

MACPAC June 2022 Report to Congress

Chapter 2: Oversight of Managed Care Directed Payments

For Medicaid managed care payments, states pay managed care organizations (MCOs) a per-member per-month capitation rate, and states have historically had little control over the rates that MCOs pay providers. 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. States project that over \$25 billion was spent via directed payments in 2020, demonstrating how these payments are a large and growing share of Medicaid spending. Directed payment arrangements are used a variety of ways by the states. They can be used to set base payment rates for services provided in managed care, increase the adoption of value-based payment methods, and making 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.

The MACPAC Commission made the following recommendations to the Secretary of the U.S. Department of Health and Human Services:

- Make directed payment approval documents, managed care rate certifications, and evaluations for directed payments publicly available on the Medicaid.gov website to improve the transparency of Medicaid spending.
- Make provider-level data on directed payment amounts publicly available in a standard format that enables analysis to inform assessments of whether managed care payments are reasonable and appropriate.
- 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 provide additional clarity about the goals and uses of directed payments.
- 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 allow for more meaningful assessments of directed payments.
- Clarify roles and responsibilities for states, actuaries, and divisions of CMS involved in the review of directed payments and the review of managed care capitation rates to promote more meaningful oversight of directed payments.

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

Out of the 12.2 million people who are dually eligible for Medicaid and Medicare, only about 1 million full-benefit dually eligible beneficiaries were enrolled in integrated care models in 2020. Integrating care for these beneficiaries has the potential to improve care and reduce federal state spending. MACPAC urges

that Congress make integrated care the standard for these dually eligible beneficiaries. The Commission understands that each state may be at a different stage in the process and that there are obstacles cited by state officials such as competing priorities and limitations on staff capacity and experience with dual enrollments. Despite these challenges, the following recommendation was made:

- 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.

Chapter 6: Medicaid's Role in Advancing Health Equity

The chapter discusses policy levers that States and the federal government can use to promote equity and lays the groundwork for future MACPAC work. The Commission stated that there is action needed at both the state and federal levels to deal with established disparities. 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 vulnerable populations, and strengthening the role of Medicaid in serving both child and adult beneficiaries with behavioral health needs. The chapter highlighted key areas for Medicaid policy development to advance health equity. These 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 their work. 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 (MCAC) to increase beneficiary engagement. The Commission will continue to monitor federal and state efforts to promote equity to understand their effects.