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MACPAC Holds December 2024 Meeting

On December 12 and 13, the Medicaid and CHIP Payment and Access Commission (MACPAC) held a virtual public meeting, which included the following sessions:

- State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Organizations, and
- Potential Areas for Comment on CMS Proposed Rule on MA for CY 2026.

The full agenda and presentations for the sessions are available here.

STATE AND FEDERAL TOOLS FOR ENSURING ACCOUNTABILITY OF MEDICAID MANAGED CARE ORGANIZATIONS

Medicaid managed care is the main delivery system in Medicaid. MedPAC staff reviewed federal policy and guidance of Medicaid Managed Care Organizations (MCOs) and an overview of MACPAC's staff initial findings on their scan into State Request for Proposals (RFP). The staff first presented their previous and current studies on Managed Care Accountability work. A 2022 MACPAC study on procurement found that CMS defers to state Medicaid agencies but found that there were opportunities to assist states and MCOs during readiness reviews. Additionally, between 2022 and 2024, a study was performed where sixty stakeholder interviews and an analysis of the 2024 managed care final rule was conducted. Finally, in 2023, MACPAC made seven recommendations to Congress based on a study examining monitoring, oversight, and beneficiary experience with denials and appeals.

MACPAC staff then presented on federal policy and guidance on MCOs relating to managed care procurement, state Medicaid agency responsibilities, and CMS's direct oversight authorities. The federal government often defers to states regarding procurement as states each have their own regulations regarding applications, selection criteria, and contract details. However, the federal government does provide states with guidance in two areas: conflict of interest safeguards and the statutory definition of an MCO. Once the contract is established, the state Medicaid agencies must develop and implement a quality assessment and improvement strategy (QAPI) to guide MCOs, they must develop actuarially sound capitation payments for their contracted MCOs, and they must include intermediate sanctions provisions.

Regarding CMS's direct oversight authorities, CMS approves states' actual rate certifications, approves state Medicaid agency contracts, and has the statutory authority to deny federal match on state capitation payments. Furthermore, the 2024 Managed Care Rule expanded CMS's oversight starting in 2028 that requires states to submit and implement a formal remedy plan when an MCO fails to meet access to care standards.

MACPAC staff also presented their initial state scan findings on RFPs in 23 states. Among other findings, staff found that states vary in using past performance to award contracts. Some of the most common contract sanction tools include monetary policies as well as CAPs and contract termination. Common contract incentive tools include capitation payment bonuses to meet or exceed performance standards or targets and auto assignment of enrollees.

Commission Discussion

Following the presentation, MACPAC staff asked for Commissioner feedback on findings from federal policy review and the environmental scan. Additionally, they seek feedback on stakeholder interviews for their next stage of analysis on MCPARs.

Commissioners' discussion largely focused on what MACPAC staff could improve upon or investigate further for the next phase of work. Multiple commissioners suggested tiering sanctions in their next scan, as terminating the contract is the last resort, and they would want to see what other middle steps exist. Additionally, others would like staff to complete some sort of regression analysis to look at how sanctions are being used. Commissioners were also interested in understanding differences between states, with a scan examining differences between smaller states and more mature states or a scan considering why some states are more transparent than others suggested as options.

Commissioners also suggested some ideas for questions that MACPAC can explore in future interviews with stakeholders, including any information on when sanctions are applied, and how often states take the provisions. Commissioners expressed interest in understanding MCO relationships further.

MACPAC DISCUSSES POTENTIAL AREAS FOR COMMENT ON CMS PROPOSED RULE ON MEDICARE ADVANTAGE FOR CY2026

MACPAC analysts updated the commission on CMS's proposed rule for Medicare Advantage (MA) and Part D for 2026, focusing on how it will affect Medicaid, dual-eligible individuals, and areas for potential comment. The presenters discussed three main areas: coverage of anti-obesity medications (AOMs), integrated care for dually eligible individuals, and access to cost-sharing tools.

