[8]

CMCS has also issued guidance to state Medicaid programs on ways to adopt strategies that address SDOH, including through Section 1115 demonstrations (CMS 2021d). At the end of 2021, CMS approved the California Medicaid's combined Section 1115 demonstration and Section 1915(b) waiver that will help address beneficiaries' health-related social needs and strengthen access to care (CMS 2021e).[9] CMS has also set priorities for outreach to communities of color in its most recent outreach and enrollment grant opportunity (CMS 2022c). Specifically, the notice encouraged states and other applicants for outreach and enrollment grants to consider strategies that bridge racial and demographic coverage disparities.[10] In addition, CMS encourages outreach strategies that use parent mentors and community health workers (CMS 2022c).[11]

CMCS has noted key actions it has taken to address health equity thus far. CMCS is encouraging all states to adopt the option to extend postpartum coverage to 12 months.[12] It is considering how to make investments in key populations with especially large disparities in health outcomes, such as individuals involved in the justice system and individuals experiencing housing instability. For example, it is working with states to identify ways to connect justice-involved individuals with community-based services upon release. CMCS has also made changes to policies that it views as creating additional barriers to access to coverage and care and has been working to implement the home- and community-based services provisions of the American Rescue Plan Act (P.L. 117-2) (CMS 2022d).

The Commission is encouraged by the commitment of CMS to set priorities for health equity. We look forward to learning about the specific actions that will be taken and how CMS will set expectations and create opportunities for states to be full partners in this work. We encourage the agency to obtain input from states, beneficiaries, and other stakeholders as its work moves forward. MACPAC will continue to monitor the release of more targeted guidance from CMS to states, especially around Section 1115 demonstrations.

BOX 6-1. Prior Federal Efforts to Address Health Disparities

Medicaid's history is intimately connected to changes in federal policy to provide equal rights and equal treatment for people of color. Because the 1964 Civil Rights Act barred discrimination on the basis of race in programs receiving federal funding, the creation of Medicaid (and Medicare) in 1965 led to desegregation of hospitals and nursing homes (Barton Smith et al. 2007).

Since then, federal agencies have focused on racial and ethnic disparities at various times. For example, after the 1985 *Report of the Secretary's Task Force on Black & Minority Health*, the first federal report focused on the health of racial and ethnic minority groups, the U.S. Department of Health and Human Services (HHS) established the Office of Minority Health (HHS 1985). Over time, HHS agencies, including the Centers for Medicare & Medicaid Services (CMS), created their own offices of minority health.

Federal government efforts intensified in the 1990s, when goals were established to eliminate racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, and immunization by 2010 (Brooks 1998). In 2000, the HHS Office of Minority Health released national standards for culturally and linguistically appropriate services, and efforts were taken to improve services provided by federal agencies for individuals with limited English proficiency; these are still in use by the Medicaid program (OMH 2000, DOJ 2000). In 2003, the Agency for Healthcare Research and Quality released the first of what is now known as the National Healthcare Quality and Disparities Report, which measures trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care (HHS 2022). Further emphasis on eliminating disparities was reflected in Healthy People 2010, the decennial effort to set goals for improving the nation's health and well-being. Subsequently, Healthy People 2020 and 2030 also included explicit goals to eliminate health disparities and achieve health equity (CDC 2020b).

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) increased the number of people of color eligible for Medicaid. Under Section 4302 of the ACA, HHS issued implementation guidance on data collection standards for race and ethnicity (HHS 2011). In 2011, HHS also released an action plan to reduce racial and ethnic health disparities with four key priorities to:

- assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities;

- increase the availability, quality, and use of data to improve the health of minority populations;

- measure and provide incentives for better health care quality for minority populations; and

- monitor and evaluate the department's success in implementing the plan (ASPE 2015).

Specific Medicaid goals and actions included improving language access for applicants with limited English proficiency or low literacy and implementation of targeted asthma initiatives (ASPE 2015).

In addition, through the Health Equity Technical Assistance program, CMS has assisted state Medicaid agencies, health plans, providers, health systems, and others on matters such as approaches to achieve health equity among the individuals their programs serve and how to assess the effect of their programs on disparities (CMS 2021a).

Opportunities for Medicaid Action

There are multiple opportunities for state Medicaid programs to advance racial health equity. States are taking different approaches in the actions they will take to address equity, the expectations and accountability for state staff and contractors in participating in such activities, and the resources they are devoting to these efforts. The following sections highlight some current state activities and point out opportunities for others. We also note where CMS and others could provide additional support or direction.

Data collection and reporting

The Commission has discussed the need for improvements in collection and reporting of data on race and ethnicity to ensure greater consistency, granularity, and completeness. Improved data collection and reporting is foundational to the ability of CMS, states, and MCOs to identify disparities and priority areas for equity efforts.[13] This includes data collected by states at application and renewal and data collected as part of federal household surveys.[14] Both data sources are important for assessing racial disparities, and each has benefits and limitations when assessing use of services by and care experiences of Medicaid and CHIP beneficiaries. Administrative data can be used to analyze use of services but cannot capture unmet need or care experience. Federal household surveys can be helpful in examining different aspects of health care use and experiences, but none supports comprehensive federal or state-level analyses of coverage and access by race and ethnicity (Johnson et al. 2010). Additionally, the survey sample size for many racial and ethnic groups from federal surveys are often too small to provide reliable estimates. Poor data quality and limited collection of data at the subgroup level can lead to aggregating data as one race or ethnicity, which can obscure variation in access to care, health status, and health outcomes (Nguyen 2022).

The quality of Medicaid data on the race and ethnicity of its beneficiaries varies by state. MACPAC has assessed data available in the Transformed Medicaid Statistical Information System (T-MSIS) in terms of its completeness and validity. Consistent with problems reported in CMS's Data Quality (DQ) Atlas, our assessment found that 9 states had data of low concern, 21 states had data of medium concern, 17 states had data of high concern, and 4 states had unusable data. In total, only 30 states (those with low and medium data quality concerns) meet the minimum data quality standards necessary for conducting analyses with race and ethnicity data.[15] When comparing T-MSIS data to external benchmarks, such as the American Community Survey, MACPAC analysis found that data reported on T-MSIS are not always consistent with other data sources, raising concerns about validity (MACPAC 2022c).[16]

Poor quality or missing race and ethnicity data in T-MSIS may reflect difficulties in how states transform data when reporting to CMS, but they may also reflect inconsistencies or lack of attention to these data elements at the time of application. In 2021, the State Health Access Data Assistance Center reviewed how 33 states are collecting data on race and ethnicity from paper and online Medicaid applications. They found that many states used inconsistent race and ethnicity categories on their paper and online applications.[17] Although providing write-in responses and allowing applicants to select multiple races and ethnicities can improve accuracy, use of these methods is inconsistent across states and between paper and online applications.[18]

It is also important to note that those applying for or renewing their Medicaid coverage cannot be required to report their race and ethnicity, as this is not a condition of eligibility. People of color may hesitate to report this information because they do not understand why they are asked to provide it or how the data will be used. They may also have concerns about privacy and potential discrimination (James et al. 2021, Shimasaki

2013, AHIP 2004).[19] State instructions and explanations for collecting this information vary considerably, although there are known strategies for improving response rates.

Although insufficient and inaccurate data make it difficult to assess disparities, develop appropriate interventions, and monitor progress, the absence of complete data should not prevent the work of promoting equity and reducing disparities from progressing. The Commission has urged CMS to place a higher priority on these fields in its data validation activities and support states in gathering these data. This includes providing technical assistance to states on proven methods that both improve data collection and build trust with beneficiaries regarding the use of such data (MACPAC 2021f). As noted previously, CMS recently announced that it plans to issue revised guidance on how to improve the quality and completeness of data collection as well as guidance to improve measurement of health disparities across a core set of stratified metrics (CMS 2022b).

In the year ahead, the Commission will examine steps that CMS and states can take to improve the collection of race and ethnicity data from Medicaid beneficiaries to ensure greater completeness of these data. This work will also explore beneficiary experience in reporting these data to understand concerns and barriers.

Leadership and infrastructure

State-level leadership and infrastructure are critical to the success of Medicaid health equity activities. In some states, this leadership is coming from the top with governors declaring racism a public health crisis and directing all state agencies to assess policies and actions from a racial equity lens (APHA 2021).[20] In other states, leadership and commitments have been initiated by the secretary of health and human services or the Medicaid director. Such leadership makes a statement that this work is a priority and provides authority for agency staff to engage in (and be held accountable for) equity work.

Some states have established infrastructure to support their health equity work, designating a health equity advisor and developing health equity plans with medium- and long-term strategies and actions to reduce health disparities. Some states are designating a dedicated Medicaid health equity official, who is tasked with coordinating and leading efforts that ensure equity is embedded in all policies and practices across the Medicaid agency.[21] In some states, equity plans apply statewide or at the department level, and in others, there is a specific Medicaid equity plan (Box 6-2). The content of these plans varies.[22] Initiatives often focus on maternal health, such as extending Medicaid postpartum coverage or providing coverage of doula services. States also describe plans to improve collection of race and ethnicity data.

BOX 6-2. State Spotlight: Louisiana

The Louisiana Medicaid health equity plan is a component of the equity initiative of the Louisiana Department of Health (LDH). The LDH Office of Community Partnerships and Health Equity leads this work. All LDH agencies, including Medicaid, have a health equity action team (HEAT), which reports to LDH leadership. The role of the HEAT is to create a Medicaid-specific repository of health equity-related data and conduct a needs assessment for vulnerable populations. This information will be used to inform future policy (LDH 2020). The HEAT developed a tool that helps staff systematically review existing and new agency policies with a health equity lens. For example, the tool includes a checklist that staff can use to assess whether the language used in a policy is person centered. The staff leader of the Medicaid HEAT reports progress on the equity initiatives to the Medicaid director, who in turn reports to departmental leadership.

States are also looking internally at agency processes and taking steps to equip staff to engage in equity initiatives. For example, the Illinois Department of Health developed a health equity checklist for all state officials to integrate equity-based principles in the design and implementation of programs (Thoumi et al. 2021). Some Medicaid agencies are facilitating implicit bias and antiracist trainings for all staff members to be more aware of how privilege and prejudices can manifest in their work (Everette 2021). In addition to such training for all staff, some states are working to ensure the Medicaid agency workforce is diverse and representative of the populations it serves.

States may face several challenges in their work to set priorities for health equity in Medicaid. Staff may have taken on these initiatives without additional resources. Moreover, changing political landscapes and policy priorities, as well as budgetary constraints, create uncertainty for the longevity of equity initiatives.

Beneficiary engagement strategies

Medicaid beneficiaries are often left out of discussions of the policies that affect their health and coverage (Coburn et al. 2021). Beneficiaries have much to offer in the development of policies and can also provide valuable feedback on how well the policies and programs are serving them as well as areas for improvement. Beneficiary engagement strategies can help build trust between the community and the state Medicaid agency and promote accountability to beneficiaries. But this work must be sustained over time to do so (Chomilo 2022).

