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MACPAC Holds February 2025 Meeting

On February 27 and 28, the Medicaid and CHIP Payment and Access Commission (MACPAC) held a virtual public meeting, which included the following sessions:

- Hospital Non-DSH Supplemental Payment and Directed Payment Targeting Analyses,
- Overview of the Self-Directed Model Design,
- Interview Findings on Self-Direction Program Design and Administration, and
- Automation in the Prior Authorization Process.

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

MACPAC DISCUSSES THE ROLE OF HOSPITAL NON-DSH SUPPLEMENTAL PAYMENTS AND DIRECTED PAYMENT TARGETING IN MEDICAID

In this session, MACPAC discussed hospital non-Disproportionate Share Hospital (DSH) payments, supplemental payments, and directed payment targeting. Non-DSH supplemental payments provide additional Medicaid funding to hospitals beyond base payments and DSH payments. These payments help cover Medicaid shortfalls, support teaching hospitals, and improve access to care in rural and underserved areas. MACPAC staff and commissioners primarily focused on state strategies for distributing these payments, recent analyses on their effectiveness, and policy considerations for future improvements. This work is part of MACPAC's long-term work plan on hospital payment and financing.

MACPAC staff first reviewed the structure and impact of non-DSH supplemental payments, including Upper Payment Limit (UPL) payments, graduate medical education (GME) payments, uncompensated care pools, and directed payments. These five categories combined account for over 20 percent of Medicaid hospital spending. UPL payments are a major funding source for fee-for-service (FFS) hospitals, while directed payments use is rising in managed care settings. Approaches for allocating these payments vary, with each state utilizing different criteria including Medicaid shortfalls, service volume, or quality metrics.

MACPAC staff also reported on differences in payments by hospital types. This included how rural hospitals, including Critical Access Hospitals (CAHs), are twice as likely to receive non-DSH payments. Government-owned and teaching hospitals also receive targeted funding. States use different methods to distribute UPL payments, with some prioritizing Medicaid shortfalls and others using volume-based or fixed-dollar allocations. In CY 2022, 33 states implemented 129 directed payment programs, mostly targeting acute care, teaching, and rural hospitals, though inconsistencies in reporting make evaluation difficult.

Commissioners stressed the need for standardized evaluation criteria to ensure these payments improve hospital access and quality, while others considered the role of variation. Some suggested aligning non-DSH payment evaluations with the 2024 managed care rule. Commissioners highlighted the importance of financial support for hospitals serving high-needs populations and called for better data transparency. Discussions also covered Medicaid's role as a payer and ways to compare hospital payments across funding sources.

Given the complexity of the issue, commissioners agreed that further analysis is needed to refine targeting strategies, as well as align federal and state policies.

MACPAC PROVIDES OVERVIEW OF THE SELF-DIRECTED MODEL

In this session, staff provided an overview of the self-directed model for Home and Community-Based Services (HCBS) within Medicaid. Self-directed programs allow participants (or their representatives) to take direct responsibility for the management of certain services. These programs are authorized through Medicaid waivers under an existing framework, but allow states meaningful flexibility to develop specific implementation strategies. Many states also operate multiple programs with different conditions and levels of available support to best cater to their demographic and population needs.

Before presenting their findings, staff explained the key components of self-direction. Key program actors include beneficiaries, employer representatives, HCBS workers, and state oversight agencies. Responsibilities include recruiting and training workers, managing Medicaid budget allocations, and ensuring program compliance. States are also responsible for monitoring outcomes and addressing fraud, waste, and abuse concerns within the HCBS program. MACPAC staff also highlighted available information and assistance support states offer program participants, including case managers, support brokers, and financial management services (FMS) agencies.

Following the overview, staff presented their findings on self-direction. One major issue identified was the lack of national data tracking participation. States employ varying

approaches, and no single predominant model has emerged. Most states use Section 1915(c) waivers due to their flexibility, while some also utilize 1915(i) and 1915(k) waivers to access enhanced federal funding. Additionally, commissioners noted that information and assistance support is critical in self-direction, including case managers, support brokers, and financial management services (FMS). These entities help beneficiaries develop service plans, track budgets, and navigate employer responsibilities.

In the discussion portion, commissioners began by raising concerns about conflicts of interest, particularly when family members serve as paid caregivers. Some states prohibit household members from acting as HCBS workers to mitigate potential conflicts, while others allow it under certain programs. The discussion also touched on worker benefits, including the lack of paid time off and health insurance for self-directed workers compared to agency-based caregivers. Some states are exploring resource pooling to address these disparities, and beneficiaries may offer additional caregiver compensation to help offset costs.

Another key discussion point was Electronic Visit Verification (EVV), a federally mandated system to prevent fraud in Medicaid HCBS. Commissioners and panelists debated the balance between accountability and privacy concerns, with some states still determining how to effectively implement EVV. MACPAC's future work will examine how EVV affects Medicaid self-direction and offer potential recommendations for improvement.

