Highlights from MACPAC December Public Meeting

Overview: On December 14 and 15th, 2023 the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public meeting. Presentation slides and the agenda for this meeting can be found on MACPAC's website.

Session 1: Medicaid Sexual Orientation and Gender Identity (SOGI) Data Collection

Presenter:

- Linn Jennings, Senior Analyst

Background

In the current work, MACPAC is emphasizing the gathering of data on primary language, limited English proficiency (LEP), sexual orientation and gender identity (SOGI), and disabilities to evaluate and mitigate health disparities. The November meeting was centered around the methodologies of accumulating Medicaid language information. This session delved into the intricacies of SOGI data collection, examining its objectives, along with federal and state-level initiatives for collecting these data. This included an exploration of the recent guidance from the Centers for Medicare & Medicaid Services (CMS) regarding the integration of SOGI data in Medicaid applications. Additionally, the meeting addressed the existing practices in the collection and utilization of SOGI data, paying special attention to factors like data privacy.

Key Themes

- Sexual and gender minorities (SGM) are more likely than straight and cisgender individuals to experience chronic conditions or disabilities and have a higher need for mental health services. They often face negative healthcare experiences, including discrimination, lack of culturally competent care, and provider refusal of care. Additionally, SGM individuals encounter more difficulties in accessing healthcare due to costs and coverage gaps.
- In 2022, the Biden Administration's Executive Order 14075 aimed to promote equality for LGBTQ+ individuals. This led to the creation of a roadmap for federal agencies to develop SOGI Data Action Plans and establish best practices for collecting SOGI data in federal surveys. Subsequently, in November 2023, CMS incorporated SOGI questions into the model single, streamlined application and issued guidelines for including them in state Medicaid and CHIP applications.
- Collecting beneficiary-level SOGI information in Medicaid applications can shed light on the characteristics of Medicaid populations and help in measuring disparities in service use. However, only a few Medicaid programs currently gather SOGI data either on the application itself or through optional state demographic surveys. Additionally, there's a notable lack of consistency in how states frame these questions.

- Population-level data from federal surveys can be analyzed to assess experiences of Medicaid-covered SGM individuals in accessing health services, provider satisfaction, and quality of care. Out of 13 reviewed population health surveys, five include questions about sexual orientation and two about gender identity. However, the analysis of this data faces challenges due to variations in the questions asked and the small sample size of SGM individuals, limiting the comparability and robustness of findings.
- SOGI data collection in Medicaid has various purposes, including ensuring program inclusivity for SGM populations and informing targeted interventions through research. However, states are in the early stages of integrating SOGI questions, with current data insufficient for research. Challenges include the absence of federal SOGI data collection standards, need for language translation, training for application assistants, and length of applications.
- Updating data systems is resource-intensive, and T-MSIS currently lacks SOGI data elements, though this is set to change in 2025.
- Data quality considerations involve self-reporting, changes in SOGI over time, standardization, representativeness, and data privacy.

Commissioners' Comments

Commissioners are excited by the inclusion of background on SOGI data collection as a chapter in their next report to Congress. One Commissioner mentioned the importance of making sure questions are asked in a way that avoids causing offense and reinforced the need to continually consult with SGM individuals. Commissioners feel as though better data will reduce health disparities and improve access to culturally competent care.

Session 2: Barriers to Improving Transparency of Medicaid Financing

Presenter:

- *Rob Nelb, Principal Analyst*

Background

MACPAC conducted expert interviews on the complexity of enhancing Medicaid financing transparency. States use various sources, including general revenue and health care-related taxes, for Medicaid's non-federal share. The limited data on states' reliance on non-general revenue sources was noted. The presentation revisited MACPAC's past suggestions for CMS to gather provider-level financial data for more insightful analysis of Medicaid payments. It also identified key barriers to transparency, such as unclear transparency goals, varying state methods, multiple potential approaches for data collection, and the difficulty in calculating net payments using provider-level data.

Overview

- States can fund Medicaid through different sources, such as state funds, healthcare taxes, and transfers. Between 2008 and 2018, there was a shift from state funds (decreasing from 75% to 68%) to healthcare taxes (increasing from 7% to 17%).
- Supplemental Medicaid payments are increasingly supported by providers, often through taxes or transfers. This trend affects the balance of federal and state funding and lowers the actual payments received by providers.
- MACPAC has recommended CMS collect detailed data on the non-federal share of payments for hospitals and nursing facilities. This is vital to ensure payments are in line with statutory goals and to guide broader Medicaid financing policies.