Efforts to improve beneficiary participation should be mindful of historic mistrust of health care systems and the factors that affect beneficiaries' ability to provide feedback. Lack of trust and uncertainty as to whether feedback will be heard may discourage beneficiaries from sharing their views (Musa et al. 2009). Tailoring engagements to smaller groups with common backgrounds may help participants feel more comfortable sharing

their experiences with state Medicaid program and plan officials. For example, after acknowledging the current and historical structural racism that contributes to racial health disparities in Minnesota, the state's Medicaid program specifically engaged U.S.-born Black beneficiaries to identify policy priorities and administrative changes that could improve racial equity. Meeting participants informed and guided a Medicaid agency report, recommending specific changes and actions to advance racial health equity. The state is now examining how to integrate voices from the U.S.-born Black community into routine policy, budget, and administrative activities (Chomilo 2022).[23]

Although all state Medicaid programs are required to have a medical care advisory committee (MCAC) to provide input on state policies and practices, the power dynamics and structure of such committees may affect beneficiary engagement (§ 1902(a)(4) of the Social Security Act, 42 CFR 431.12). MCACs must include (at a minimum) board-certified physicians and other health professionals who are familiar with the medical needs of low-income population groups, Medicaid beneficiaries and members of other consumer organizations, and the director of the public welfare department or the public health department (42 CFR 431.12(d)).[24] Given the makeup of these boards and the use of jargon that can occur at the meetings, many advocates note that beneficiaries report that these meetings can feel tokenizing and intimidating. Some states are coordinating with community-based organizations that can provide beneficiary representatives with technical support and preparation that enables them to feel more confident participating (Allen et al. 2021). Others are convening members-only advisory councils to make the engagement opportunities more accessible. For example, Colorado Medicaid has created member experience advisory councils that consist of members, their families, and caregivers to advise on what is working and what is not in the state's Medicaid program (HCPF 2022). Arkansas Medicaid is also developing a members-only beneficiary advisory council (AR DHS 2021).

Beneficiaries may face logistical barriers, such as the inability to take time off work, secure transportation, and procure child care, that limit their participation in advisory councils. For MCACs specifically, states must make financial arrangements, if necessary, to support beneficiary participation, but federal rules do not specify the type of expenses that can be reimbursed (42 CFR 431.12(f)).[25] State Medicaid agencies are also beginning to host more virtual advisory council meetings to eliminate transportation barriers and provide interpretation services to facilitate participation by those with limited English proficiency (Coburn et al. 2021). Other strategies to increase participation include hosting advisory council meetings outside of traditional work hours, providing food, or providing transportation to and from the meeting (Allen et al. 2021).

Given that managed care is now the predominant delivery system in Medicaid, MCOs can play a role in engaging beneficiaries in program design and implementation. States may require MCOs to have member advisory committees (Bailit Health 2022). For example, Oregon's Medicaid beneficiaries are enrolled in coordinated care organizations; each organization must have at least one community advisory council, and more than half of the council's voting members must be Medicaid enrollees (OEI OHA 2022). Medicaid officials can attend MCO beneficiary meetings to engage directly with beneficiaries. States can also solicit feedback from beneficiary surveys and promote transparency by publishing reports and seeking input on report findings.

Given the importance of and challenges in beneficiary engagement, we hope to learn more about current state practices for engaging beneficiaries of color (e.g., via advisory committees), including their accessibility, opportunities to promote greater participation, and the manner in which beneficiary input is being incorporated into program policies and operations.

Enrollment, redetermination, and renewal processes

Some states are examining enrollment and renewal processes to identify opportunities to reduce systemic barriers that prevent beneficiaries of color from gaining and keeping coverage. MACPAC's analysis of churn and continuous coverage in 26 states with reliable race and ethnicity data found that Black and Hispanic beneficiaries were more likely than white beneficiaries to disenroll and reenroll within 12 months. However, white beneficiaries were slightly more likely to be enrolled for fewer than 12 months (MACPAC 2021g).

Beneficiaries of color may be at greater risk of disruptions in coverage, particularly as states look to the return of routine redeterminations and renewals once the COVID-19 public health emergency (PHE) ends. Given that states could not disenroll beneficiaries, except in extremely limited circumstances, during the PHE if they accepted the 6.2 percentage point increase in federal match, the need to redetermine all beneficiaries once the PHE ends creates a high risk of disenrollment for procedural reasons (Boozang and Striar 2021).

Some states are taking steps to reduce systemic barriers at application and renewal. For example, in response to feedback from Black beneficiaries about the complexity of these processes, Minnesota Medicaid is exploring how to make renewal materials more easily accessible electronically and considering options for partnering with navigators and the community to ensure eligible Black Minnesotans gain and maintain Medicaid coverage. The state hopes to implement any such changes in time for the resumption of routine renewals (Chomilo 2022). In February 2022, Oregon applied for a Section 1115 demonstration waiver that requests federal match to provide continuous enrollment for children until their sixth birthday and then establish two-year continuous eligibility for children older than age six and adults to preserve the coverage gains during the PHE (OHA 2022).

MACPAC is concerned about the potential for disruption in coverage and care when the PHE ends, given the unprecedented volume of redeterminations. CMS's recent guidance and tools describe strategies states can use to mitigate these effects, such as adopting the state plan option to provide 12-month continuous eligibility, using sample social media messages to increase beneficiary awareness of actions they will need to take to maintain coverage, and partnering with MCOs to obtain updated beneficiary contact information (CMS 2022e, 2022f, 2022g). Moreover, it will be important for CMS and states to consider how to mitigate the effects on people of color, including, for example, by supporting beneficiaries with limited English proficiency and working with trusted community-based organizations.

Delivery system levers

Delivery system levers to advance health equity and address disparities in care and outcomes include embedding health equity requirements in managed care contracts, leveraging payment methodologies, and setting priorities for equity in quality initiatives.

Managed care contract requirements. Many state Medicaid programs require MCOs to address inequities and reduce gaps in access and outcomes, but the required activities vary and practices are evolving. One study of managed care contracts in 20 states found that most include definitions of health equity or health disparities and require MCOs to collect member race, ethnicity, and language data and stratify quality measures by those same demographics (Bailit Health 2022). For example, Michigan and Minnesota have required MCOs to collect such data for nearly a decade (MI DHHS 2021, MN DHS 2021).

Others require MCOs to develop health equity plans. For example, MCOs in North Carolina must develop a member engagement plan that engages historically marginalized populations and describes how they will incorporate health equity into external and internal policies and procedures (NC

DHHS 2021a). Louisiana's request for proposals for MCO reprocurement states that MCOs should have a health equity plan that is specifically tailored to address the cultural, socioeconomic, racial, and regional disparities that their beneficiaries face (LDH 2021).

Some states require MCOs to take steps to address some of the social determinants of health, such as housing, transportation, and access to healthy food. In fiscal year (FY) 2021, 33 of 37 states with MCOs reported that the COVID-19 pandemic prompted the development of more strategies to address SDOH, such as requirements for plans to address housing. Other SDOH initiatives include increasing social needs screenings, connecting beneficiaries to social services, and partnering with community-based organizations (Gifford et al. 2021). For example, in Nevada's current MCO procurement, vendors must describe how they will identify and address SDOH affecting their members (NV DHHS 2021).

States are also requiring MCOs to do the following:

- conduct internal staff health equity trainings;
- implement the national standards for culturally and linguistically appropriate services;
- hire a health equity director;
- report the race and ethnicity of contracted providers to assess cultural congruency with beneficiaries;
- report on health disparities and propose interventions to mitigate these disparities; and
- implement alternative payment models focused on reducing health disparities (Bailit Health 2022).

Some states work with MCOs as they develop contract requirements related to equity. By doing this, states can leverage MCOs' technical expertise (e.g., data collection) to assess feasibility and implementation considerations for new

requirements being considered as well as to gain MCO buy-in before formalizing them. For example, Michigan Medicaid worked with its MCOs before requiring them to report the Healthcare Effectiveness Data and Information Set (HEDIS) disaggregated by race and ethnicity to ensure they shared a mutual understanding of the methodology for such reporting and definitions of race and ethnicity. In addition to providing a transparent process, engaging the MCOs early on provided time for MCOs to make the necessary systems and policy changes for compliance (MACPAC 2021h).

Payment. Some states are starting to use payment policies to drive plan and provider action on health equity, such as requiring value-based payment arrangements or implementing alternative payment models that tie MCO performance targets to reducing disparities on certain measures (Bailit Health 2022).[26] Equity-focused value-based payment efforts may address the SDOH (Patel et al. 2021).

State Medicaid agencies are encouraging providers to work with high-need populations. For example, California's value-based payment program directs MCOs to address health disparities by making enhanced payments to providers that serve beneficiaries with behavioral health needs and beneficiaries experiencing homelessness (Gifford et al. 2021). North Carolina's Medicaid program worked directly with providers to pilot an enhanced payment initiative to better serve historically marginalized beneficiaries and to reduce disparities. Providers received enhanced per-member per-month payments based on a minimum beneficiary poverty score. This score is based on the average poverty rate where the beneficiary lives.[27] Providers had flexibility in how these funds could be used as long as they ensured beneficiary access to care with the goal of reducing health inequities. For example, providers could use these funds to enhance primary care medical home services, such as increasing telehealth access, conducting staff training on trauma-informed care, or engaging patients to close care gaps in maternal or child health. North Carolina is now evaluating the pilot, including surveying providers on how the funds were used (NC DHHS 2021b).

State Medicaid agencies can develop alternative payment models that provide incentives for person-centered care and reduce disparities in quality, outcomes, and patient experience (HCPLAN 2022). Models, such as an accountable care organization or bundled payment for episodes of care, can adjust up-front payments to providers to support capacity-building efforts, such as building the data and analytics infrastructure needed to successfully carry out alternative payment models (McGinnis et al. 2022). Alternative payment models, however, are not typically designed to account for the effects of historical inequities in access to care and the health care system, which affect the health status and needs of individuals of color (Yearby 2022). Thus, CMS and states should consider whether certain models could inadvertently provide penalties for providers caring for historically disadvantaged and underserved beneficiaries who may have greater medical complexity stemming from unmet need (CMS 2021b).

A few states—Louisiana, Michigan, and Ohio—have begun using capitation withholds to advance health equity goals (Bailit Health 2022). For example, in Louisiana's request for proposals for MCO reprocurement, the state indicates it may withhold 2 percent of the monthly capitation payment to encourage quality, health outcomes, value-based payments, and health equity. MCOs may earn back this withhold based on their reporting and performance relative to health equity requirements, which will be established in the final contracts that will go into effect in July 2022 (LDH 2021). Michigan Medicaid has used capitation withholds to provide incentives for reductions in racial disparities since FY 2020 (Gifford et al. 2021). The Ohio Department of Medicaid noted in its current reprocurement request for proposals that it will determine the quality withhold payouts based on an evaluation of the reduction of racial disparities (ODM 2021).

There may also be opportunities to use rate setting processes to support health equity initiatives. Actuaries in some state Medicaid programs are in the early phases of exploring how this can be done, including how to incorporate social needs into risk adjustment models (Patel et al. 2021). However, because capitation rates are based on historical utilization, including underutilization of services driven by systemic inequities, current managed care capitation rate setting processes may build in inequities.

Quality. The processes for monitoring and ensuring quality of care can also be deployed to address disparities. These include state quality strategies, external quality review, quality measurement, MCO quality assessment and improvement projects, and accreditation. CMS has provided resources and guidance to states on how to incorporate a health equity lens into these activities, but state adoption remains somewhat limited.

All states contracting with MCOs must implement a quality strategy for assessing and improving the quality of care provided by managed care entities.[28] Although these can be used to advance health equity, one review found that such strategies lacked information on how states planned to address racial and ethnic disparities, in some cases providing only a paragraph about pertinent state actions or referring only to state data collection activities (Machledt 2021). CMS has created a toolkit to help states craft their strategies, recommending that they consider demographic data, including information on trends related to health disparities and SDOH and, if available, the state public health agency's disparities reduction plan. CMS also recommends that states consider selecting quality measures for which there are considerable health disparities (CMS 2021g).