Overall, commissioners agreed that additional data and analysis are needed to understand the full scope of self-directed programs in Medicaid HCBS. Commissioners also offered broad support for improved transparency and resource pooling to support HCBS workers. Moving forward, the commission aims to explore strategies to enhance worker benefits, assess potential policy adjustments, and gather more state-level data on self-direction trends. Additionally, they will evaluate cost, quality, and access implications of self-direction versus agency-based care to inform future policy decisions.

MACPAC DISCUSSES INTERVIEW FINDINGS ON SELF-DIRECTION PROGRAM AND ADMINISTRATION

MACPAC staff reviewed findings from 33 interviews with key stakeholders involved in Medicaid Self-Directed Home and Community-Based Services (HCBS). Building on earlier discussions (including the prior session – see *MACPAC Provides Overview of the Self-Directed Model Design*), staff explored regulatory frameworks, program design and implementation challenges. Interview findings were categorized into state design

considerations and state administration considerations. Participants interviewed for this work included state Medicaid officials, financial management services (FMS) agencies, managed care organizations (MCOs), beneficiary advocates, and representatives from one area agency on aging (AAA).

MACPAC staff highlighted their findings on state design considerations and state administration considerations across the varied interviewees. When establishing programs, Medicaid waiver authority under Section 1915(c) was most frequently used, with some programs utilizing Sections 1915(i), 1915 (j), and 1915 (k) authorities. States generally allow self-directed personal care services (e.g. bathing and dressing), though certain services require specific training. Interviewees noted the differences between available programs, and how those with self-directed budget authority (management of program funds) are more complex for beneficiaries than programs which only allow self-directed employer authority (to recruit, hire, supervise, and direct workers). All states also permit family caregivers to serve as paid employees for self-directed programs, with the goal of minimizing HCBS workforce shortages. Regarding state administration considerations, MACPAC staff discussed the spectrum of collaboration between relevant state agencies, differing definitions of information and assistance, and approaches to case management (in-house, vendor or hybrid). Interviewees emphasized the need for clearer contracting expectations with FMS agencies, and a stronger, more robust data infrastructure to streamline reporting and oversight.

Commissioners offered varying feedback during the discussion, with common themes including consumer choice versus agency control, program integrity, and how to best conduct effective oversight. A few commissioners were concerned about the potential for fraud, waste, and abuse within self-directed and agency programs, with an eye to ensuring Medicaid funds are used appropriately. One commissioner also had questions about the role of EVV (Electronic Visit Verification) in monitoring care delivery. Commissioners emphasized the importance of self-direction allowing beneficiaries to choose their caregivers (including family members), while acknowledging challenges in oversight and workforce availability. Two commissioners also broadly discussed the importance of consumer-directed models, and their preference for this over the agency model.

Commissioners also raised concerns about administrative burden and duplication. These discussions focused on addressing overlapping roles among different entities (AAAs, case managers, support brokers) and how to streamline these processes while maintaining access to accurate information. Overall, key policy considerations centered on improving the integrity of the program, reducing administrative burdens on beneficiaries, expanding access for underserved populations, and integrating workforce and Medicaid data.

MACPAC DISCUSSES AUTOMATION IN PRIOR AUTHORIZATION

MACPAC staff began the session by providing an overview of prior authorization in Medicaid. This included details on the submission processes and medical context in which prior authorization is typically utilized – highlighting coverage for nonemergency medical transportation, durable medical equipment, and inpatient stays. Next, they provided a framework for classifying the different types of automation in healthcare. This included drawing the distinction between an algorithm (where a procedure or set of rules are applied to a dataset), versus Artificial Intelligence (AI - a machine-based system that when given objectives, can create recommendations). They also grouped AI models into two buckets; generative (creates original content such as long-form text or images) or predictive (finds patterns and creates forecasts based on historical data). After establishing this background, the discussion progressed to existing oversight capacities, which are primarily conducted by state Medicaid agencies. Oversight of automation in Medicaid varies by state, while federal Medicaid-specific authority on the matter is limited. However, additional prior authorization requirements concerning timely decisions, transparency, and reporting will come into effect for FFS Medicaid programs in 2026.

On the automation of prior authorization, MACPAC staff outlined use cases, including both payer and provider-side automation. For payers, automation would speed up authorization review and organization, with the goal of preventing untimely delays in delivering decisions to patients and providers. This includes the use of predictive AI to quickly triage requests, enable faster processing times, review trends in previous requests to identify potential policy changes, and detect fraud. For providers, automation could ease the submission and appeals process by reducing the amount of paperwork providers are required to fill out manually.

Commissioners were split overall on the role of automation in prior authorization. Several commissioners who were skeptical of AI involvement expressed concerns about bias. Another commissioner responded to these comments by highlighting the presence of bias in human reviewers. Many commissioners defended the use of automation, emphasizing the potential for many aspects of clinical practice, including capturing and summarizing patient-provider meetings for later review. Another commissioner questioned the purpose of prior authorization in general, and if it is simply used as a barrier to moderate costs.

Commissioners were highly interested in examining this topic. In their upcoming April meeting, MACPAC staff plan to hold a panel to discuss this topic further.

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