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MACPAC Holds October 2024 Meeting

On October 31 and November 1, 2024, the Medicaid and CHIP Payment and Access Commission (MACPAC) held a virtual public meeting, which included the following sessions:

- Medications for Opioid Use Disorder and Related Policies,
- Timely Access to Home- and Community-Based Services: Provisional Plans of Care,
- Managed Care External Quality Review Policy Options, and
- Directed Payments in Medicaid Managed Care.

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

MACPAC PROVIDES OVERVIEW OF MEDICATIONS FOR OPIOID USE DISORDER AND RELATED POLICIES

MACPAC provided an overview of Medications for Opioid Use Disorder (MOUD) and recent policy updates aimed at expanding access through federal mandates and Medicaid requirements. The discussion emphasized the effectiveness of these treatments, current federal policies, and identified barriers. Future work will analyze MOUD coverage data and gather insights from stakeholders.

Overview of MOUD Programs

Medications for Opioid Use Disorder (MOUD) are Food and Drug Administration (FDA)-approved treatments that help reduce opioid use and overdose risk. These medications are effective in managing withdrawal symptoms and supporting recovery, often tailored to fit individual patient needs.

MOUD includes 3 FDA-approved treatments: methadone, buprenorphine, and naltrexone. All three show strong evidence of effectiveness; both methadone and buprenorphine have strong evidence of effectiveness in reducing overdose deaths. However, each medication has distinct guidelines, requirements, dosing frequencies, and regulatory considerations. Federal guidance supports access to MOUD without requiring counseling and additional services – making treatment more widely accessible. Each MOUD option has unique characteristics that allow providers to tailor treatments to best meet patient needs.

Recent Federal Policies Regarding MOUD

Recent federal policies have increasingly focused on improving access to MOUD. The MOUD benefit mandate, established under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act requires Medicaid to cover these treatments for a five-year period, which has now been made permanent in the Consolidated Appropriations Act (CAA) in 2024. States that have provider shortages are required to recertify their exceptions every five years, with only three states currently facing this challenge due to a lack of Opioid Treatment Programs (OTPs).

Federal Medicaid policies also include Section 1115 demonstrations that provide alternative payment mechanisms for MOUD and treatment access. These demonstrations are designed to enhance access to MOUD, particularly in relation to substance use disorder (SUD) services and reentry programs. Additionally, the CAA 2024 made permanent state plan options for institutions for mental diseases (IMDs), requiring these facilities to offer at least two forms of MOUD on-site to better support patients.

To further expand access, the SUPPORT Act authorized SUD provider capacity demonstrations, which have provided 15 planning grants, with five states selected for a post-planning period aimed at enhancing MOUD availability and increasing the number of providers. The establishment of Health Homes under the Patient Protection and Affordable Care Act also supports the integration of care for individuals with chronic conditions, including opioid use disorder, by offering enhanced federal funding for related services.

Broader federal policies have also improved regulations surrounding MOUD access. The Substance Abuse and Mental Health Services Administration (SAMHSA) implemented permanent changes to methadone access that relaxed take-home distribution rules, initially introduced during the pandemic. Flexibility for buprenorphine prescription via telehealth has also been temporarily extended, with proposed rules that limit prescriptions to 30 days without an in-person evaluation; ensuring that telehealth remains a viable option for patients. Finally, the CAA eliminated the federal waiver requirement and patient caps for buprenorphine prescribers, removing significant barriers to expanding MOUD provider availability.

Factors Limiting MOUD Access

Access to MOUD is significantly hindered by provider availability, with 34 percent of U.S. counties lacking opioid treatment programs or providers for Medicaid enrollees. This scarcity of providers can be attributed to several factors, including stigma surrounding addiction treatment, the high costs associated with offering these services, and restrictive regulations on treatment, which can deter potential providers from

participating. Additionally, previous restrictive requirements for buprenorphine prescribers have created further barriers, limiting the number of healthcare professionals willing or able to offer MOUD.

Utilization management practices also pose challenges to accessing MOUD. While these practices are intended to reduce fraud, they often create timely barriers to care. Prior authorization processes have become a significant deterrent for patients seeking treatment as they delay access to necessary medications. Restrictions on maximum daily doses can impede the ability of healthcare providers to tailor treatments effectively to individual patient needs.

Commissioners Discussion

The Commission raised several pressing concerns regarding the accessibility and efficacy of substance use disorder (SUD) treatment, particularly focusing on the complexities of payment structures and the impact of new parity guidance on treatment access. There is a clear need to examine how substance use providers are compensated, as current payment rates are perceived as inadequate and contribute to provider shortages.

Additionally, the Commission highlighted the unique challenges posed by fentanyl addiction, which presents different treatment needs and withdrawal symptoms compared to other opioids. They cited an urgent need for programming to address the unique circumstances and treatment of fentanyl.