Although it is not required, some states have incorporated health equity work into external quality review activities that assess the quality, timeliness, member satisfaction, and access to care provided by MCOs.[29] These activities are conducted by external quality review organizations (EQROs) under

contract.[30] For example, California's EQRO conducts focused studies on disparities based on age, gender, race and ethnicity, and primary language on a range of quality measures, including ones related to children's health, women's health, behavioral health, and acute and chronic disease management for racial and ethnic disparities (CA DHCS 2020).[31] Since 2018, Louisiana's EQRO has administered surveys to examine how MCOs are addressing disparities. The latest survey asked MCOs to describe efforts to identify and reduce disparities in outcomes, health status, and quality of care between Medicaid beneficiaries and those with other sources of coverage and among beneficiaries, including differences by race, ethnicity, and age (IPRO 2021).[32] The EQRO reports are posted on the state's website.

CMS has encouraged states to report measures in the Child and Adult Core Sets stratified by race, ethnicity, sex, primary language, disability status, and geography; it has also provided technical assistance to states (CMCS et al. 2019, CMS 2016). However, the extent to which states are doing this is unclear.[33] Some states stratify HEDIS measures by race and ethnicity and report on them for state-specific purposes (Machledt 2021). Creating more overlap between HEDIS measures (which MCOs routinely use) and the core sets could lead to greater reporting of stratified measures, but this is not required.

Some states are creating MCO requirements to address the quality of care received by beneficiaries of color as part of their comprehensive quality assessment and performance improvement programs (42 CFR 438.330(a)-(b)).[34] Other states are requiring that performance improvement projects (PIPs), a required element of quality assessment and performance improvement programs, focus on equity and disparities. For example, in 2017 to 2020, California required MCOs to conduct a health disparities PIP, such as testing blood sugar levels among Black men to monitor diabetes, controlling high blood pressure among Hispanic beneficiaries, and increasing childhood immunization among Black children (HSAG 2019). For the 2019 to 2021

PIP period, California required all MCOs to conduct two PIPs, including one related to an identified health disparity (HSAG 2021).

Finally, MCOs may also seek the newly established health equity accreditation from the National Committee for Quality Assurance.[35] This designation adds new requirements to the existing multicultural health care distinction standards that focus on organizational diversity, equity, inclusion and reducing bias, collecting gender identity and sexual orientation data, and stratifying HEDIS measures by race and ethnicity (NCQA 2021a).[36] It is unclear how many Medicaid MCOs will seek this accreditation, but currently 50 MCOs have already received the existing multicultural health care distinction (NCQA 2021b).[37]

Development of a diverse and culturally competent workforce

A workforce that is representative of the beneficiaries it serves and also provides care with cultural competence, regardless of cultural congruence, can drive improvements in equity for Medicaid beneficiaries. Several studies have shown that when patients and providers share the same race or ethnicity, preventive health screenings increase and patient perception of treatment decisions improves (Saha and Beach 2020, Wilbur et al. 2020, Penner et al. 2016). However, only 23 percent of Black, 26 percent of Hispanic, and 39 percent of Asian American patients have a physician who shares their race or ethnicity, compared with 82 percent of white Americans (Wilbur et al. 2020). Additionally, when provider-patient language is in concordance or interpreter services are available, patients report greater satisfaction (Nguyen et al. 2022).

Medicaid equity activities focused on the workforce include providing training in cultural competence, cultural humility, and trauma-informed care; recruiting a more diverse and representative Medicaid workforce; and covering the services of the non-clinical workforce, who have an in-depth understanding of community needs.[38] Some states are already actively engaged in these activities. For example, a study of MCO contracts found that 6 of 20 states are requiring MCOs to have cultural competency or cultural humility trainings for all network providers (Bailit Health 2022). Louisiana's recent MCO reprocurement includes model contract language to ensure services are delivered by network providers in a culturally appropriate manner that promotes cultural humility (LDH 2021). Kentucky Medicaid requires MCOs to promote the delivery of services in a culturally competent manner and develop strategies that are respectful of culturally diverse backgrounds (KY CHFS 2021). Development of provider networks presents another opportunity to improve beneficiary-provider cultural congruence, but better data on the race and ethnicity of both providers and beneficiaries may be needed to do so effectively. Additional guidance may be needed to inform state and MCO practices and to address provider concerns about how the data will be used.[39]

Some state Medicaid programs are using non-clinical professionals, such as community health workers (CHWs), peer support specialists, and doulas, who share lived experiences with beneficiaries and can help support and connect beneficiaries to services. CHWs, who are either members of the community they serve or have close ties to it, act as a liaison between beneficiaries and the health care system (Moses et al. 2021). Currently, at least 21 state Medicaid programs cover CHW services (MACPAC 2022d).[40] Peer support specialists have lived experiences with substance use disorder, a mental health diagnosis, or both (SAMHSA 2022). Most state Medicaid programs cover peer support services for beneficiaries with mental health conditions or substance use disorder (MACPAC 2019). Given racial and ethnic disparities in birth outcomes, states may also choose to cover doula services to support mothers during pregnancy, including in making decisions about the birth process (Safon et al. 2021). Several states have authorized pilot or demonstration programs to require Medicaid

coverage of doula services (Robles-Fradet 2021).[41] MACPAC has also initiated new work to examine state coverage of doula services.

Some states have implemented modest workforce programs using Medicaid policy levers. Massachusetts, for example, incorporated workforce development initiatives into its Delivery System Reform Incentive Payment program.[42] Massachusetts used a portion of the program funds to provide loan repayment to reduce the shortage of providers in community-based settings, such as primary care physicians, nurse practitioners, CHWs, peer specialists, and recovery support professionals (CMS 2021h).[43] Massachusetts also used workforce professional development grants to support a range of activities to increase and enhance the capacity of the non-clinical workforce, such as awarding training grants to increase the number of training slots for CHWs and peer specialists, implementing a training program for CHW supervisors, and paying for supervisor training for recovery coaches (CMS 2021h). In addition, numerous federal and many state programs aim to recruit and retain primary care clinicians as well as other health professionals, such as dentists and behavioral health providers, to provide care in underserved areas and for underserved populations (Schwartz et al. 2019, Block 2018).[44] These strategies include scholarships, tax credits, and stipends to community-based groups to support recruitment and retention (Schwartz et al. 2019). We note that although these workforce programs are not specific to Medicaid, they can increase the workforce serving Medicaid beneficiaries.

The Commission has previously discussed the importance of diversity and cultural competence of the health workforce serving Medicaid beneficiaries (MACPAC 2022e, 2021i).[45] Efforts by CMS, other federal agencies, and states to address cultural competence and cultural humility among Medicaid participating providers and expand the use of professionals, such as CHWs, may promote greater trust in and connection to the health care system among Medicaid beneficiaries.

Next Steps

Looking ahead, the Commission will deepen its work on health equity and continue using a health equity lens throughout our work. For example, the Commission has work underway to examine strategies to improve the collection and reporting of race and ethnicity data, explore Medicaid's role in improving access for those with limited English proficiency, and leverage medical care advisory committees to increase beneficiary engagement. In addition to our focus on racial health equity, we plan to build our analyses of inequities for other beneficiaries who have been historically marginalized on the basis of age, geography, disability, sexual orientation, and gender identity as well as those at the intersection of these identities with race and ethnicity. We will continue to monitor federal and state efforts to promote equity to understand their effects.

Endnotes

[1] In its analyses, MACPAC uses the five racial categories required by the Office of Management and Budget (OMB) to report federal data: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and white. The OMB ethnic categories are Hispanic or Latino. OMB established minimum standards for race and ethnicity data in federally sponsored data collection efforts and administrative reporting to improve the consistency and comparability of these data across agencies (OMB 1997). We recognize that such terms have evolved over time and that people of color may prefer to use different terms when self-identifying their race and ethnicity (e.g., American Descendants of Slaves; Latinx or Latine; Indigenous).

[2] Some analysts are beginning to use the term "drivers of health," considering it more inclusive and descriptive of all the forces that perpetuate racial inequities in health care (Lumpkin et al. 2021).

[3] In 2019, compared with the total adult population in the United States, adult Medicaid beneficiaries were less likely to be Asian American, non-Hispanic: 6.3 percent of the

total population compared with 5.7 percent of Medicaid beneficiaries. Similarly, in 2019, compared with the total child population in the United States, child Medicaid or CHIP beneficiaries were less likely to be Asian American, non-Hispanic: 4.3 percent of the total population compared with 2.6 percent of Medicaid or CHIP beneficiaries. For all racial and ethnic groups, the differences for the Medicaid or CHIP population from the U.S. total population is statistically significant at the 0.05 level. MACPAC could not produce an estimate for the American Indian or Alaska Native (AIAN) population due to limitations of the 2019 National Health Interview Survey. Our analyses include all of the OMB racial and ethnic categories with the exception of Native Hawaiian or other Pacific Islander, as these responses are not included in the publicly available data (MACPAC 2022a). Analyses of the 2017 American Community Survey data found that more than 50 percent of all AIAN children were covered by Medicaid or CHIP (ASPE 2021b).

[4] The Kaiser Family Foundation analysis is based on 2021 Medicaid eligibility levels and the Annual Social and Economic Supplement of the Current Population Survey from the U.S. Census. Hispanic people may be of any race but are categorized as Hispanic; other groups are all non-Hispanic.

[5] We note that in these cited publications, the Assistant Secretary for Planning and Evaluation uses the term "Latino" to refer to all individuals of Hispanic and Latino origin.

[6] MACPAC uses the term "pregnant women" as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women.

[7] The majority of the CMMI payment and delivery system reform models have focused on Medicare, while only a few (e.g., Maternal Opioid Misuse Model) focus on Medicaid and CHIP (CMS 2022a).

[8] The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required the Secretary of HHS to report to Congress periodically on approaches for identifying, collecting, and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status in Medicaid and CHIP; state, and CMS efforts; and to make recommendations for improvements for data collection and evaluation (Sebelius 2014).

[9] Targeted interventions and services that can improve health outcomes outside the traditional health care setting and prevent institutionalization will be provided as in-lieu-of services—that is, services provided as substitutes for traditional medical services. For example, managed care plans will be able to cover support services, such as housing supports, home modifications, and medically tailored meals. California's demonstration also seeks to transform the delivery system by building stronger collaboration and alignment between the needs of historically underserved communities, providers, and community-based organizations as well as improving the integration of physical and behavioral health services (CMS 2021e).

[10] CMS released a notice of funding opportunity for the 2022 Connecting Kids to Coverage HEALTHY KIDS program grants that "will make available $49.4 million, ranging between $500,000 to $1.5 million per awardee for a three-year period of performance, to fund efforts to increase the participation of eligible children, parents, and pregnant individuals in Medicaid and CHIP." This program is authorized under Section 2113 of the Social Security Act, as amended by Section 3004(a) of the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act enacted as part of P.L. 115-120). Section 50103 of the Advancing Chronic Care, Extenders, and Social Services Act (ACCESS Act included as part of P.L. 115-123) further extended the program, providing funding for future cooperative agreement awards (CMS 2022c).

[11] Parent mentors are parents with at least one child enrolled in Medicaid or CHIP who can assist other parents with the application and renewal process. These mentors also provide education about health insurance coverage, provide guidance on identifying medical and dental homes, provide assistance and referrals to address social determinants of health, and serve as a liaison between families and the state (CMS 2022c).