CMS proposes to allow Medicare and Medicaid coverage of AOMs for obesity, recognizing it as a chronic disease. These medications are not covered under Medicare Part D unless a beneficiary has some kind of condition like diabetes, but some states do cover them under Medicaid. The rule would mandate Medicaid coverage sooner than Medicare, which could make a gap in applicability for dually eligible beneficiaries. The estimated cost of the mandate over ten years is $11 billion for federal Medicaid and $3.8 billion for state Medicaid. The commission may recommend a clarifying definition of obesity, which could also align effective dates for Medicare and Medicaid coverage and help issue guidance for Medicaid coverage criteria during gaps.

For integrated care, CMS proposes requiring applicable integrated plans (AIPs) to provide integrated member ID cards and help health risk assessments (HRAs) with care plan timelines. CMS hopes to improve the burden on beneficiaries and care integration. The commission may support these measures due to past similar recommendations. Also, CMS will consider whether to publicly post state Medicaid agency contracts (SMACs) to encourage state collaboration, but concerns about confidentiality remain.

On cost-sharing tools, CMS proposes that MA brokers inform beneficiaries about available supports, such as Medicare Savings Programs (MSPs) and Medigap, and codify rules for supplemental benefit debit cards. To prevent misleading marketing, the rule would prohibit advertisements emphasizing debit card dollar values without linking them to covered benefits. The Commission might endorse these measures to improve MSP enrollment and safeguard beneficiaries from misleading offers that could detract from integrated care models.

The commission's comments on these provisions are due by January 27, 2025. Staff will use the feedback in a draft letter for review, which will shape the new potential policies for the Medicare and Medicaid programs.

Commission Discussion

The commissioners' discussion revolved around considerations on anti-obesity medications, integration of Medicare and Medicaid services, and broader considerations of health equity and system functionality. Overall, participants expressed support for integrating services and refining Medicaid policies to improve service to beneficiaries. They emphasized the importance of data-driven approaches, stakeholder input, and flexibility for states to address diverse population needs effectively.

Anti-Obesity Medications in Medicaid

Some commissioners raised concerns about the prescriptive use of anti-obesity drugs and their potential lifelong necessity for some individuals to maintain health benefits.

While medications like GLP-1s have significant benefits, they will also be very costly. The commissioners debated the implications of defining obesity solely through body mass index (BMI), emphasizing that narrowly focusing on weight may lead to unintended consequences, such as incentivizing weight gain to qualify for treatment. Suggestions included considering the totality of a person's health when determining eligibility and acknowledging the long-term savings and health improvements these drugs can bring.

Two commissioners highlighted parallels to the introduction of costly hepatitis C drugs in the past, stressing the need for prior authorization criteria and sustainable funding approaches. Others emphasized making sure there is equitable access to these medications for low-income and minority populations, arguing that failure to do so could widen existing gaps.

Integration of Medicare/Medicaid

Some commissioners emphasized the need to better integrate Medicare and Medicaid, especially for beneficiaries with special needs. They pointed to inefficiencies such as duplicative health risk assessments (HRAs) and problems with unified care plans. To help with these problems, the commissioners suggested clearer processes and state-specific flexibility to help dual-eligible beneficiaries' needs.

Recommendations

Commissioners recommended more clarity for regulations and suggested how CMS can guide Medicaid programs. Specific recommendations included publicly posting SMAC agreements, which would require agents to implement oversight for Medicare Savings Program options, and addressing gaps in dual-eligibility drug coverage during transition periods between Medicaid and Part D. They also debated the inclusion of broader policy discussions in comment letters to CMS, noting the limits of MACPAC's clinical expertise.

Equity and Systemic Considerations

Commissioners also discussed the need to consider social determinants of health and avoid policies that would cause inequities among ethnic and disadvantaged socioeconomic groups. They want to see better balancing of cost containment with health outcomes, focusing on reducing hospitalizations and improving quality of life for Medicaid beneficiaries.

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This Applied Policy® Summary was prepared by Emma Hammer with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at ehammer@appliedpolicy.com or at 202-558-5272.