Findings from Stakeholder Interviews

- CMS's recent proposals, like the Medicaid fiscal accountability rule (MFAR), sparked concerns about Medicaid financing policy, with experts questioning the need for more transparency in non-federal share sources.
- Issues arise in CMS's data collection and in synthesizing state plan submissions related to state financing methodologies, including inconsistencies in reported provider taxes and lack of reporting for state-level intergovernmental transfers (IGTs) and certified public expenditures (CPEs).
- Under MFAR, CMS sought provider-level financing reports, but complexities include attributing financing to specific payments and distinguishing tax types in cost reports. Texas has begun requiring detailed provider-level financing reports.
- When using provider-level data to calculate net Medicaid payments, challenges include tracking large health system costs, identifying IGT origins, and accounting for private payment redistributions among providers.

Next Steps

- Interviews with state officials and provider associations are ongoing to identify challenges in enhancing Medicaid financing transparency. There's a plan to analyze new provider-level financing data from Texas, linking it to supplemental payment data to inform policy. This work is intended to contribute to a chapter in the June 2024 report to Congress.

Policy Questions

- How can CMS, states, and providers reduce concerns about how financing data will be used?
- What types of information about state financing methods would be most useful for informing future policy development?
- Should CMS collect information on financing amounts for all types of Medicaid financing sources?
- Should CMS collect provider-level data on the financing of all types of Medicaid payments?

- How should provider-level financing data be used to assess provider payment rates?
- What additional information would help policymakers better evaluate net payments to providers?

Commissioners' Comments

Commissioners are worried that CMS might use increased transparency as a guise to reclaim state funds being spent on Medicaid, suggesting a need to distinguish between transparency and oversight. There's concern about how these policies affect Home and Community-Based Services (HCBS) and if payment mechanisms inadvertently promote institutional bias, such as favoring nursing facilities. Texas' approach might serve as a model for wider application, although it's complex and merits further examination. One Commissioner suggested that practices like MCO taxes adhere to the law's "letter, but perhaps not its spirit," creating apprehension among providers about potential repercussions. Staff plans to return in January with policy options and an analysis of Texas' data. Draft recommendations will be presented at the January meeting for Commissioner review.

Session 3: Annual Analysis of Medicaid Disproportionate Share Hospital (DSH) Allotments to States

Presenters:

- *Jerry Mi, Analyst*
- *Aaron Pervin, Principal Analyst and Contracting Officer*

Background:

Disproportionate Share Hospital (DSH) payments are mandatory payments designed to balance the costs of care for individuals enrolled in Medicaid and those who are uninsured. The amount of DSH payments each state can distribute is capped by federal allotments, which differ significantly across states. These allotments are determined based on the state's DSH spending in fiscal year (FY) 1992. DSH payments that individual hospitals receive are limited to the actual uncompensated care costs incurred for Medicaid-enrolled and uninsured patients. A scheduled reduction in federal DSH allotments is set to take place on January 20, 2024, for 2024.

Statutorily Required Analyses:

- Number of uninsured individuals: In 2022, the Census Bureau reported approximately 26 million uninsured individuals in the U.S., making up 7.9% of the population. The uninsured rate decreased by 0.4 percentage points from 2021.
    - The highest rates of uninsured were among non-elderly adults, individuals of Hispanic origin, and those below the federal poverty level.
    - Following the end of the continuous coverage requirement, states began reassessing Medicaid eligibility. This reassessment is expected to lead to