[12] A provision in the American Rescue Plan Act of 2021 (P.L. 117-2) gave states a new option to extend Medicaid postpartum coverage to 12 months via a state plan amendment. This new option took effect on April 1, 2022, and is available to states for five years (CMS 2022b).

[13] MCOs also collect race and ethnicity data for several purposes, such as identifying members in need of enhanced care coordination or support services and identifying disparities in access and outcomes (AHIP 2004). MCOs collect these data from member surveys, member outreach, and health and social risk assessments.

[14] In 2011, HHS published updated guidelines for collecting data on race, ethnicity, sex, primary language, and disability status. The revised guidelines expand on the minimum OMB standards and include more granular subcategories that roll up into OMB's five minimum race categories and two minimum ethnicity categories (HHS 2011). Although some states collect and report data that meet the more detailed 2011 HHS guidance, most states are still using the OMB standards (SHADAC 2021).

[15] MACAPC analyzed these data using methods from the DQ Atlas T-MSIS Analytic File (CMS 2021f).

[16] For example, in 13 states, reported enrollment among Hispanic individuals differed by more than 10 percentage points compared with those of the Medicaid population in the American Community Survey. In four states, this differed by more than 30 percentage points (MACPAC 2022c).

[17] CMS has issued guidance to states on how to collect more robust race and ethnicity data at application, but states are required to collect only the minimum OMB race and ethnicity categories. States can request approval to modify the application based on state needs.

[18] The U.S. Census Bureau conducted research to improve the data collection methods for the 2020 Census, finding that certain methods both increased response rates and improved the accuracy of the responses. These include using a combined race and ethnicity question, explicitly writing in the application that respondents should report all responses that apply, and including write-in options if the desired category or subcategory is not included. Another recommendation is to provide an option for individuals to choose a Middle Eastern or North African race or ethnicity as these groups are currently defined as white, non-Hispanic (SHADAC 2021).

[19] One study found that 28 percent of patients felt considerable discomfort reporting their race and ethnicity and that 58 percent were somewhat concerned that such information could be used to discriminate against patients (Shimasaki 2013).

[20] As of publication, the governors of Michigan, Nevada, New York, and Wisconsin have all declared racism as a public health crisis. The Centers for Disease Control and Prevention has also called racism a serious threat to the public's health (APHA 2021).

[21] Of the 34 states examined, 11 have designated Medicaid health equity officials: Arizona, California, Illinois, Indiana, Louisiana, Massachusetts, Minnesota, New York, Pennsylvania, Virginia, and Washington. Some states have a state-level equity policy advisor who coordinates Medicaid health equity efforts with those of other state agencies (e.g., Delaware (director of statewide equity initiatives) and Indiana (chief equity, inclusion, and opportunity officer)).

[22] There is no federal requirement for states or Medicaid agencies to have an equity plan.

[23] The Minnesota Department of Human Services is also considering beneficiary engagement efforts with other communities of color to promote health equity for Minnesotans who are AIAN, Hispanic or Latino, or AAPI individuals; immigrants; and new Minnesotans (Chomilo 2022).

[24] There are no federal requirements regarding demographic characteristics of Medicaid beneficiaries serving on MCACs. Some states have such requirements, however. For example, Texas requires the MCAC (but not specifically the beneficiary members) to be racially and geographically diverse. Texas also requires its MCAC to include beneficiaries with intellectual, developmental, or physical disabilities, or their advocates; advocates for children with special health care needs; and beneficiaries who use mental health services, or their advocates, among others (THHSC 2020).

[25] States receive a 50 percent federal match for expenditures on the committee's activities (42 CFR 431.12(g)). States vary in their policies for compensating members. For example, Arizona reimburses beneficiaries for necessary costs, such as transportation and child care (AHCCCS 2020). The Kentucky Department of Medicaid Services provides reimbursement for travel expenses (KY CHFS 2018).

[26] In a study of selected state MCO contracts, 7 of 20 contracts included value-based payment arrangements (Bailit Health 2022).

[27] The enhanced per-member per-month payment amounts were a $9 enhancement for practice locations identified as Poverty Tier I (poverty scores of more than 17 percent through 21 percent) and an $18 enhancement for practice locations identified as Poverty Tier II (poverty scores of more than 21 percent) (NC DHHS 2021b).

[28] The strategy must describe the state's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status (42 CFR 438.340(b)(6)). This requirement also applies in CHIP (42 CFR 457.1240(e)). States must also describe network adequacy standards, continuous quality improvement goals, performance metrics, performance improvement projects (PIPs), and arrangements for external quality review.

[29] Federal Medicaid rules require states to contract with independent external quality review organizations to conduct oversight and assess quality, timeliness, and access to care provided by MCOs, prepaid inpatient health plans, prepaid ambulatory health plans, or primary care case management entities (42 CFR 438.350).

[30] Mandatory activities include validation of PIPs, validation of performance measures, review of compliance with federal quality requirements, and validation of provider network adequacy. Optional activities include validation of encounter data, administration or validation of consumer or provider surveys, calculation of performance measures, conduct of PIPs, administration of focused studies on particular aspects of clinical or non-clinical services, and assistance of the quality ratings (42 CFR 438.358).

[31] The state disaggregates data on these quality measures by race and ethnicity where possible.

[32] Specifically, the external quality review survey asked each MCO about identification or analysis of the MCO's Medicaid population based on risk characteristics; identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers; identification of gaps in quality of care for the MCO's

Medicaid members and Medicaid subgroups; identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations; and development and implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members with at-risk characteristics.

[33] Reporting on the core sets is voluntary, and states may report on different measures. However, beginning in FY 2024, reporting on the Child Core Set and the behavioral health measures of the Adult Core Set will be mandatory.

[34] Quality assessment and performance improvement programs must include, at a minimum, PIPs; collection and submission of performance measurement data; mechanisms to detect underuse and overuse; mechanisms to address quality of care for enrollees with special health care needs; and for MCOs, prepaid inpatient health plans, prepaid ambulatory health plans, mechanisms to assess quality of care for enrollees using long-term services and supports, and activities to prevent, detect, and remediate critical incidents (42 CFR 438.330(b)).

[35] The National Committee for Quality Assurance (NCQA) is transitioning its existing multicultural health care distinction to the health equity accreditation beginning in July 2022 (NCQA 2021c). MCOs that satisfy NCQA standards for providing culturally and linguistically sensitive services and efforts to address health care disparities earn this distinction.

[36] The health equity accreditation is distinct from the general health plan accreditation. Federal rules do not require MCOs to have a general health plan accreditation; however, 33 states do (NCQA 2020).

[37] For example, Pennsylvania became the first state to require all its MCOs to achieve the NCQA Multicultural Health Care Distinction; state officials have signaled that they will require all MCOs to have the health equity accreditation (NCQA 2021d).

[38] There is a difference between cultural competency and cultural humility. Cultural competency training enhances provider knowledge about the cultures and practices of social groups, including those who have been historically marginalized and underserved, to more effectively serve

them. States are also incorporating cultural humility into equity efforts. Cultural humility is the acknowledgment of beneficiaries' unique cultural experiences and the willingness to learn from them to ensure culturally appropriate care (Lekas et al. 2020).

[39] One study of health plans found that less than half (46.5 percent) collect provider race and ethnicity. This same study found that 67 percent of plans reported that they distribute the provider demographic data to beneficiaries via the plan website, and 27 percent distribute this information through provider directories (AHIP 2004).

[40] California, Illinois, Nevada, and Wisconsin plan to add CHWs as a Medicaid-covered service in FY 2022. Arizona, California, the District of Columbia, and Illinois reported they are establishing or planning to establish CHWs as a Medicaid provider type. Colorado and Oregon are incorporating CHWs into case management redesign and care coordination improvement efforts (Gifford et al. 2021).

[41] These include Minnesota, Oregon, New Jersey, Florida, Rhode Island, Indiana, Maryland, Washington, California, and the District of Columbia.

[42] CMS is no longer approving new Delivery System Reform Incentive Payment (DSRIP) programs or renewing existing DSRIP programs when they expire. Many states with existing DSRIP programs are exploring ways to continue to support delivery system reform efforts using other Medicaid authorities; however, it is unclear to what extent these efforts include the workforce initiatives.

[43] Loan repayment amounts generally range from $30,000 up to $50,000 depending on the type of provider, in exchange for a four-year service commitment (MassLeague 2021).

[44] The Health Resources and Services Administration designates health professional shortage areas, which include geographic areas, populations, and facilities with an inadequate supply of primary care, dental, and mental health providers and services. Population health professional shortage areas have a shortage of services for a specific population subset (e.g., low-income individuals) within an established geographic area.

[45] For example, Medicaid is the nation's primary payer for home- and community-based services, and the majority (59 percent) of those providing such services are people

of color (Campbell et al. 2021). The home- and community-based services workforce, comprised largely of women and often immigrants, also faces inequities (PHI 2021). These include, for example, wage disparities; within the direct care workforce, women earn less than men on average, and people of color earn less than white people (Campbell et al. 2021).

References

Allen, E., J. Haley, J. Aarons, et al. 2021. *Leveraging community expertise to advance health equity*. Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/104492/leveraging-community-expertise-to-advance-health-equity_1.pdf.

American Public Health Association (APHA). 2021. *Analysis: Declarations of racism as a public health crisis*. Washington, DC: APHA. https://www.apha.org/-/media/Files/PDF/topics/racism/Racism_Declarations_Analysis.ashx.

America's Health Insurance Plans (AHIP). 2004. *Collection of racial and ethnic data by health plans to address disparities*. Princeton, NJ: Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2004/07/collection-of-racial-and-ethnic-data-by-health-plans-to-address-.html.

Arizona Health Care Cost Containment System (AHCCCS). 2020. *Bylaws for the AHCCCS state Medicaid advisory committee.* Phoenix, AZ: AHCCCS. https://www.azahcccs.gov/AHCCCS/Downloads/SMAC/SMACbylaws.pdf.

Arkansas Department of Human Services (AR DHS). 2021. Arkansas Department of Human Services seeking clients to serve on first Medicaid client voice council. November 5, 2021, press release. Little Rock, AR: DHS. https://humanservices.arkansas.gov/news/arkansas-department-of-human-services-seeking-clients-to-serve-on-first-medicaid-client-voice-council/.

Bailey, Z., J. Feldman, and M. Bassett. 2021. How structural racism works—Racist policies as a root cause of U.S. racial health inequities. *New England Journal of Medicine* 384: 768–773. https://www.nejm.org/doi/full/10.1056/NEJMms2025396.

Bailit Health. 2022. *Medicaid managed care contract language: Health disparities and health equity*. Princeton, NJ:

State Health and Value Strategies. https://www.shvs.org/resource/medicaid-managed-care-contract-language-health-disparities-and-health-equity/.

Barton Smith, D., Z. Feng, M. Fennel, et al. 2007. Separate and unequal: Racial segregation and disparities in quality across U.S. nursing homes. *Health Affairs* 26, no. 5: 1448–1458. https://www.healthaffairs.org/doi/10.1377/hlthaff.26.5.1448.

Block, R. 2018. *Behavioral health integration and workforce development*. New York, NY: Milbank Memorial Fund. https://www.milbank.org/publications/behavioral-health-integration-workforce-development/.

Braveman, P., E. Arkin, T. Orleans, and A. Plough. 2017. *What is health equity?* Princeton, NJ: Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.

