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MACPAC Holds September 2024 Meeting

On September 19 and 20, 2024, the Medicaid and CHIP Payment and Access Commission (MACPAC) held a virtual public meeting, which included the following sessions:

- Overview of recent Centers for Medicare and Medicaid Services (CMS) final rules, and
- Themes from hospital payment index Technical Expert Panel.

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

MACPAC REVIEWS RECENTLY PUBLISHED FINAL RULES

MACPAC provided a summary of recent CMS rulemaking and its connection to MACPAC's ongoing work on Medicaid and CHIP policy for Commissioners. The discussion focused on key final rules, including updates on eligibility and enrollment (CMS-2421-F, CMS-2421-F2), access to services (CMS-2442-F), managed care access, finance, and quality (CMS-2439-F), and nursing facility staffing and payment (CMS-3442-F). These rules reflect CMS's efforts to improve service access, strengthen program integrity, and enhance care quality.

MACPAC will closely monitor the implementation and impact of the final rules, including the release of sub-regulatory guidance and state experiences.

Eligibility and Enrollment (CMS-2421-F and CMS-2421-F2)

The final rule on Eligibility and Enrollment (CMS-2421-F and CMS-2421-F2) is part of CMS's broader initiative to simplify enrollment processes across Medicaid, CHIP, and the Basic Health Program (BHP). MACPAC had previously commented in support of these efforts, advocating for streamlined procedures and greater flexibility in implementation.

To facilitate Medicaid enrollment, the rule allows states to consider anticipated costs for noninstitutionalized individuals when determining financial eligibility, providing more flexibility for those who are medically needy. It also clarifies that electronic data sources and reasonable compatibility standards can be used for verifying resources.

This builds on MACPAC's prior findings, which showed that the use of electronic data sources can help states achieve administrative efficiencies. Additionally, the rule eliminates the need for individuals to provide extra proof of identity when citizenship is verified through the DHS Systematic Alien Verification for Entitlements (SAVE) Program or a state vital statistics agency, also applying this change to CHIP.

The rule also promotes the enrollment and retention of eligible individuals by aligning policies for Medicaid beneficiaries across different eligibility categories. This includes ensuring that states accept applications submitted through various methods and prohibiting states from requiring in-person interviews. It also mandates that states renew eligibility no more than once every 12 months (except for certain groups) and send pre-populated renewal forms if automatic renewal cannot be completed. MACPAC supported these streamlined processes to promote equity, especially for individuals over age 65 and those with disabilities. Furthermore, the rule establishes clear timeframes for states to act on information requests and eligibility determinations, giving beneficiaries more time to respond.

The rule also emphasizes eliminating barriers to access. It removes the option for states to limit the number of 90-day reasonable opportunity periods for individuals to provide documentation to verify citizenship. It also eliminates the requirement for applicants to seek other benefits (such as VA compensation or unemployment insurance) as a condition for Medicaid eligibility. Specific changes were also made to CHIP and BHP to reduce access barriers. MACPAC supported these changes, referencing its 2017 recommendation to eliminate CHIP premiums for families with incomes below 150 percent of the federal poverty level.

Finally, the rule includes several provisions to simplify eligibility determination for MSPs. CMS extended the timeline for state compliance to April 1, 2026, and these changes align with MACPAC's June 2020 recommendations aimed at improving participation in MSPs.

Access to Services (CMS-2442-F)

The final rule on Access to Services (CMS-2442-F), finalized on May 10, 2024, focuses on increasing transparency in Medicaid payment rates, standardizing reporting requirements, and enhancing beneficiary engagement. MACPAC expressed general support for several provisions, particularly those aligned with its prior work. MACPAC had recommended addressing challenges related to beneficiary recruitment and providing financial arrangements to facilitate meaningful engagement.

The rule restructures the existing Medical Care Advisory Committees (MCACs), renaming them as Medicaid Advisory Committees (MACs), expanding their scope, and requiring states to establish a Beneficiary Advisory Council (BAC).

For Home and Community-Based Services (HCBS), the rule introduces a grievance system for Section 1915(c) waiver services delivered via Fee-for-Service (FFS), aligning with procedures already in place for managed care. The rule also mandates that 80 percent of Medicaid payments for homemaker, home health aides, and personal care services be allocated to direct care worker compensation, with certain exemptions. MACPAC supported these provisions to strengthen the direct care workforce and noted concerns about the lack of coordination on HCBS quality metrics, which the rule addresses by applying standardized quality measure requirements.

The rule also enhances payment rate transparency by requiring states to publish Medicaid FFS rates for key services on public websites. CMS further mandates that states gather ongoing input from beneficiaries and providers on access to care through advisory groups and other mechanisms. MACPAC supported this move, citing its June 2022 recommendation for greater beneficiary input in monitoring access to care. CMS addressed MACPAC's concerns about the complexity of rate reporting by committing to issue sub-regulatory guidance on various factors, including supplemental payments and bundled rates.

