MACPAC

Review of Secretary's Reports to Congress

Medicaid and CHIP Payment and Access Commission

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Overview

- Two reports
  - Managed care coverage of institutions for mental diseases (IMDs)
  - Best practices for state prescription drug monitoring programs (PDMPs)

- Two presentations
  - Background
  - Report summary
  - Possible areas for MACPAC comment
  - Next steps: Staff will draft comment letters

Secretary's Report to Congress on Managed Care Coverage for Beneficiaries in IMDs

Background

- Section 12002 of the 21st Century Cures Act (P.L. 114-255) directed the Secretary to report to Congress on:
  - Use of IMD in-lieu-of services (ILOS) authority
  - Effect on capitation payments to managed care plans
  - Beneficiaries receiving services in IMDs
  - Number and lengths of stays in IMDs
  - Decisions to pay for services in IMDs

Background, cont.

- The IMD exclusion generally prohibits payment for services for beneficiaries in IMDs
  - IMD is a unique Medicaid definition for hospitals, nursing facilities, or other institutions with more than 16 beds primarily serving patients with mental illness or substance use disorder (SUD)
- The 2016 final managed care rule clarified that states can pay for services in IMDs as ILOS
  - Services must be medically appropriate, cost-effective alternatives voluntarily chosen by the beneficiary
  - IMD stays cannot exceed 15 days in a given month

State Use of the IMD ILOS Authority

- In 2019, 32 states reported making capitation payments for beneficiaries in IMDs in lieu of covered services
- States do this to increase access to inpatient behavioral health and recognize IMDs as a critical part of the continuum of care
- Some states use this authority while awaiting Section 1115 demonstration approval
- The effect of the 2016 final rule on access to inpatient behavioral health treatment is unclear, or it was too soon to assess

Effect on Capitation Payments

- The effect on capitation payments was mixed
  - About half the states reporting said use of the IMD ILOS authority led to an increase in rates and roughly half reported a decrease
- States use different strategies to avoid making capitation payments for IMD stays exceeding 15 days
  - Prorating capitation payments
  - Paying for stays with state general funds
  - Full recoupment of the capitation rate
  - Disenrolling beneficiaries from managed care

Beneficiaries Receiving Services in IMDs

- The number of beneficiaries with at least one IMD stay in lieu of covered services in the past 12 months ranged from roughly 100 to 50,000 across the states
- The percentage of beneficiaries with at least one IMD stay in the past 12 months ranged from roughly 0.1 to 3.8 percent
- The reasons for these state variations are unclear

Number and Lengths of Stays in IMDs

- The average number of IMD stays per Medicaid beneficiary covered as an ILOS by state ranged from 1.0 to 2.8 stays
- Average lengths of stay ranged from 4.2 to 23.2 days
  - The average was fewer than 10 days in roughly 80 percent of states reporting
- Factors contributing to these state variations are not discussed

Decisions to Pay for Services in IMDs

- Plans determine if an inpatient level of care is required and use IMDs when beds in non-IMD settings are unavailable
- Criteria for medical necessity and utilization review apply to inpatient care generally, not just IMDs
- State contracts with managed care plans stipulate that IMD stays covered in lieu of other services must be voluntarily chosen
  - Few states have specific requirements or instructions related to communicating with beneficiaries about their options

Possible Areas for MACPAC Comment

- The IMD ILOS authority is an important pathway for covering beneficiaries in IMDs
  - The Commission has previously discussed the role of IMDs in addressing gaps in the continuum of care for beneficiaries with behavioral health conditions
  - Prior work has outlined various exemptions and authorities states can use to pay for services in IMDs
- The report raises questions about state and plan practices, as well as the experience of beneficiaries
  - What factors contribute to state variation in the use of IMDs?
  - How are states ensuring that beneficiaries have meaningful choice?
  - Why do states disenroll certain beneficiaries with long IMD stays from managed care and how does this practice affect care continuity?

Secretary's Report to Congress on Prescription Drug Monitoring Program Best Practices

Background

- Sections 5042(b) and 5042(c) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) required the Secretary to report to Congress on:
  - Best practices for the use of PDMPs
  - Best practices for protecting the privacy of Medicaid beneficiary information in PDMPs
  - Model practices for data sharing agreements between state Medicaid programs and PDMPs to prevent fraud, waste, and abuse and to improve health care for individuals transitioning in and out of Medicaid coverage
- The SUPPORT Act also established criteria for a qualified PDMP and required states to comply with new requirements by October 2021

State Use of the 100 Percent Enhanced Federal Match

- Efforts to bring PDMPs into compliance with federal requirements for qualified PDMPs
- Other operational improvements:
  - Planning and development
  - Infrastructure development
  - Systems integration
  - Enhancements in data and analytics
- Expand access to non-clinician entities, including Medicaid agencies

Challenges Implementing Qualified PDMP Requirements Under the SUPPORT Act

- Lack of coordination between Medicaid and PDMPs
  - Particularly difficult when Medicaid and the PDMP are not located within the same state agency, requires a cross-departmental agreement
  - Few states have integrated Medicaid and PDMP data
- State and federal privacy laws
  - Limit the ability of Medicaid staff to access PDMP data

Promising Practices

- Too early to identify best practices specific to Medicaid and PDMPs
- PDMP promising practices more generally:
  - Coordinating among state agencies
  - Collaborating across states
  - Leveraging CDC funding
  - Granting PDMP access for emergency medical services (EMS) personnel
  - Integrating PDMP data into electronic health records (EHRs) and health information exchanges (HIEs)
  - Allowing providers to delegate access to non-clinicians
  - Increasing frequency of mandated checks
  - Requiring that the PDMP is housed in departments of health
- State case studies from Colorado, Nebraska, and Rhode Island

Lessons Learned

- Insufficient time (only 2 years) to implement qualified PDMPs and use the enhanced federal funding
- Need for federal guidance to facilitate cross-state data sharing
- Challenge of coordinating multiple federal funding streams for PDMPs, each with their own requirements
- Opportunities to increase use of PDMPs:
  - Ensuring as close to real-time data as possible
  - Integrating PDMP data with EHRs
  - Registering providers for PDMP access during licensure or renewal

Possible Areas for MACPAC Comment

- Need for additional research and information-sharing on best practices for data sharing between PDMP and Medicaid
  - A wider review of states selected based on their status as innovators could yield additional best and promising practices
- Future state and federal reporting on PDMPs may provide further insights

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