Brooks, J. 1998. *Clinton announces racial and ethnic health disparities initiative*. Rockville, MD: Office of Minority Health Resource Center. https://www.minorityhealth.hhs.gov/assets/pdf/checked/Clinton%20Announces%20Racial%20and%20Ethnic%20Health%20Disparities%20Initiative.pdf.

Brooks-LaSure, C., and D. Tsai. 2021. A strategic vision for Medicaid and the Children's Health Insurance Program (CHIP). *Health Affairs Blog*, November 15. https://www.healthaffairs.org/do/10.1377/hblog20211115.537685/full.

Brooks-LaSure, C., E. Fowler, M. Seshamani, et al. 2021. Innovation at the Centers for Medicare and Medicaid Services: A vision for the next 10 years. *Health Affairs Blog*, August 12. https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full.

Boozang, P., and A. Striar. 2021. The end of the COVID public health emergency: Potential health equity implications of ending Medicaid continuous coverage. Princeton, NJ: State Health and Value Strategies. https://www.shvs.org/the-end-of-the-covid-public-health-emergency-potential-health-equity-implications-of-ending-medicaid-continuous-coverage/.

California Department of Health Care Services (CA DHCS). 2020. *2020 Health disparities report*. Sacramento, CA: DHCS. https://www.dhcs.ca.gov/Documents/MCQMD/CA2020-21-Health-Disparities-Report.pdf.

Campbell, S., A. Del Rio Drake, R. Espinoza, K. Scales. 2021. Caring for the future: The power and potential of America's direct care workforce. Bronx, NY: PHI. http://phinational.org/wp-content/uploads/2021/01/Caring-for-the-Future-2021-PHI.pdf.

Center for Medicaid and CHIP Services (CMCS), Office of Minority Health, and Mathematica. 2019. Technical assistance webinar: Collecting and using stratified data for quality improvement in Medicaid and CHIP. Baltimore, MD: CMCS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/core-set-stratification-webinar.pdf.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021a. Health equity considerations and racial and ethnic minority groups. Atlanta, GA: CDC. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021b. About Social Determinants of Health (SDOH). Atlanta, GA: CDC. https://www.cdc.gov/socialdeterminants/about.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2020a. Reaching for health equity. Atlanta, GA: CDC. https://www.cdc.gov/healthequity/features/reach-health-equity/index.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2020b. Healthy people 2030. Atlanta, GA: CDC. https://www.cdc.gov/nchs/healthy_people/hp2030/hp2030.htm.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2008. Racial/ethnic disparities in self-rated health status among adults with and without disabilities—United States, 2004–2006. *Morbidity and Mortality Weekly Report* 57, no. 39: 1069–1073. Atlanta, GA: CDC. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5739a1.htm.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. Accountable health communities model. Baltimore, MD: CMS. https://innovation.cms.gov/innovation-models/ahcm.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. *CMS framework for health equity 2022−2032*. Baltimore, MD: CMS. https://www.cms.gov/files/document/cms-framework-health-equity.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Connecting kids to coverage HEALTHY KIDS 2022 outreach and enrollment cooperative agreements. January 27, 2022, grants notice. Baltimore, MD: CMS. https://www.grants.gov/web/grants/view-opportunity.html?oppId=337485.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022d. *CMS strategic plan pillar: Health equity*. Baltimore, MD: CMS. https://www.cms.gov/files/document/health-equity-fact-sheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022e. Letter from Daniel Tsai to state health officials regarding "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency." March 3, 2022. https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022f. *Medicaid and CHIP continuous enrollment unwinding: A communications toolkit*. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022g. *Medicaid and Children's Health Insurance Program eligibility and enrollment data specifications for reporting during unwinding*. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/unwinding-data-specifications.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. Health equity technical assistance. Baltimore, MD: CMS. https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/Health-Equity-Technical-Assistance.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. Strategic direction. Baltimore, MD: CMS. https://innovation.cms.gov/strategic-direction.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021c. Quality of care health disparities. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/quality-of-care-health-disparities/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021d. Letter from Anne Marie Costello to state health officials regarding "Opportunities in Medicaid and CHIP to address social determinants of health (SDOH)." January 7, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021e. Letter from Daniel Tsai to Jacey Cooper regarding "Extension of California Advancing and Innovating Medi-Cal (CalAIM)." December 29, 2021. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021f. *DQ Atlas background and methods resource: Race and ethnicity*. Baltimore, MD: CMS. https://www.medicaid.gov/dq-atlas/downloads/background_and_methods/TAF_DQ_Race_Ethnicity.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021g. *Medicaid and CHIP managed care quality strategy toolkit*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021h. Letter from Angela Garner to Amanda Cassel Kraft regarding "Approving the protocol edits MassHealth submitted on May 17, 2021." July 21, 2021. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/cms-aprvd-dsrip-prtcl-07212021.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. *The state of children's health care quality in Medicaid and CHIP: State strategies to promote reporting and performance*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/child-core-set-hps-strategies-brief.pdf.

Child and Adolescent Health Measurement Initiative (CAHMI). 2014. Children's overall health status by race/ethnicity. Washington, DC: CAHMI. https://www.childhealthdata.org/browse/survey/results?q=3367&r=1&g=588.

Chomilo, N. 2022. *Building racial equity into the walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans*. St. Paul, MD: Minnesota Department of Human Services. https://t.co/rlQu0gLKk4.

Coburn, K., K. Keating, and J. Jennings-Shaffer. 2021. Addressing bias and advancing equity in state policy. Washington, DC: Zero to Three. https://www.zerotothree.org/resources/4198-addressing-bias-and-advancing-equity-in-state-policy.

Colorado Department of Health Care Policy and Financing (HCPF). 2022. Member experience advisory councils. Denver, CO: HCPF. https://hcpf.colorado.gov/meac.

Crenshaw, K. 1989. Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum* 1989, no. 1: 8. https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf.

Cross-Call, J. 2020. *Medicaid expansion has helped narrow racial disparities in health coverage and access to care*. Washington, DC: Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and.

Everette, T., D. Sathasivam, and K. Siegel. 2021. *Health equity language guide for state officials: Discussing racism*. Princeton, NJ: State Health and Value Strategies. https://www.shvs.org/resource/health-equity-language-guide-for-state-officials/.

Gifford, K., A. Lashbrook, S. Barth, et al. 2021. *States respond to COVID-19 challenges but also take advantage of new opportunities to address long-standing issues: Results from a 50-State Medicaid budget survey for state fiscal years 2021 and 2022*. San Francisco, CA: Kaiser Family Foundation. https://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-social-determinants-of-health/.

Gulley S., E. Rasch, and L. Chan. 2014. Difference, disparity & disability: A comparison of health, insurance coverage and health service use on the basis of race/ethnicity among U.S. adults with disabilities, 2006–2008. *Medical Care* 52, no. 10: S9–S16. https://journals.lww.com/lww-medicalcare/Fulltext/2014/10001/Difference,_Disparity,_and_Disability__A.5.aspx.

Health Care Payment Learning and Action Network (HCPLAN). 2022. *Advancing health equity through APMs: Guidance for equity-centered design and implementation*. McLean, VA: HCPLAN. https://hcp-lan.org/advancing-health-equity-through-apms/.

Health Services Advisory Group (HSAG). 2021. *Medi-Cal managed care external quality review technical report. July 1, 2019–June 30, 2020*. Phoenix, AZ: HSAG. https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf.

Health Services Advisory Group (HSAG). 2019. *Medi-Cal managed care external quality review technical report. July 1, 2017–June 30, 2018*. Phoenix, AZ: HSAG. https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2017-18_EQR_Technical_Report_F1.pdf.

IPRO. 2021. *State of Louisiana Department of Health Medicaid managed care quality strategy evaluation*. Lake Success, NY: IPRO. https://ldh.la.gov/assets/medicaid/EQRO/2021/Medicaid-Managed-Care-QualityStrategyEvaluation-FY21_8321.pdf.

James, C., B. Lyons, P. Saynisch, et al. 2021. *Federal action is needed to improve race and ethnicity data in health programs*. Washington, DC: Grantmakers in Health. https://www.gih.org/publication/federal-action-is-needed-to-improve-race-and-ethnicity-data-in-health-programs.

Johnson, P.J., L. Blewett, and M. Davern, 2010. Disparities in public use data availability for race, ethnic, and immigrant groups: National surveys for healthcare disparities research. *Medical Care* 48, no. 12: 1122–1127. https://journals.lww.com/lww-medicalcare/Abstract/2010/12000/Disparities_in_Public_Use_Data_Availability_for.12.aspx.

Kentucky Cabinet for Health and Family Services (KY CHFS). 2021. Medicaid managed care organization contract between the Commonwealth of Kentucky Cabinet for Health and Family Services and WellCare Health insurance company. Louisville, KY: CHFS. https://chfs.ky.gov/agencies/dms/dpqo/Documents/WellCareSignedAmendment.pdf.

Kentucky Cabinet for Health and Family Services (KY CHFS). 2018. *Kentucky advisory council for medical assistance*. Frankfort, KY: CHFS. https://chfs.ky.gov/agencies/dms/mac/Documents/MACBylaws.pdf.

Lekas, H.M., K. Pahl, and C. Fuller-Lewis. 2020. Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights* 13. https://journals.sagepub.com/doi/full/10.1177/1178632920970580.

Louisiana Department of Health (LDH). 2021. Louisiana Medicaid managed care organizations request for proposals and model contract. Baton Rouge, LA: LDH. https://wwwcfprd.doa.louisiana.gov/osp/lapac/dspBid.cfm?search=department&term=4.

Louisiana Department of Health (LDH). 2020. *Phase I: Health equity plan*. Baton Rouge, LA: LDH. https://ldh.la.gov/assets/cphe/Equity_Framework.pdf.

Lumpkin, J., R. Perla, R. Onie, and R. Seligson. 2021. What we need to be healthy—and how to talk about it. *Health Affairs Blog*, May 3. https://www.healthaffairs.org/do/10.1377/forefront.20210429.335599.

Machledt, D. 2021. *Addressing health equity in Medicaid managed care*. Washington, DC: National Health Law Program. https://healthlaw.org/resource/addressing-health-equity-in-medicaid-managed-care/.

Magana, S., S. Parish, M. Morales, et al. 2016. Racial and ethnic health disparities among people with intellectual and developmental disabilities. *Intellectual and Developmental Disabilities* 54, no. 3: 161–172. https://pubmed.ncbi.nlm.nih.gov/27268472/.

Massachusetts League of Community Health Centers (MassLeague). 2021. Student loan repayment program. Worcester, MA: MassLeague. https://massleague.org/Programs/DSRIPStatewideInvestments/StudentLRP.php.

McGinnis, T., A. Smithey, and S. Patel. 2022. *Harnessing payment to advance health equity: How Medicaid agencies can incorporate LAN guidance into payment strategies*. Hamilton, NJ: Center for Health Care Strategies. https://www.chcs.org/harnessing-payment-to-advance-health-equity-how-medicaid-agencies-can-incorporate-lan-guidance-into-payment-strategies/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. Exhibit 2: Characteristics of non-institutionalized individuals by age and source of health coverage, 2019. March 2022. Washington, DC: MACPAC. https://www.macpac.gov/publication/characteristics-of-non-institutionalized-individuals-by-source-of-health-insurance/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022b. *Access in brief: Experiences in accessing medical care by race and ethnicity*. Washington, DC: MACPAC. https://www.macpac.gov/publication/access-in-brief-experiences-in-accessing-medical-care-by-race-and-ethnicity/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022c. *Availability of race and ethnicity data for Medicaid beneficiaries*. Washington, DC: MACPAC. https://www.macpac.gov/publication/availability-of-race-and-ethnicity-data-for-medicaid-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022d. *Medicaid coverage of community health worker services*. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-coverage-of-community-health-worker-services/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022e. Presentation before the Medicaid and CHIP Payment and Access Commission, March 3, 2022, Washington, DC. https://www.macpac.gov/wp-content/uploads/2021/04/MACPAC-March-2022-Meeting-Transcript.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. Chapter 2: Advancing maternal and infant health by extending the postpartum coverage period.