Managed Care Access, Finance, and Quality (CMS-2439-F)

The final rule on Managed Care Access, Finance, and Quality (CMS-2439-F), published on May 10, 2024, introduces comprehensive updates to managed care regulations, addressing key areas like access, payment, and quality. MACPAC's comments on the proposed rule were largely informed by its prior work on access monitoring, state-directed payments (SDPs), and quality measurement. The rule implements several provisions related to improving managed care access, including new standards for enrollee experience surveys, wait times for routine services, and secret shopper surveys to validate compliance by 2027. Although CMS did not adopt a federal or standardized survey tool as MACPAC recommended, the Commission supported efforts to enhance oversight of provider directories and appointment availability.

In the area of managed care payment and financing, the rule strengthens oversight of state-directed payments, exempting certain fee schedules from preprint requirements, and requiring robust documentation for SDPs. The rule limits total payments for hospitals, nursing facilities, and academic medical centers to the average commercial rate, addressing MACPAC's concern that states might raise payments without regard to any goals. The rule also requires states to submit evaluation reports for SDPs that exceed 1.5 percent of total capitation, enhancing transparency through public reporting, aligning with MACPAC's recommendation for more rigorous evaluations.

Regarding managed care quality, CMS now requires more transparency in state quality strategies and mandates that external quality review (EQR) reports include outcomes data. MACPAC's prior research supported these moves, emphasizing the need for more

performance data to compare outcomes across states. The rule also finalizes a framework for a uniform quality rating system (QRS), which must be displayed on state websites by 2028, aligning with stakeholders' agreement on the importance of standardized measures in quality assessments.

While MACPAC commended many of these changes, the lack of a standardized survey and concerns about the complexity of state-directed payment approval processes were noted. Additionally, the Commission encouraged further consideration of access monitoring strategies and the development of sub regulatory guidance to help states harmonize data and improve managed care quality assessments.

Nursing Facility Staffing and Payment (CMS-3442-F)

The final rule on Nursing Facility Staffing and Payment (CMS-3442-F), published on May 10, 2024, establishes new federal minimum staffing requirements and reporting obligations for nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs). The rule is part of broader efforts to enhance transparency and accountability in long-term care settings. MACPAC's comment letter to CMS, submitted during the rule's proposal stage in September 2023, focused on technical aspects and echoed the Commission's recommendations for nursing facility payment transparency from its March 2023 report to Congress.

The new staffing standards set a minimum of 3.48 hours per resident day (HPRD) for all staff, with flexibility for facilities to meet this requirement using a mix of registered nurses (RNs) and nurse assistants. The rule also clarifies how facilities must use assessments to inform staffing decisions and introduces hardship exemptions, accounting for workforce shortages. Unlike the proposed rule, the final rule does not include a distance requirement for these exemptions but adds public transparency obligations for facilities granted exemptions. Urban facilities must comply with the on-site RN and 3.48 HPRD staffing requirements within two years, while rural facilities are given three years, with additional compliance timelines for other staffing standards.

On the issue of payment rate transparency, the final rule mandates that states report annually on the share of Medicaid payments to long-term care facilities that is allocated to direct care worker compensation. States have four years to implement these reporting requirements. CMS acknowledged MACPAC's March 2023 recommendations, which called for broader payment transparency, including making payment rates publicly available and capturing data on all care costs for Medicaid beneficiaries. Although CMS did not fully adopt these recommendations, the new reporting requirements are a step toward greater transparency. However, CMS has left it to states to decide whether to make additional payment information publicly available.

While the rule strengthens minimum staffing standards and increases transparency around Medicaid payments for staffing, it does not fully implement MACPAC's broader suggestions for payment rate transparency or quality outcome comparisons.

BUILDING ON PRIOR WORK, MACPAC CONSIDERS THE HOSPITAL WAGE INDEX AND FUTURE ANALYSIS

MACPAC staff presented themes from the Technical Expert Panel (TEP) held on the hospital wage index. This work builds on MACPAC's 2017 state-level payment index, which found that, after considering supplemental payments and provider financing (in addition to base payments), inpatient Medicaid payments were similar to or higher than Medicare payments. Inpatient hospital base payments varied widely across states. The TEP convened to discuss incorporating data on outpatient services and managed care payments and reapportioning the hospital payment index with respect to payment system and service type. However, issues with the outpatient data pose difficulties for determining an outpatient-specific hospital payment index. Even so, they favored a payment index centered on specific components, such as service type, rather than an overall hospital payment index. This individualized approach extended to supplemental payment validation, for which they supported allocation at the provider level. Increased transparency for Medicaid spending and payments with attention to value-based criteria were also identified as objectives for a refined payment index.

In discussion, commissioners considered breaking down the hospital wage index further and proposed characteristics to incorporate for more detailed analysis. Commissioners also expressed concern for data recency and granularity. One commissioner remarked on the significant changes in the past five years and suggested requesting that the GAO conduct surveys again for newer data. Other suggestions for data analysis included distinguishing safety net hospitals, academic medical centers, hospital size, rural versus urban hospitals, and tax status (for-profit versus non-profit). Another commissioner expressed interest in examining the introduction of value-based components to the hospital payment index.

As next steps, MACPAC will construct an updated payment index to compare Medicaid hospital payments across states and to Medicare payment rates. The Commission will also continue to review Upper Payment Limit (UPL) narratives and directed payment preprints to understand how states are targeting these payments to providers.

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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.