a decline in Medicaid enrollment and an increase in the number of uninsured individuals.
    - By October 2023, it was reported that over 9 million people had been disenrolled from Medicaid.
- Unpaid costs of care for uninsured individuals: In 2021, hospitals incurred $39 billion in combined charity care and bad debt expenses, which accounted for 3.6% of their operating costs. Of this total, $22 billion, or 57%, was spent on charity care for uninsured individuals. Charity care for those with insurance amounted to $5 billion, representing 12% of the total. The remaining 31%, equating to $12 billion, was allocated to bad debt expenses incurred for both insured and uninsured individuals.
- Medicaid shortfall: The American Hospital Association (AHA) regularly surveys and reports on Medicaid shortfalls, although it has not yet released data for 2021. According to their 2020 report, the total Medicaid shortfall for all hospitals was estimated at $25 billion, with an aggregate Medicaid payment-to-cost ratio of 88%. In 2019, DSH facilities reported a Medicaid shortfall of $21 billion, as determined through Medicaid DSH audits. Before considering DSH payments, these hospitals had a Medicaid payment-to-cost ratio of 87%. However, this ratio varied across states, with many states reimbursing DSH hospitals at rates exceeding 100% of their Medicaid costs.
- Hospital margins: Hospital finances can be assessed using two key measures: operating margins and total margins. Operating margins focus on revenues and costs directly associated with patient care, while total margins include additional sources of income such as COVID-19 Provider Relief Funding (PRF). After accounting for DSH payments, operating margins were negative, with all hospitals averaging -0.8% and deemed DSH hospitals at -4.6%. However, when considering total margins, which include PRF, the financial picture was more positive. Total margins for all hospitals averaged 10%, and for deemed DSH hospitals, they stood at 9%.
- Hospitals that provide essential community services: MACPAC has a statutory obligation to identify hospitals that deliver essential services to their communities. To define what constitutes essential community services, MACPAC referred to the types of services outlined in the statute, such as inpatient psychiatric care, burn services, and similar offerings. The number of providers that fit MACPAC's criteria for offering essential community services has remained relatively stable. In
- In 2019, 694 hospitals qualified as deemed Disproportionate Share Hospitals (DSH). Among these, 92% provided at least one essential service, and 55% offered three or more such services. This is in contrast to 38% of hospitals not deemed as DSH, which provided three or more essential services.

DSH Allotment Reductions:

- DSH allotment reductions are set to commence on January 20, 2024. These reductions will amount to $8 billion annually from fiscal years 2024 to 2027. The impact of these reductions will vary significantly across states, with estimated cuts ranging from 5.1 to 90.0% of the unreduced allotment amounts in fiscal year 2024. MACPAC has consistently observed that current DSH allotments do not correlate with actual measures of need, either before or after these planned reductions. MACPAC will keep a close watch on any Congressional actions related to DSH allotments and intends to revise their estimates if Congress opts to postpone the DSH reductions.

Future Work:

- Supplemental payment background: The Commission advocates for evaluating DSH policy within the broader framework of all payments that hospitals receive. This includes base payments, both in fee-for-service and managed care contexts, Upper Payment Limit (UPL) supplemental payments, and managed care directed payments. In recent years, some states have started to replace DSH payments with managed care directed payments. These directed payments can reach up to the average commercial rate for Medicaid services, consequently reducing the DSH payments a hospital is eligible to receive. Notably, the average commercial rate often significantly exceeds Medicaid costs, potentially leading to a Medicaid surplus that surpasses the costs incurred for uninsured patient care.
- MACPAC analysts are engaging on an extensive long-term project to delve deeper into the newly accessible data on various types of supplemental payments. This effort involves several key activities: documenting the methods and objectives of supplemental payments, analyzing how these payments are targeted, and developing an index to evaluate overall Medicaid payment rates to hospitals. As part of this effort, MACPAC analysts will study how different types of Medicaid payments to hospitals function independently and in conjunction with each other. Key considerations include whether these policies align with principles of efficiency, economy, quality, and access to care. They will also assess whether payments are being directed effectively based on actual needs. Furthermore, the Commission plans to explore the implications and value of providing hospitals with payments that exceed the costs of care for Medicaid patients or what Medicare would have paid under similar circumstances.

Next Steps:

- The chapter detailing these findings and analyses will be included in MACPAC's March report to Congress. Additionally, staff will continue to monitor any ongoing legislative actions concerning DSH payments by Congress.

Commissioners' Comments

The Commission provided minimal feedback on the MACPAC analysts' briefing regarding the allocation of DSH payments to states. The Commissioners plan to review the draft report language in detail and suggest any necessary revisions. They are looking forward to reviewing the ongoing efforts of the analysts on this topic.

Session 4: Engaging Beneficiaries through Medical Care Advisory Committees (MCAC) to Inform Medicaid Policymaking

Presenter:

- *Audrey Nuamah, Senior Analyst*

Background:

A MACPAC senior analyst continued the conversation as it relates to potential recommendations on Medical Care Advisory Committees (MCACs). For previous MACPAC discussions on this topic, please read here. The analyst presented a preliminary chapter for the Commission's March 2024 report to Congress. This chapter included three suggestions for state Medicaid agencies to enhance the involvement of beneficiaries in MCACs and proposed measures the federal government could take to support states in this effort. Analysts emphasized the significance of involving beneficiaries because of the value of their real-world experiences in shaping state Medicaid policies and programs and the importance of building their trust in a process that requires consistent and focused efforts. Following the presentation, the Commission will vote on the recommendations the following day of the MACPAC meeting.