In *Report to Congress on Medicaid and CHIP*. March 2021. Washington, DC: MACPAC. https://www.macpac.gov/publication/advancing-maternal-and-infant-health-by-extending-the-postpartum-coverage-period/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. Chapter 3: Improving Medicaid estate recovery: Improving policy and promoting equity. In *Report to Congress on Medicaid and CHIP*. March 2021. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-estate-recovery-improving-policy-and-promoting-equity/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021c. Chapter 2: Access to mental health services for adults covered by Medicaid. In *Report to Congress on Medicaid and CHIP*. June 2021. Washington, DC: MACPAC. https://www.macpac.gov/publication/access-to-mental-health-services-for-adults-covered-by-medicaid/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021d. *Medicaid and rural health*. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-and-rural-health/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021e. *Racial and ethnic disparities in Medicaid: An annotated bibliography*. Washington, DC: MACPAC. https://www.macpac.gov/publication/racial-and-ethnic-disparities-in-medicaid-an-annotated-bibliography/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021f. Comment letter on request for information: Methods and leading practices for advancing equity and support for underserved communities through government action. *Federal Register* 86, no. 85, (May 5). Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/07/Comment-on-RFI-on-Advancing-Equity.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021g. *An updated look at rates of churn and continuous coverage in Medicaid and CHIP*. Washington, DC: MACPAC. https://www.macpac.gov/publication/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicaid-and-chip-abstract/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021h. Presentation before the Medicaid

and CHIP Payment and Access Commission, December 10, 2021, Washington, DC. https://www.macpac.gov/wp-content/uploads/2020/08/MACPAC-December-2021-Meeting-Transcript.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021i. Presentation before the Medicaid and CHIP Payment and Access Commission, September 23, 2021, Washington, DC. https://www.macpac.gov/wp-content/uploads/2020/08/MACPAC-September-2021-Meeting-Transcript.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Update from MACPAC: Responding to the public health crises of COVID-19 and racism. July 27, 2020, press release. Washington, DC: MACPAC. https://www.macpac.gov/news/update-from-macpac-responding-to-the-public-health-crises-of-covid-19-and-racism/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Chapter 5: Medicaid's role in maternal health. In *Report to Congress on Medicaid and CHIP*. June 2020. Washington, DC: MACPAC. https://www.macpac.gov/publication/chapter-5-medicaids-role-in-maternal-health/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. *Recovery support services for Medicaid beneficiaries with a substance use disorder.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2019/07/Recovery-Support-Services-for-Medicaid-Beneficiaries-with-a-Substance-Use-Disorder.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. *Access in brief: Children and youth with special health care needs*. Washington, DC: MACPAC. https://www.macpac.gov/publication/access-in-brief-children-and-youth-with-special-health-care-needs/.

Michener, J. 2022. *A racial equity framework for assessing health policy*. New York, NY: The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2022/jan/racial-equity-framework-assessing-health-policy.

Michigan Department of Health and Human Services (MI DHHS). 2021. State of Michigan: Medicaid managed care contract. Lansing, MI: MI DHHS. https://www.michigan.gov/documents/contract_7696_7.pdf.

Minnesota Department of Human Services (MN DHS). 2021. Minnesota Department of Human Services contract for prepaid medical assistance and MinnesotaCare. St, Paul, MN: MN DHS.

Moses, K., L. Kelly, A. Nuamah, et al. 2021. *Advancing California's community health worker & promotor workforce in Medi-Ca*l. Sacramento, CA: California Health Care Foundation. https://www.chcf.org/resource-center/advancing-californias-community-health-worker-promotor-workforce-medi-cal/.

Musa, D., R. Schulz, R. Harris, et al. 2009. Trust in the health care system and the use of preventive health services by older Black and white adults. *American Journal of Public Health* 99, no. 7: 1293–1299. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696665.

National Committee on Quality Assurance (NCQA). 2021a. Health equity accreditation FAQs. Washington, DC: NCQA. https://www.ncqa.org/programs/health-equity-accreditation/faqs/.

National Committee for Quality Assurance (NCQA). 2021b. Health plans. Washington, DC: NCQA. https://reportcards.ncqa.org/health-plans?order=desc&pg=1&order-filter=filter-plan&filter-plan=Medicaid&filter-distinction=Multicultural%20Health%20Care.

National Committee for Quality Assurance (NCQA). 2021c. Current multicultural healthcare customers. Washington, DC: NCQA. https://www.ncqa.org/current-multicultural-healthcare-customers/.

National Committee for Quality Assurance (NCQA). 2021d. *Health equity: How employers can drive improvements*. Washington, DC: NCQA. https://www.ncqa.org/wp-content/uploads/2021/03/20210315_NCQA_Employer_Health_Equity_Guide.pdf.

National Committee for Quality Assurance (NCQA). 2020. *42 states deem or require NCQA health plan accreditation*. Washington, DC: NCQA. https://www.ncqa.org/wp-content/uploads/2020/02/20200228_HPA_Commercial_Use.pdf.

Nevada Division of Health Care Financing and Policy, Nevada Department of Health and Human Services (NV DHHS). 2021. Nevada Medicaid managed care

organizations request for proposals. Carson City, NV: NV DHHS. https://nevadaepro.com/bso/external/bidDetail.sdo?bidId=40DHHS-S1457&parentUrl=activeBids.

Nguyen, K. 2022. Disaggregating Asian American and Pacific Islander health data: Opportunities to advance health equity. New York, NY: Milbank Memorial Fund. https://www.milbank.org/2022/02/disaggregating-asian-american-and-pacific-islander-health-data-opportunities-to-advance-health-equity/.

Nguyen, K., I. Wilson, A. Wallack, et al. 2022. Racial and ethnic disparities in patient experience of care among nonelderly Medicaid managed care enrollees. *Health Affairs* 41, no. 2. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01331.

North Carolina Medicaid, North Carolina Department of Health and Human Services (NC DHHS). 2021a. Medicaid prepaid health plan model contract. Raleigh, NC: NC DHHS. https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf.

North Carolina Medicaid, North Carolina Department of Health and Human Services (NC DHHS). 2021b. Health equity payment initiative. *North Carolina Department of Health and Human Services*, March 19. Raleigh, NC: NC DHHS. https://medicaid.ncdhhs.gov/blog/2021/03/19/health-equity-payment-initiative.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2022. *Health insurance coverage and access to care among Black Americans: Recent trends and key challenges*. Washington, DC: ASPE. https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-black-americans.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2021a. *Health insurance coverage and access to care among Latinos: Recent trends and key challenges*. Washington, DC: ASPE. https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-latinos.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2021b. *Health insurance coverage and access to care for American Indians and Alaska Natives: Current trends and key*

challenges. Washington, DC: ASPE. https://aspe.hhs.gov/reports/health-insurance-coverage-changes-aian.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2021c. *Health insurance coverage changes: Asian Americans and Pacific Islanders*. Washington, DC: ASPE. https://aspe.hhs.gov/reports/health-insurance-coverage-changes-asian-americans-pacific-islanders.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2015. *HHS action plan to reduce racial and ethnic health disparities: Implementation progress report 2011–2014*. Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//151711/DisparitiesActionPlan.pdf.

Office of Equity and Inclusion (OEI), Oregon Health Authority (OHA). 2022. Community advisory council. Portland, OR: OHA. https://www.oregon.gov/oha/oei/Pages/cac.aspx.

Office of Management and Budget (OMB).1997. Revisions to the standards for the classification of federal data on race and ethnicity. Notice of decision. *Federal Register* 62, no. 210 (October 30): 58782-58790. https://www.federalregister.gov/documents/1997/10/30/97-28653/revisions-to-the-standards-for-the-classification-of-federal-data-on-race-and-ethnicity.

Office of Minority Health (OMH), U.S. Department of Health and Human Services. 2021. The presidential COVID-19 health equity task force. Washington, DC: OMH. https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=100.

Office of Minority Health (OMH), U.S. Department of Health and Human Services. 2000. National standards on culturally and linguistically appropriate services (CLAS) in health care. Final Rule. *Federal Register* 65, no. 247 (December 22): 80865-80879. https://www.federalregister.gov/documents/2000/12/22/00-32685/office-of-minority-health-national-standards-on-culturally-and-linguistically-appropriate-services.

Ohio Department of Medicaid (ODM). 2021. Ohio Medicaid provider agreement for managed care organization. Columbus, OH: ODM. https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/38e87337-f168-4a0f-a341-d3379b5dcf9c/MCO+Provider+Agreement_2021+06+29_final+for+signature.pdf?MOD=AJPERES&CVID=nGHQqH.

O'Kane, M., S. Agrawal, L. Binder, et al. 2021. *An equity agenda for the field of health care quality improvement*. Washington, DC: National Academy of Medicine. https://nam.edu/an-equity-agenda-for-the-field-of-health-care-quality-improvement/.

Oregon Health Authority (OHA). 2022. Section 1115 of the Social Security Act Medicaid demonstration application: Renewal of the Oregon health plan. February 18, 2022. Salem, OR: OHA. https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-Waiver-Application-Final.pdf.

Orgera, K., R. Rudowitz, and A. Damico. 2021. A closer look at the remaining uninsured population eligible for Medicaid and CHIP. Washington, DC: Kaiser Family Foundation. https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip.

Patel, S., A. Smithey, and T. McGinnis. 2021. *Leveraging value-based payment approaches to promote health equity: Key strategies for health care payers*. Hamilton, NJ: Center for Health Care Strategies, Inc. https://www.chcs.org/resource/leveraging-value-based-payment-approaches-to-promote-health-equity-key-strategies-for-health-care-payers/.

Penner, L., J. Dovidio, R. Gonzalez, et al. 2016. The effects of oncologist implicit racial bias in racially discordant oncology interactions. *Journal of Clinical Oncology* 34, no. 24: 2874–2880. https://pubmed.ncbi.nlm.nih.gov/27325865/.

PHI. 2021. Workforce data center. Bronx, NY: PHI. https://phinational.org/policy-research/workforce-data-center/.

Robles-Fradet, A. 2021. Medicaid coverage for doula care: State implementation efforts. Washington, DC: National Health Law Program. https://healthlaw.org/medicaid-coverage-for-doula-care-state-implementation-efforts/.

Safon, C.B., L. McCloskey, C. Ezekwesili, et al. 2021. Doula care saves lives, improves equity, and empowers mothers. State Medicaid programs should pay for it. *Health Affairs Blog*, May 26. https://www.healthaffairs.org/do/10.1377/hblog20210525.295915/full/.

Saha, S., and M.C. Beach. 2020. Impact of physician race on patient decision-making and ratings of physicians: A randomized experiment using video vignettes. *Journal of General Internal Medicine* 35: 1084–1091. https://link.springer.com/article/10.1007/s11606-020-05646-z.