Despite recent efforts to remove utilization management barriers, individuals with opioid use disorder and co-occurring mental health issues still face major barriers. These include limited provider availability, high treatment costs, and challenges in coordinating mental health care. Commissioners highlighted the importance of supporting treatment that addresses both opioid use and mental health needs simultaneously.

The discussion also emphasized the importance of revisiting Medicaid payment policies and considering the implications of recent 1115 authority demonstrations to better understand their impact on access and provider capacity. Overall, the Commission is advocating for a more nuanced approach to addressing these systemic issues while ensuring patient safety and effective treatment delivery, particularly in underserved communities.

MACPAC REVIEWS USE OF PROVISIONAL CARE PLANS IN 1915(C) WAIVER PROGRAMS

MACPAC reviewed the use of provisional plans of care in Medicaid's 1915(c) waiver programs, including the eligibility process for non-MAGI (Modified Adjusted Gross

Income) populations seeking home and community-based services (HCBS). These plans are one way states can expedite Medicaid eligibility determinations and enrollment for individuals who need HCBS. There are multiple steps in the eligibility process for individuals seeking these services. MedPAC staff highlighted the third step in eligibility, which is to create a Person-Centered Service Plan (PCSP), a plan that shows the required services and supports for individuals before they can receive HCBS. Staff also highlighted how CMS allows states to expedite services by implementing provisional or interim plans of care, enabling beneficiaries to access essential services within the first 60 days of waiver eligibility.

The Lewin Group, a consulting firm, conducted a waiver analysis and an environmental scan. The review showed state adoption of flexible policies, as 23 states initially allowed provisional plans of care across 57 Section 1915(c) waivers. The policies varied throughout the states, as most states allow provisional plans for 60 days, though some specify shorter periods of 30 or 45 days. The staff also reviewed the plans' targeting towards certain populations, as provisional plans of care commonly serve individuals with intellectual and developmental disabilities, physical disabilities, and older adults.

MACPAC also conducted interviews with official in five states, CMS officials, and national experts. Interviews showed few states actively use provisional plans, which are typically used in emergency situations, such as natural disasters or hospitalizations in these respective states. Among the states, data showed low usage rates for the provisional plans overall, with one state reporting usage ranging from 0 percent to 6 percent across its waivers. Despite this low usage, states noted that provisional plans are valuable plans as they offer essential services quickly without awaiting a complete eligibility determination.

While CMS has permitted provisional plans of care since 2000, there has been limited guidance following implementation. Some states are content with the present framework, but national experts want to see more CMS guidance to encourage wider use of provisional plans. Despite this feedback, CMS does not plan to issue new guidance, citing the longstanding flexibility and a lack of recent technical assistance requests on the issue. Instead, CMS has promoted provisional plans through various channels, including webinars, informational bulletins, and HCBS conferences.

As next steps, MACPAC will share a draft chapter for the March 2025 Report to Congress during the January 2025 meeting, integrating findings on presumptive eligibility, expedited eligibility, and provisional plans of care. Future analysis will focus on level of care assessments and person-centered planning.

Commissioner Discussion

Commissioners expressed concern about the reluctance and low usage of provisional plans of care among the states. One commission specifically noted Tennessee's success with facilitating timely service delivery since the early 2000s. The states have the authority to offer provisional plans of care, but the commissioners want to understand why the states do not exercise that authority. The commissioners agreed that understanding this reluctance among states for provisional plans of care, whether it may be because of financial, operational, or administrative reasons, is essential to expanding the provisional plans' flexibility.

The commissioners were also concerned with the lack of rapid financial eligibility determinations in Medicaid, which can take up to a month, making states' ability to provide HCBS quickly in crisis situations quite limited. The commissioners mentioned that presumptive eligibility or provisional care plans could help improve this limited access, but slow financial eligibility processes often delay HCBS placements, contrasting with the quicker process available for nursing facilities. Commissioners also supported the need for the CMS to issue updated guidance and continue to promote provisional plan use. The commissioners agreed that CMS' 24-year-old guidance on this topic is far too outdated and insufficient to instill confidence in states about adopting provisional plans. New guidance could improve implementation and awareness among the states.

Public commenters echoed these points, stressing that lack of CMS guidance and awareness has created barriers. They suggested that clearer CMS guidance would support states in understanding the flexibility around provisional plans and encourage broader adoption to improve HCBS access. The discussion concluded with encouragement and agreement for MACPAC to continue researching and formulating recommendations for policy adjustments to increase HCBS accessibility through provisional plans.