Federal statute and requirements: Federal rules mandate that each state must establish a MCAC to counsel the state's Medicaid agency, as specified in 42 CFR 431.12.

- The composition of MCACs is required to consist of:
    - Doctors and other healthcare professionals serving Medicaid recipients.
    - Individuals who are Medicaid beneficiaries or part of consumer advocacy groups.
    - The head of the state's public welfare or public health department.
- The Centers for Medicare & Medicaid Services (CMS) has issued a notice for proposed rulemaking (NPRM), which aims to modify the existing federal regulations governing MCACs.

State implementation of MCACs:

- Involvement and selection of beneficiaries
    - A large number of states report unfilled positions for beneficiaries.
    - There's a notable absence of diverse representation among beneficiaries.
- Financial support for beneficiaries in state programs

    - Many beneficiaries are either not aware of these financial supports or don't utilize them sufficiently.
    - Officials in state Medicaid have expressed uncertainties regarding the implementation of these financial supports.
- Enhancing beneficiary participation in MCAC discussions
    - Challenges related to state resources are hindering efforts to boost further engagement.
    - The NPRM indicates that additional guidance, including best practices for effective beneficiary involvement, will be forthcoming.

Beneficiary experience participating in MCACs:

- Process of applying and being appointed:
    - The complexity, length, and excessive formality of application forms may discourage potential beneficiaries from applying.
- Requirements for participating in MCAC:
    - There are difficulties associated with attending meetings.
- Involvement in MCAC discussions:
    - Beneficiaries are often uncertain about how Medicaid agencies utilize their input.
    - There is a demand for additional technical support to facilitate more effective engagement in MCAC discussions.
- Subcommittees exclusive to beneficiaries:
    - A number of states have observed enhanced engagement and participation from consumers in these specialized subcommittees.

Draft recommendations, rationale, and implications:

- Draft recommendation 1: In issuing guidance and in providing technical assistance to states on engaging beneficiaries in MCACs under Section 42 CFR 431.12, CMS should address concerns raised by states related to beneficiary recruitment challenges, strategies to facilitate beneficiary engagement in Medicaid MCAC meetings, and clarify how states can provide financial arrangements to facilitate beneficiary participation.
    - Rationale: States officials have indicated a need for direction and technical support from CMS. This assistance is needed to effectively utilize the knowledge and experiences of beneficiary members in MCACs in shaping their program policies and procedures. The aspects highlighted by states encompass: Methods to attract and keep beneficiary members from groups that have historically been underrepresented, techniques to help beneficiaries comprehend complex subjects, and clear guidelines regarding the provision of financial support without impacting the eligibility of beneficiaries.

    - Implications:
        - Impact on federal budget: CMS would be required to allocate funds for formulating guidelines and extending technical help to states.
        - State benefits: The guidance from the federal government could support state efforts to involve beneficiaries in MCACs, which would amplify the voices of beneficiaries and enhance their role in shaping policies.
        - Advantages for enrollees: Enhanced active participation by states can lead to a more favorable experience for beneficiaries, potentially boosting their input in MCAC deliberations.
        - Effect on plans and providers: There would be no immediate impact on health plans and healthcare providers.
- Draft recommendation 2: In implementing requirements in 42 CFR 431.12(d)(2) that MCAC membership include beneficiaries, state Medicaid agencies should include provisions in their MCAC bylaws that address diverse beneficiary recruitment and develop specific plans for implementing policies to recruit beneficiary members from across their Medicaid population, including those from historically marginalized communities.
    - Rationale: Involving beneficiaries who come from historically underrepresented groups enables them to contribute their distinct experiences and issues. Research on community engagement has shown that individuals most impacted by certain programs and policies frequently possess insightful ideas for their improvement. Existing federal regulations mandate the inclusion of Medicaid beneficiaries in state Medicaid agencies. However, these regulations do not specifically address the aspect of diversity among these beneficiaries.
    - Implications: Federal budget impact:
        - There would be no immediate effect on federal expenditure.
        - State-level responsibilities: States would need to dedicate resources to devise strategies and policies for attracting beneficiaries from underrepresented communities. This task may prove difficult in light of other programmatic priorities.
        - Enrollee involvement: There would be a rise in participation among beneficiaries from historically marginalized groups.
        - Effect on plans and providers: There would be no direct impact on health plans and healthcare providers.
- Draft recommendation 3: In implementing requirements in 42 CFR 431.12(e) to increase the participation of beneficiary members in MCACs, state Medicaid agencies should develop and implement a plan to reduce the burden on

beneficiaries in engaging in MCACs by streamlining application requirements and processes, and by addressing logistical, financial, and content barriers.