Schwartz, M., D. Patterson, and R. McCarty. 2019. *State incentive programs that encourage allied health professionals to provide care for rural and underserved populations*. Seattle, WA: University of Washington Center for Health Workforce Studies. http://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2019/12/State-Incentive-Programs-Allied-Health-FR-2019.pdf.

Sebelius, K. 2014. Report to Congress: *Approaches for identifying, collecting, and evaluating data on health care disparities in Medicaid and CHIP*. Washington, DC: U.S. Department of Health and Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/4302b-rtc.pdf.

Shimasaki, S. 2013. *How race and ethnicity data is collected and used*. Denver, CO: The Colorado Trust. https://www.coloradotrust.org/sites/default/files/CT_Race_EthnicityBrief_vFinal2.pdf.

State Health Access Data Assistance Center (SHADAC), University of Minnesota. 2021. *Collecting race, ethnicity, and language (REL) data on Medicaid applications: 50-state review shows wide variation in how states gather this Information*. Princeton, NJ: State Health and Value Strategies. https://www.shvs.org/resource/collection-of-race-ethnicity-language-rel-data-in-medicaid-applications-a-50-state-review-of-the-current-landscape/.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2022. Who are peer workers? Rockville, MD: SAMHSA. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

Texas Health and Human Services Commission (THHSC). 2020. State Medicaid managed care advisory committee. Austin, TX: THHSC. https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=351&rl=805.

Thielke, A., P. Curtis, and V. King. 2021. *Addressing COVID-19 health disparities: Opportunities for Medicaid programs*. New York, NY: Milbank Memorial Fund. https://www.milbank.org/publications/addressing-covid-19-health-disparities-opportunities-for-medicaid-programs.

Thoumi, A., K. Kaalund, E. Chhean, et al. 2021. Championing health equity: Experiences from state COVID-19 health equity task forces. Washington, DC: National Academy of State Health Policy, Duke-Margolis Center for Health Policy, National Governors Association. https://www.nga.org/center/publications/championing-health-equity/.

U.S. Department of Health and Human Services (HHS). 2022. Health equity timeline. Washington, DC: HHS. https://thinkculturalhealth.hhs.gov/clas/health-equity-timeline.

U.S. Department of Health and Human Services (HHS). 2011. *Implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status*. Washington, DC: HHS. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//43681/index.pdf.

U.S. Department of Health and Human Services (HHS). 1985. *Report of the Secretary's task force on Black & minority health*. Washington, DC: HHS. https://archive.org/details/reportofsecretar00usde/page/n1/mode/2up?view=theater.

U.S. Department of Justice (DOJ). 2000. Improving access to services for persons with limited English proficiency. *Federal Register* 65, no. 159 (August 16). https://www.lep.gov/executive-order-13166.

Wilbur, K., C. Snyder, A. Essary, et al. 2020. Developing workforce diversity in the health professions: A social justice perspective. *Health Professions Education* 6, no. 2: 222–229. https://www.sciencedirect.com/science/article/pii/S245230112030016X?via%3Dihub#bib16.

Yearby, R., B. Clark, and J. Figueroa. 2022. Structural racism in historical and modern U.S. health care policy. *Health Affairs* 41, no. 2. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01466.

Appendix

Authorizing Language (§ 1900 of the Social Security Act)

Medicaid and CHIP Payment and Access Commission

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as "MACPAC").

(b) DUTIES.—

    (1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

        (A) review policies of the Medicaid program established under this title (in this section referred to as "Medicaid") and the State Children's Health Insurance Program established under title XXI (in this section referred to as "CHIP") affecting access to covered items and services, including topics described in paragraph (2);

        (B) make recommendations to Congress, the Secretary, and States concerning such access policies;

        (C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

        (D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

    (2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

        (A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

            (i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

            (ii) payment methodologies; and

            (iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

        (B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees

of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

(A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term "appropriate committees of Congress" means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as "MedPAC") established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5)   CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6)   MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d)   DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1)   employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2)   seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3)   enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));

(4)   make advance, progress, and other payments which relate to the work of MACPAC;

(5)   provide transportation and subsistence for persons serving without compensation; and

(6)   prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e)   POWERS.—

(1)   OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2)   DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A)   utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B)   carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C)   adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Melanie Bella, MBA, (Chair), is head of partnerships and policy at Cityblock Health, which facilitates health care delivery for low-income urban populations, particularly Medicaid beneficiaries and those dually eligible for Medicaid and Medicare. Previously, she served as the founding director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services (CMS), where she designed and launched payment and delivery system demonstrations to improve quality and reduce costs. Ms. Bella also was the director of the Indiana Medicaid program, where she oversaw Medicaid, the State Children's Health Insurance Program (CHIP), and the state's long-term care insurance program. Ms. Bella received her master of business administration from Harvard University.

Kisha Davis, MD, MPH, (Vice Chair), is vice president of health equity for Aledade. Previously, Dr. Davis was Maryland medical director for VaxCare Corporation; worked as a family physician at CHI Health Care in Rockville, Maryland; and served as program manager at CFAR in Philadelphia, Pennsylvania, where she supported projects for family physicians focused on payment reform and practice transformation to promote health system change. Dr. Davis has also served as the medical director and director of community health at CHI and as a family physician at a federally qualified health center (FQHC) in Maryland. As a White House Fellow at the U.S. Department of Agriculture, she established relationships among leaders of FQHCs and the Women, Infants, and Children nutrition program. Dr. Davis received her degree in medicine from the University of Connecticut and her master of public health from Johns Hopkins University.

Heidi L. Allen, PhD, MSW, is an associate professor at Columbia University School of Social Work, where she studies the impact of social policies on health and financial well-being. She is a former emergency department social worker and spent several years in state health policy, examining health system redesign and public health

insurance expansions. In 2014 and 2015, she was an American Political Science Association Congressional Fellow in Health and Aging Policy. Dr. Allen is also a standing member of the National Institutes of Health's Health and Healthcare Disparities study section. Dr. Allen received her doctor of philosophy in social work and social research and a master of social work in community-based practice from Portland State University.

Sonja L. Bjork, JD, is the chief operating officer of Partnership HealthPlan of California (PHC), a non-profit community-based Medicaid managed care plan. Before joining PHC, Ms. Bjork worked as a dependency attorney representing youth in the child welfare system. During her tenure at PHC, she has overseen multiple benefit implementations and expansion of the plan's service area. Ms. Bjork served on the executive team directing the plan's $280 million strategic investment of health plan reserves to address social determinants of health. These included medical respite, affordable housing, and substance use disorder treatment options. Ms. Bjork received her juris doctor from the UC Berkeley School of Law.

Tricia Brooks, MBA, is a research professor at the McCourt School of Public Policy at Georgetown University and a senior fellow at the Georgetown University Center for Children and Families (CCF), an independent, non-partisan policy and research center whose mission is to expand and improve health coverage for children and families. At CCF, Ms. Brooks focuses on issues relating to policy, program administration, and quality of Medicaid and CHIP coverage for children and families. Before joining CCF, she served as the founding CEO of New Hampshire Healthy Kids, a legislatively created non-profit corporation that administered CHIP in the state, and served as the Medicaid and CHIP consumer assistance coordinator. Ms. Brooks holds a master of business administration from Suffolk University.

Martha Carter, DHSc, MBA, APRN, CNM, is an independent consultant. She is the founder and former CEO of FamilyCare Health Centers, a community health center that serves four counties in south-central West Virginia. Dr. Carter practiced as a certified nurse-midwife in Kentucky, Ohio, and West Virginia for 20 years and is a member of the West Virginia Alliance for Creative Health Solutions, a practice-led research and advocacy network. Dr. Carter was a Robert Wood Johnson Foundation Executive Nurse Fellow from 2005 to 2008 and received the Robert Wood Johnson Foundation Community Health Leader award in 1999. She holds a doctorate of health sciences from A.T. Still University in Mesa, Arizona, and a master of business administration from West Virginia University.

Frederick Cerise, MD, MPH, is president and CEO of Parkland Health and Hospital System, a large public safety-net health system in Dallas, Texas. Previously, he oversaw Medicaid and other programs for the state of Louisiana as secretary of the Department of Health and Hospitals. Dr. Cerise also held the position of medical director and other leadership roles at various health care facilities operated by Louisiana State University. He began his career as an internal medicine physician and spent 13 years treating patients and teaching medical students in Louisiana's public hospital system. Dr. Cerise received his degree in medicine from Louisiana State University and his master of public health from Harvard University.

Robert Duncan, MBA, is chief operating officer of Connecticut Children's – Hartford. Before this, he served as executive vice president of Children's Wisconsin, where he oversaw the strategic contracting for systems of care, population health, and the development of value-based contracts. He was also the president of Children's Community Health Plan, which insures individuals with BadgerCare Plus coverage and those on the individual marketplace, and Children's Service Society of Wisconsin. He has served as both the director of the Tennessee Governor's Office of Children's Care Coordination and the director of the

Tennessee Children's Health Insurance Program, overseeing the state's efforts to improve the health and welfare of children across Tennessee. Earlier, he held various positions with Methodist Le Bonheur Healthcare. Mr. Duncan received his master of business administration from the University of Tennessee at Martin.

Jennifer L. Gerstorff, FSA, MAAA, is a principal and consulting actuary with Milliman's Seattle office. Since joining the firm in 2006, she has served as lead actuary for several state Medicaid agencies. In addition to supporting state agencies through her consulting work, Ms. Gerstorff actively volunteers with the Society of Actuaries and American Academy of Actuaries work groups, participating in research efforts, developing content for continuing education opportunities, and facilitating monthly public interest group discussions with Medicaid actuaries and other industry experts. She received her bachelor in applied mathematics from Columbus State University.

Angelo P. Giardino, MD, PhD, MPH, is the Wilma T. Gibson Presidential Professor and chair of the Department of Pediatrics at the University of Utah's Spencer Fox Eccles School of Medicine and chief medical officer at Intermountain Primary Children's Hospital in Salt Lake City, Utah. Before this, Dr. Giardino worked at Texas Children's Health Plan and Texas Children's Hospital from 2005 to 2018. He received his medical degree and doctorate in education from the University of Pennsylvania, completed his residency and fellowship training at the Children's Hospital of Philadelphia, and earned a master of public health from the University of Massachusetts. He also holds a master in theology from Catholic Distance University and a master in public administration from the University of Texas Rio Grande Valley.

Darin Gordon is president and CEO of Gordon & Associates in Nashville, Tennessee, where he provides health care–related consulting services to a wide range of public- and private-sector clients. Previously, he was director of Medicaid and CHIP in Tennessee for 10 years, where he

oversaw various program improvements, including the implementation of a statewide value-based purchasing program. During this time, he served as president and vice president of the National Association of Medicaid Directors for four years. Before becoming director of Medicaid and CHIP, he was the chief financial officer and director of managed care programs. Mr. Gordon received his bachelor of science from Middle Tennessee State University.