MACPAC REVIEWS POLICY OPTIONS TO IMPROVE EXTERNAL QUALITY REVIEW PROCESS

EQR, which is performed by EQR organizations (EQROs), releases annual technical reports on the quality of managed care organizations (MCOs) to promote and ensure MCO efficacy and accountability. Currently, EQR predominantly evaluates process measures and regulatory compliance, as opposed to outcomes. MACPAC staff found that alignment between EQR and state quality measures is often lacking and reported that annual technical reports were sometimes poorly accessible and often difficult to interpret and compare. There is also variability in state enforcement of EQR findings, as states are not required by law to act on findings. Additionally, CMS oversight of the

EQR process is likely limited. Staff outlined three policy options to address these challenges:

- Policy Option 1 specified that EQR reports must include outcomes data. This suggestion is in line with efforts to shift to a value-based or outcomes-directed healthcare system.
- Policy Option 2 proposed standardization of EQR protocols across states.
- Policy Option 3 suggested a common webpage (at Medicaid.gov) on which to make readily available all annual technical reports. This option was directed at increasing the accessibility of EQRO findings and was ultimately the least criticized of the three.

Although most commissioners expressed support for the policy options, others voiced concerns about policy options one and two. These commissioners questioned the fine details of the standardization implicit to policy option two and refrained from endorsing the options until provider feedback had been communicated and specific data measures decided upon. MACPAC staffers stated that they are unable to reach out to providers for feedback until receiving approval. A commissioner also requested an estimate from the Congressional Budget Office (CBO). Chair Verlon Johnson followed up on this comment, and the presenters replied that historically CBO has not scored such measures as an increase in federal spending. Some commissioners suggested a common, basic set of requirements for EQR reports so as not to impair reporting efforts from states who are already doing an excellent job. Commissioners also advised a thorough look at the data already available to avoid repetitive and duplicative data collection.

Broadly, the move to support more outcomes measures as opposed to process measures received support. In the public comments, Arvin Goyle, the Medicaid Medical Director of Illinois, strongly urged specific measures tailored to patients' health outcomes. In closing remarks, Chair Johnson noted that the session found broad support for the policy options albeit with modifications and with clarifications.

COMMISSION UPDATES WORK ON DIRECTED PAYMENTS IN MEDICAID MANAGED CARE

In 2016, the Centers for Medicare and Medicaid Services (CMS) updated the regulations for Medicaid managed care and created a new option for states to direct managed care organizations (MCOs) to make additional payments to providers. In prior work, MACPAC has reviewed directed payment arrangements approved up to February 2023. In this session, MACPAC updated an issue brief that discusses the history of directed payments, changes CMS made in the 2024 managed care rule, and examines the use of

directed payments from February 1, 2023, to August 1, 2024. MACPAC staff present their updates in this session.

There are three main types of directed payments. The first is minimum or maximum fee schedule which can use a state plan approved rate, a Medicare fee schedule, or alternative fee schedule that the state develops to set base payment rates that plans pay for specified services. The second is a uniform rate increase which requires plans to pay a uniform dollar or percent increase in payment above the negotiated payment rates. This type of directed payment is most similar to lump-sum supplemental payments in fee for service Medicare. The third type is a value-based payment (VBP) which requires plans to implement VBP models such as pay-for-performance incentives, shared savings arrangements, or other alternative payment models.

Payment methods differ across the three directed payment types. Directed payments can be incorporated as either adjustments to the base capitation rate or as separate payment terms which are a separate, predetermined pool of funding to the base capitation rate. Most uniform rate increases and VBP arrangements use separate payment terms where provider taxes and intergovernmental transfers (IGTs) financed the majority of the payments. However, the 2024 managed care rule will eliminate separate payment terms starting on or after July 9, 2027, and directed payments currently incorporated as separate payment terms must transition to capitation rate adjustments.

MACPAC Findings from Updated Issue Brief

Following the brief overview, staff presented their findings. Overall, MACPAC staff found substantial growth in the use of directed payments since 2017, and therefore, an increase in directed payment spending. Although the most common stated goal in directed payment arrangements is to improve access, MACPAC staff found that the link between additional payments and access is often unclear.

MACPAC found that most uniform rate increases and VBP arrangements were targeted to hospitals and hospital-affiliated providers whereas minimum or maximum fee schedules were more likely to target behavioral health providers.

Commissioner Discussion

The commissioners expressed great concern with the fact that MACPAC and the greater public in general do not have access to data showing where the directed payments are going, and their general frustration with the lack of transparency in this process. One commissioner specifically brought up the issue that they do not know how much providers are getting paid to treat a Medicaid patient. Other commissioners discussed the concern with provider taxes funding some of the directed payments, as then payments may heavily favor institutional providers. Commissioners then discussed

access, whether directed payments are fulfilling their main goal, and how MACPAC staff can measure this in the future. Much of this discussion focused on the difficulty of measuring the success of these payments. Overall, the commissioners generally agreed that more transparency in the directed payment process is needed for successful and helpful recommendations.

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