- Rationale: Beneficiaries have pointed out obstacles in engaging with MCACs, specifically regarding: the process of applying and being appointed, logistical and financial challenges, and the intricacy of Medicaid-related subjects. Tackling these hurdles would address the issues that beneficiaries have raised in interviews.
- Implications:
  - Impact on federal finances: No direct effect is anticipated on federal spending.
  - Responsibilities for states: States would need to allocate resources to evaluate existing obstacles to beneficiary involvement and formulate strategies to overcome these barriers. Balancing this with other program needs might pose a challenge.
  - Benefits for enrollees: Simplifying the MCAC application procedure and resolving logistical, financial, and subject-related issues for beneficiaries would diminish major participation obstacles.
  - Effect on plans and providers: There would be no immediate impact on health plans and healthcare providers.

Commissioners' Comments

The Commission applauded MACPAC analysts for their inclusion of previous feedback and comments during prior sessions into the proposed recommendations. There was discussion on potentially adding specific language that mandates states to boost beneficiary participation in regard to Recommendation 3. The Commissioners believe that it is crucial to amplify beneficiaries' input and emphasized the importance of prioritizing beneficiaries' perspectives. They believe it goes beyond merely ticking off a requirement; it's about the integration of beneficiary feedback into a state's operational processes. There was overall support for all three recommendations and the Commission reconvened Friday morning to vote. The analyst had updated language to Recommendation 3 that emphasizes "meaningful" beneficiary engagement. The Commissioner's voted on all three recommendations as a package that passed unanimously (17 Y, 0 N) for inclusion in their 2024 report to Congress.

Session 5: Data Update on Unwinding the Continuous Coverage Provisions

Presenter:

- *Martha Heberlein, Principal Analyst and Research Advisor*

Background:

This presentation covered an overview of the necessary reports for the phasing out of Medicaid's continuous coverage mandate. It also included the latest data from CMS,

focusing on renewal results, shifts in enrollment numbers, coverage transitions, and operational results. CMS issued a format and detailed guidelines in March 2022 for monthly reports to oversee the unwinding process. States must submit data on applications and renewals that are either pending or completed, as well as any ongoing fair hearings. Additionally, the Consolidated Appropriations Act of 2023 (CAA, P.L. 117-328) legally established various unwinding metrics and additional reporting obligations, mandating CMS to disclose certain measures publicly. An interim final rule, which took effect on December 6, 2023, puts these requirements into action and introduces related financial penalties.

National renewal outcomes, as of August 2023:

Reporting metric	August 2023 (50 states and DC)		To date (March-August 2023)	
	Number	Percent	Number	Percent
Total renewals due	**7,428,192**	**100%**	**27.3 million**	**100%**
Coverage renewed	3,804,556	51%	13.5 million	50%
Ex parte or automatic renewal	2,340,350	32% (62% of renewals)	8.0 million	29% (41% of renewals)
Renewed based on returned form	1,464,206	20% (39% of renewals)	5.5 million	20% (59% of renewals)
Coverage terminated	1,977,764	27%	7.5 million	27%
Determined ineligible	574,967	8% (29% of terminations)	2.0 million	7% (27% of terminations)
Procedural terminations	1,402,797	19% (71% of terminations)	5.5 million	20% (73% of terminations)
Renewals pending	1,645,872	22%	6.3 million	23%

- Kansas had the highest renewal rate with 96% of individuals successfully renewed, while South Carolina had the lowest at 12%. Idaho saw over three-quarters (77%) of individuals losing their coverage, the highest in this category, whereas Kansas had the lowest rate of coverage termination, under 1%. Additionally, more than half of the coverage terminations in 38 states were due to procedural reasons, and this figure rose above 75% in 26 states.
- Enrollment changes: Between March and July 2023, the total number of Medicaid enrollees dropped by approximately 2.3 million, which included around 1.1 million children. New Hampshire recorded the most significant percentage decrease in overall enrollment at 23%, while South Dakota had the greatest reduction in child enrollment at 24%.
    - On the other hand, 12 states reported a rise in overall Medicaid enrollment, and eleven states saw an increase in child enrollees. Oregon had the highest percentage growth in overall enrollment at 4%, and Wyoming experienced the largest growth in child enrollment, at 2%.
- Operations data, call center statistics: From April to August, there was an uptick in call center traffic in all states except for three. In August, the average wait time for these call centers was roughly 12 minutes, with variations between 0 and 46 minutes. Among the states, 22 had wait times of 5 minutes or less, while five

states had wait times exceeding 30 minutes. Most states, totaling 35, saw a rise in the duration of call wait times during this period. The rate at which calls were abandoned varied widely, from less than 1% in four states to about 56% in Nevada.