Dennis Heaphy, MPH, MEd, MDiv, is a health justice advocate and researcher at the Massachusetts Disability Policy Consortium, a Massachusetts-based disability rights advocacy organization. He is also a dually eligible Medicaid and Medicare beneficiary enrolled in One Care, a plan operating in Massachusetts under the CMS Financial Alignment Initiative. Mr. Heaphy is engaged in activities that advance equitable whole person-centered care for beneficiaries in Massachusetts and nationally. He is cofounder of Disability Advocates Advancing Our Healthcare Rights (DAAHR), a statewide coalition in Massachusetts. DAAHR was instrumental in advancing measurable innovations that give consumers voice in One Care. Examples include creating a consumer-led implementation council that guides the ongoing development and implementation of One Care, an independent living long-term services and supports coordinator role on care teams, and an independent One Care ombudsman. Previously, he worked as project coordinator for the Americans with Disabilities Act for the Massachusetts Department of Public Health (MDPH) and remains active on various MDPH committees that advance health equity. In addition to policy work in Massachusetts, Mr. Heaphy is on the advisory committee of the National Center for Complex Health & Social Needs and the Founders Council of the United States of Care. He is a board member of Health Law Advocates, a Massachusetts-based nonprofit legal group representing low-income individuals. He received his master of public health and master of divinity from Boston University and master of education from Harvard University.

Verlon Johnson, MPA, is senior vice president, corporate strategy, at CNSI, a Virginia-based health information technology firm that works with state and federal agencies to design technology-driven products and solutions that improve health outcomes and reduce health care costs. Ms. Johnson previously served as an associate partner and vice president at IBM Watson Health. Before entering private industry, she was a public servant for more than 20 years, holding numerous leadership positions, including associate consortium administrator for Medicaid and CHIP at CMS, acting regional director for the U.S. Department of Health and Human Services, acting CMS deputy director for the Center for Medicaid and CHIP Services (CMCS), interim CMCS Intergovernmental and External Affairs group director, and associate regional administrator for both Medicaid and Medicare. Ms. Johnson earned a master of public administration with an emphasis on health care policy and administration from Texas Tech University.

Rhonda M. Medows, MD, is a nationally recognized expert in population health and health equity. As president of Providence Population Health Management, Dr. Medows uses her platform to change the way health care organizations approach large-scale issues, such as improving equity in the Medicare and Medicaid programs. Before joining Providence, she was an executive vice president and chief medical officer at UnitedHealth. In the public sector, she served as commissioner for the Georgia Department of Community Health, secretary of the Florida Agency for Health Care Administration, and chief medical officer for the CMS Southeast Region. Dr. Medows holds a bachelor's degree from Cornell University and earned her medical degree from Morehouse School of Medicine in Atlanta, Georgia. She practiced medicine at the Mayo Clinic and is board certified in family medicine. She is also a fellow of the American Academy of Family Physicians.

William Scanlon, PhD, is an independent consultant working with West Health, among others. He began conducting health services research on

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Laura Herrera Scott, MD, MPH, is executive vice president of population health at Summit Health, responsible for executing on Summit Health's value-based care strategy. Previously, she was vice president of clinical strategy and product at Anthem, where she developed payer and data alignment policies to support efforts to advance population health. Prior to this, she held several leadership positions in the Maryland Department of Health and Mental Hygiene and the Veterans Health Administration. Dr. Herrera Scott's work has focused on payment reform and delivery system transformation to improve health status and outcomes in underserved communities. She received her degree in medicine from SUNY Health Science Center at Brooklyn and her master of public health from the Johns Hopkins Bloomberg School of Public Health.

Katherine Weno, DDS, JD, is an independent public health consultant. Previously, she held positions at the Centers for Disease Control and Prevention, including senior adviser for the National Center for Chronic Disease Prevention and Health Promotion and director of the Division of Oral Health. Dr. Weno also served as the director of the Bureau of Oral Health in the Kansas Department of Health and Environment. Previously, she was the CHIP advocacy project director at Legal Aid of Western Missouri and was an associate attorney at Brown, Winick, Graves, Gross, Baskerville, and Schoenebaum in Des Moines, Iowa. Dr. Weno started her career as a dentist in Iowa and Wisconsin. She earned degrees in dentistry and law from the University of Iowa.

Biographies of Staff

Asmaa Albaroudi, MSG, is a senior analyst. Before joining MACPAC, she was a Health and Aging Policy Fellow with the House Energy and Commerce Committee's Subcommittee on Health. Ms. Albaroudi also worked as the manager of quality and policy initiatives at the National PACE Association, where she provided research and analysis on federal and state regulations. She is currently a doctoral candidate at the University of Maryland-College Park's School of Public Health, where her research centers on long-term care. Ms. Albaroudi holds a master of science in gerontology and a bachelor of science in human development and aging from the University of Southern California.

Lesley Baseman, MPH, is a senior policy analyst. Before joining MACPAC, she was a public health fellow for Massachusetts State Senator Jo Comerford, where she worked on the Joint Committee on COVID-19 and the Joint Committee on Public Health. Ms. Baseman also worked as a data scientist and programmer at the RAND Corporation, where she focused on policy research pertaining to access to care for the uninsured and underinsured and quality of care in the Medicare program. She holds a master of public health in health policy from the Harvard T.H. Chan School of Public Health and a bachelor of arts in economics from Carleton College.

Kirstin Blom, MIPA, is a principal analyst and the contracting officer. Before joining MACPAC, Ms. Blom was an analyst in health care financing at the Congressional Research Service. Before that, Ms. Blom worked as a principal analyst at the Congressional Budget Office, where she estimated the cost of proposed legislation on the Medicaid program. Ms. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office (GAO). She holds a master of international public affairs from the University of Wisconsin, Madison, and a bachelor of arts in international studies and Spanish from the University of Wisconsin, Oshkosh.

Jim Boissonnault, MA, is the chief operating officer. He was previously MACPAC's chief information officer. Before joining MACPAC, he was the information technology (IT) director and security officer for OnPoint Consulting. At OnPoint, he worked on several federal government projects, including projects for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonnault holds a master of arts in Slavic languages and literatures from The University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

Allissa Brice, MTA, is the executive assistant. Before joining MACPAC, Ms. Brice worked as an intern for Kaiser Permanente, where she helped coordinate health and wellness events in the Washington, DC, area. Ms. Brice holds a master of tourism administration from The George Washington University and a bachelor of science with a concentration in health management from Howard University.

Caroline Broder is the director of communications. Before joining MACPAC, she led strategic communications for Steadfast Communications, working with health policy organizations and foundations to develop and implement communications strategies to reach both the public and policymakers. She has extensive experience working with researchers across a variety of disciplines to translate and communicate information for the public. She began her career as a reporter covering health and technology issues. Ms. Broder holds a bachelor of science in journalism from Ohio University.

Sean Dunbar, MS, is a principal analyst. Before joining MACPAC, he was a health policy director with the Anthem Public Policy Institute, where he directed Medicaid-focused research and data analysis. He also previously worked at the Congressional Budget Office, where he analyzed a variety of Medicaid and State Children's

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Sabrina Epstein is a research assistant. Her previous work includes conducting COVID-19 research at the Johns Hopkins Disability Health Research Center and interning in the accessibility office at the National Endowment for the Arts. She graduated from Johns Hopkins University with a bachelor of arts in public health.

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Martha Heberlein, MA, is the research advisor and a principal analyst. Before joining MACPAC, she was the research manager at the Georgetown University Center for Children and Families, where she oversaw a national survey on Medicaid and CHIP eligibility, enrollment, and renewal

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Joanne Jee, MPH, is a policy director and the congressional liaison. Before joining MACPAC, she was a program director at the National Academy for State Health Policy, where she focused on children's coverage issues. Ms. Jee also has been a senior analyst at GAO, a program manager at The Lewin Group, and a legislative analyst in the HHS Office of Legislation. Ms. Jee has a master of public health from the University of California, Los Angeles, and a bachelor of science in human development from the University of California, Davis.

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Carolyn Kaneko is the graphic designer. Before joining MACPAC, she was design lead at the Artist Group, handling a wide variety of marketing projects. Her experience includes managing publication projects at all stages of design

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Kate Massey, MPA, is the executive director. Before joining MACPAC, she was senior deputy director for the Behavioral and Physical Health and Aging Services Administration with the Michigan Department of Health and Human Services. Ms. Massey has nearly 20 years of operational and policy expertise in Medicaid, Medicare, CHIP, and private market health insurance. She previously served as chief executive officer for Magellan Complete Care of Virginia. Before that, she served as vice president for Medicaid and Medicare and government relations for Kaiser Permanente of the Mid-Atlantic States, overseeing the launch of two Medicaid managed care organizations in Virginia and Maryland. She also has worked for Amerigroup, where she established its Public Policy Institute and served as executive director. Earlier positions include working for the Office of Management and Budget, where she led a team focused on Medicaid, CHIP, and private health insurance market programs. She also served as unit chief of the Low-Income Health Programs and Prescription Drugs Unit in the Congressional Budget Office. Ms. Massey has a master of public affairs from the Lyndon B. Johnson College of Public Policy at the University of Texas at Austin and a bachelor of arts from Bard College in New York.

Jerry Mi is a research assistant. Before joining MACPAC, Mr. Mi interned for the U.S. House of Representatives Committee on Energy and Commerce, the Health Resources and Services Administration, the Food and Drug Administration, and the National Institutes of Health. Mr. Mi graduated from the University of Maryland with a bachelor of science in biological sciences.

Robert Nelb, MPH, is a principal analyst focusing on issues related to Medicaid payment and delivery system reform. Before joining MACPAC, he served as a health insurance specialist at the Centers for

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Audrey Nuamah, MPH, is a senior analyst focusing on health equity-related projects. Before joining MACPAC, Ms. Nuamah worked as a program officer at the Center for Health Care Strategies, where she worked with state agencies and provider organizations to focus on cross-agency partnerships, advance health equity, and engage complex populations. Before that, Ms. Nuamah worked for the commissioner of health at the New York State Department of Health. Ms. Nuamah holds a master of public health with a concentration in health policy and management from Columbia University Mailman School of Public Health and a bachelor of arts in health and societies from the University of Pennsylvania.

Kevin Ochieng is the senior IT specialist. Before joining MACPAC, Mr. Ochieng was a systems analyst and desk-side support specialist at American Institutes for Research, and before that, an IT consultant at Robert Half Technology, where he focused on IT system administration, user support, network support, and PC deployment. Previously, he served as an academic program specialist at the University of Maryland University College. Mr. Ochieng has a bachelor of science in computer science and mathematics from Washington Adventist University.

Chris Park, MS, is the data analytics advisor and a principal analyst. He focuses on issues related to managed care payment and Medicaid drug policy

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Kimberley Pringle is the administrative assistant. Before joining MACPAC, she was the executive assistant to the executive director of the NOVA Foundation for Northern Virginia Community College in Annandale, Virginia. Ms. Pringle attended

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Melinda Becker Roach, MS, is a senior analyst. Before joining MACPAC, Ms. Roach was a program director at the National Governors Association (NGA) Center for Best Practices, as well as NGA's legislative director for health and human services. Ms. Roach previously served as a legislative advisor on personal staff in the U.S. House of Representatives. She holds a master of science in health policy and management from the Harvard T.H. Chan School of Public Health and a bachelor of arts in history from Duke University.

Eileen Wilkie is the senior administrative officer and is responsible for coordinating human resources, office maintenance, travel, and Commission meetings. Previously, she held similar roles at National Public Radio and the National Endowment for Democracy. Ms. Wilkie has a bachelor of arts in political science from the University of Notre Dame.

Amy Zettle, MPP, is a principal analyst. Before joining MACPAC, she served as the legislative director for the Health and Human Services Committee at the NGA. Ms. Zettle has been a federal affairs director at Cigna and a health care analyst at the Potomac Research Group. Ms. Zettle holds a master of public policy from the University of Maryland and a bachelor of arts in economics from John Carroll University.