- Operations data, applications: In July 2023, there were nearly 2.8 million applications submitted for Medicaid and CHIP, marking an increase from the 2.4 million applications in March 2023. 11 states observed a surge in applications by over 30 percent, and four of these states saw their application volumes increase by 50 percent or more. However, 12 states reported a decrease in the number of applications. During the period from April to June 2023, among the 48 states that provided data on the processing times for Modified-Adjusted Gross Income (MAGI) applications, 57 percent of the decisions were made in under 24 hours. 74% percent of these applications were processed within a week, and 5 percent took more than 45 days to process.

Next steps:

- In the coming months, states and CMS will remain actively engaged in the unwinding process. MACPAC will keep providing updates to the Commission in future meetings.

Commissioners' Comments

The Commissioners thanked the analysts for continuing to provide unwinding updates. A few Commissioners emphasized the importance of noting the overarching national trends which can sometimes obscure specific issues that are present in individual states. For further discussion going forward, the need for a more detailed examination of the available data mandated to be reported, should be considered as it's essential for CMS to uphold the reporting requirements on a continuous basis.

Session 6: Potential Areas for Comment on CMS Proposed Rule on Medicare Advantage for CY2025

Presenter:

- *Kirstin Blom, Policy Director*

Background:

On November 15, 2023, CMS proposed new regulations that would adjust technical aspects of the Medicare Advantage and Medicare Part D programs for the 2025 contract year, which includes changes to D-SNPs. Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage plans designed for individuals who qualify for both Medicare and Medicaid. In 2023, over 5 million beneficiaries with dual eligibility are receiving their Medicare coverage, and sometimes Medicaid benefits, through D-SNPs. The significant enrollment in D-SNPs, their required contractual partnerships with state Medicaid agencies, and their broad availability make them a

significant point of interest for the Commission. MACPAC analysts provided an overview of the aspects of the proposed regulations that are relevant to beneficiaries with dual eligibility and that intersect with the Commission's objectives and potential areas for commentary. Should the Commission decide to provide feedback, the staff will prepare a letter of comment that includes insights from the Commissioners that are due January 5, 2024.

Summary of selected provisions affecting dually eligible beneficiaries: Potential measures to boost the proportion of beneficiaries with dual eligibility in managed care, so that they obtain their Medicare and Medicaid services from the same overarching organization, include:

- Modifications to the special enrollment periods for Medicare. Includes changing quarterly enrollment periods to monthly.
- Restricting enrollment in specific D-SNPs to those who are already part of a Medicaid managed care plan that is under the umbrella of the same parent company.
- Imposing restrictions on the quantity of D-SNPs that Medicare Advantage organizations are allowed to provide in particular scenarios.
- Reducing the benchmark that standard Medicare Advantage plans need to meet to qualify as D-SNP look-alike plans.
- Permitting the sharing of Medicare Advantage plan encounter data with state Medicaid programs to enhance care coordination and quality improvement efforts.
- Mandating that plan notifications be provided in the most commonly spoken languages within the state to accommodate individuals with limited English proficiency.

Commissioners' Comments

The Commissioners underscored that their primary objective is to ensure that every person with dual eligibility has access to an integrated care program within their state. There was a unanimous consensus on the importance of providing feedback and backing the suggested recommendations. As it relates to the possibility of switching enrollment periods from quarterly to monthly, some Commissioners pointed out that ensuring positive results for individuals after they've selected a specific plan can become challenging if there is frequent switching between plans. Therefore, it's important for analysts to approach the subject of plan-switching with caution in their commentary.

Session 7: Highlights from MACStats 2023

Presenter:

- *Jerry Mi, Analyst*

Background:

The MACStats: Medicaid and CHIP Data Book aggregates the latest statistics on Medicaid and CHIP into a comprehensive year-end report. This publication includes detailed figures on enrollment and expenditures for both programs, as well as vital information on federal matching rates, eligibility criteria, and metrics for care accessibility, among other topics. The presentation focused on outlining some of the principal facts and developments featured in the December 2023 edition of the data book.

Key statistics:

- During the fiscal year 2022, over 30% of people in the U.S. were part of Medicaid or CHIP at some point.
    - Medicaid accounted for 93.8 million individuals.
    - CHIP covered 8.3 million individuals.
- Looking at state finances without federal contributions, Medicaid represented 14.4% of state spending in state fiscal year (SFY) 2021, while spending on elementary and secondary education was higher at 24.3%.
- Regarding national healthcare spending, Medicaid and CHIP together constituted 17.8% of the total in the SFY 2021, in comparison to Medicare's share of 21.2%.

Program enrollment and spending:

- More than 70% of those beneficiaries enrolled are in comprehensive managed care plans, which are responsible for more than half of Medicaid's spending on benefits. For federal fiscal year (FY) 2021, while only 4.9% of Medicaid participants required long-term services and supports (LTSS), these services made up 28.5 percent of Medicaid's total expenditures. Individuals in the newly expanded adult category made up 25% of Medicaid enrollees and were responsible for 22% of the program's spending in FY2021. Pharmaceutical rebates led to a reduction in gross medication expenditures by 52.9% in the FY2022. In FY2022, disproportionate share hospital (DSH) payments, upper payment limit contributions, and other supplemental payments comprised more than half of the fee-for-service disbursements to hospitals.

Medicaid and CHIP eligibility:

- In 2022, 34 percent of all Medicaid enrollees came from families living with incomes under 100% of the federal poverty line (FPL), while 54% were from families with incomes under 138 percent FPL. By July 2023, 39 states plus the District of Columbia had expanded coverage to include non-disabled adults with low incomes, up to 138% of the FPL, which amounts to $20,120 for an individual.

Beneficiary health, service use, and access to care:

- In 2022, children and adults enrolled in Medicaid or CHIP were generally not as healthy as those with private insurance, reporting lower instances of excellent or very good health.
- Children covered by Medicaid or CHIP were just as likely to have seen a doctor or had a wellness check in the past year as those with private insurance, and they were more likely to do so than uninsured children. Although most children and adults with Medicaid or CHIP had a regular healthcare provider, the proportion was smaller compared to those with private insurance. Children and adults with Medicaid or CHIP were equally likely to report being able to contact their regular medical provider by phone during regular business hours without any trouble, similar to those with private insurance coverage.

Commissioners' Comments

The Commission expressed their appreciation for the information presented. There was overall consensus that the information provided is highly valuable for gaining understanding and for the reconciliation process during research studies. It was noted to the analyst –when contemplating potential areas for further analysis– to consider examining high-cost individuals to better understand certain patterns in healthcare utilization over time, specifically delving into certain attributes of those individuals.

Session 8: Medicare-Medicaid Plan (MMP) Transition Monitoring: Interviews on Stakeholder Engagement

Presenters:

- *Gabby Ballweg, Research Assistant*
- *Drew Gerber, Analyst*

Background

Medicare-Medicaid Plans (MMPs) offer integrated coverage for dual Medicare and Medicaid eligibles through a tripartite contract involving CMS, states, and health plans. As of December 2023, MMPs operated in eight states. CMS plans to phase out MMPs by the end of2025, transitioning enrollees to D-SNPs. MACPAC has been tracking this transition since December 2022, engaging with states on their progress and strategies. This latest update includes stakeholder outreach efforts from state interviews and outlines next steps as states begin procurement for the transition.

Overview & Findings from Stakeholder Interviews

- Under the Financial Alignment Initiative, Medicare-Medicaid Plans (MMPs) involve a three-way contract with CMS and state agencies, offering integrated care for dual eligibles. D-SNPs, an alternative integrated option for dual eligibles, maintain two contracts: one Medicare Advantage contract with CMS and a State Medicaid Agency Contract (SMAC) with the state they operate in.

- In May 2022, CMS issued a final rule to sunset MMPs under the Financial Alignment Initiative, encouraging states with MMPs to transition beneficiaries to integrated D-SNPs. This rule involves regulatory changes to enhance D-SNP integration, adopting elements from MMPs like integrated appeals and aligned service areas for FIDE SNPs and HIDE SNPs with their Medicaid counterparts. The Commission supported this move towards greater integration.
- Stakeholder engagement feedback for state transitions to D-SNPs highlights distinct concerns and preferences:
    - Beneficiaries: Emphasize maintaining integrated D-SNP features like a single ID card, no cost-sharing, and access to care coordination, alongside improved case management.
    - Providers: Express concerns about increased administrative responsibilities and billing complexities.
    - Plans: Focus on refining enrollment processes.
- For states with MMPs, the next phase is Medicaid managed care procurement. During this stage, most states will likely pause stakeholder engagement, though one state plans to include "consumer reviewers" in the process. Post-procurement, states intend to thoroughly review any stakeholder concerns raised before and during procurement.

Commissioners' Comments

The Commissioners emphasized the importance of maintaining stakeholder engagement throughout the procurement process for new D-SNPs. They are keen to understand how states will structure their Medicaid agency contracts with these D-SNPs, acknowledging the difficulty of this transition and expressing a desire to avoid repeating what one Commissioner described as a very challenging process in the future.

Session 9: Panel on the Medicare-Medicaid Plan Transitions and the Future of Integrated Care for Dually Eligible Individuals

Introduction:

- *Drew Gerber, Analyst*

Panelists:

- *Tim Engelhardt, Director, CMS Medicare-Medicaid Coordination Office*
- *Michael Monson, Chief Executive Officer and President, Altarum*
- *Michelle Herman Soper, Vice President of Public Policy, Commonwealth Care Alliance*

Background

Individuals eligible for both Medicaid and Medicare often face disjointed care and poor health outcomes. To address this, CMS is phasing out MMPs and shifting towards D-

SNPs, which vary in integration levels. Recent rulemaking aims to enhance integration in these plans. A moderated discussion with experts was arranged to delve into the MMP transition, state strategies for integrated D-SNPs, and the future of care for dual eligibles, providing Commissioners insights into the evolving landscape of integrated care for this population.

Michael Monson

- Altarum is a nonprofit organization that works to improve health equity and outcomes through better healthcare systems. It provides research and consulting services to federal and state health agencies and foundations, focusing on areas like care coordination, health sector economic indicators, and the development of age-friendly health systems. Monson highlighted the general lack of widespread expertise in Medicare-Medicaid plan management. He emphasized the critical role of oversight in these plans, especially considering their complexity. Monson discussed Altarum's new focus on Medicare Medicaid services for states, signaling a shift towards more specialized support in this area. He pointed out the effectiveness of procurement as a tool for states to set clear goals and objectives, noting that it's essential for states to have a well-defined understanding of their needs and expectations from these plans. The conversation also delved into the financial implications for states, underlining the high costs associated with these plans, with most savings accruing to Medicare, which presents a challenge for integrated care initiatives. Monson discussed the importance of shared savings and passive enrollment as key areas to be addressed. He raised concerns about the existing coordination-only D-SNPs, advocating for their elimination due to their “ineffectiveness.” Monson also touched upon the complexities of marketing within these plans, especially given the more permissive nature of Medicare marketing, and the risks of beneficiaries being swayed by wealthier plans with paid brokers. He called for empowering beneficiaries in their health plan choices and stressed that every state should develop a strategy for dual eligibles, as attrition remains a significant concern.

Tim Engelhardt, CMS Medicare-Medicaid Coordination Office

- Engelhardt discussed the complexity of offering multiple plan choices, emphasizing the importance of prioritizing effective health outcomes over an abundance of options. He cited the example of California's successful transition from MMP to D-SNP, with a notable 98% of beneficiaries smoothly shifting to the new plan. Engelhardt underlined CMS's commitment to transparency and shared concerns about the potential disruptions caused by the Medicaid procurement process. He stressed the aim of CMS to provide meaningful integrated care to as many beneficiaries as possible, while also acknowledging the constraints in their authority to enact certain changes. Engelhardt praised California's effective

handling of the transition and expressed ongoing concerns about potential operational issues that might arise in the process.

Michelle Herman Soper, Vice President of Public Policy, Commonwealth Care Alliance

- Representing a Boston-based nonprofit health services organization, Michelle Herman Soper shared insights into serving a large population of members in fully integrated programs. She expressed concerns about potential losses in program effectiveness with a shift to a more prescribed Medicare Advantage (MA) model. Soper stressed the importance of maintaining a focus on beneficiaries in these programs and cited the effectiveness of passive enrollment strategies. She discussed the need for substantial education around these changes and the importance of getting payment structures right. Soper also raised concerns about adopting a universal stars/quality rating system, foreseeing potential disruptions from changes in the enrollment process. She observed trends in the Medicaid market, such as consolidation and the move towards exclusively aligned enrollment. She emphasized the importance of encouraging investments in clinical innovation by plans.

Commissioners' Comments

Commissioners expressed concerns about the administrative burden of the transition to more integrated D-SNPs on states, particularly fee-for-service states with a lack of experience with managed care. Commissioners advocated for more marketing restrictions on plans, expressing concern that beneficiaries might not be steered into the appropriate plan as a result of overaggressive marketing. Commissioners vowed to continue monitoring the transition and encouraged further offers of technical assistance by CMS to states.