Highlights from MACPAC October Public meeting

Overview: On October 27 and 28, 2022 the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public virtual meeting. Presentation slides and the agenda for this meeting can be found on MACPAC's website.

Session 1: Medicaid race and ethnicity data collection and reporting: Interview findings

Presenters:

- *Linn Jennings, Analyst*
- *Jerry Mi, Research Assistant*

Background

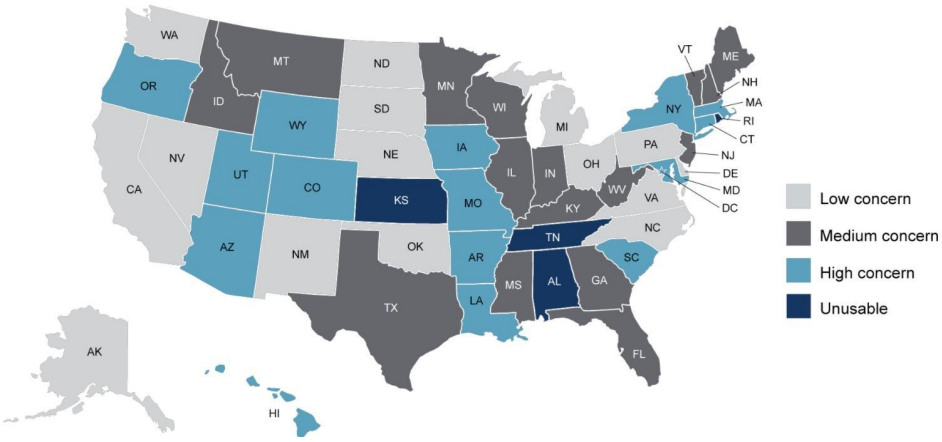
- MACPAC conducted interviews with stakeholders, including Managed Care Organizations (MCOs), state officials, the Center for Medicare and Medicaid Services (CMS) and application assisters to gauge race and ethnicity data collection in Medicaid. These findings were presented to Commissioners for potential recommendations to Congress and CMS.
- As a part of their focus on health equity, improving the usability of this data is a key priority of the Biden administration. In particular, the Biden administration wants to increase the usability of federally collected race and ethnicity data by identifying data inadequacies and supporting agency efforts to improve data quality.
- Similarly, states have equity plans and are hoping to use data to assess health disparities and support outreach. States vary in their efforts to collect and analyze this data. For example, some use data from managed care plans as well as surveys conducted by the Medicaid agency to assess disparities, and one state plans to develop a database to integrate multiple data sources.

Data Collection

- States cannot require applicants to provide race and ethnicity data, since this is not a requirement for Medicaid eligibility.
- Self-reported data is considered the "gold standard," since it allows people to best identify themselves.
- Many application assister organizations receive training in collecting data.
- To apply for Medicaid, beneficiaries can either use CMS's model application or states can develop their own with CMS approval. The model application includes race and ethnicity questions with categories that align with 2011 federal guidance.
- Many states with integrated applications for multiple government programs must meet the requirements for all these programs. For instance, SNAP applicants face more sophisticated race and ethnicity categories than Medicaid.

- CMS collects data via the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS does not collect the full range of ethnic and racial data collected by states in many cases, which leads to less information.
- In 2020, CMS analyzed the quality of its race and ethnicity data. Examining the data for significant differences (>10%) from the American Community Survey (ACS), an in-depth survey conducted by the Census Bureau, it was determined that 32 states have "usable" data (low or medium concern).

CMS Data Quality Assessment of State Medicaid Race and Ethnicity Data, FY 2020



- Stakeholders identified a need to better educate beneficiaries about the importance of collecting race and ethnicity data, and the need to create better categories that encompass more racial identities.
- Possible changes suggested: updating the CMS model application to encompass more categories and identities, updating training for Medicaid staff and application assisters, increased reporting options through T-MSIS, and additional CMS guidance to states on data collection practices.
- Staff will present draft recommendations in December, depending on Commissioner feedback.

<u>Commissioners' Comments</u>

Commissioners suggested that the technical issues outlined (e.g.,T–MSIS reporting inadequate categories) seem manageable and solvable. Commissioners noted that it's important to focus on educating states about good data collection practices. Some also suggested that data on gender identity and sexual orientation should be collected, given the disparities faced by the LGBT+ community. Finally, a Commissioner suggested that states do a "forced choice" application, where it is not acceptable to leave the race and ethnicity section empty and

someone must intentionally opt-out. Staff will draft recommendations for Commissioner review at the December meeting that take this feedback into account.

Session 2: Improving access to Medicaid coverage and care for adults leaving incarceration

Presenters:

- *Melinda Becker Roach, Senior Analyst*
- *Lesley Baseman, Senior Analyst*

Background

- The inmate exclusion policy currently in place prohibits the use of federal Medicaid funds for health care services while incarcerated. There are exceptions to this for inpatient care lasting over 24 hours.
- Medicaid is a source of coverage for ex-felons in communities and data showed that more than 28% (between 2015 and 2019) of non-institutionalized adults were enrolled in Medicaid.
- Currently incarcerated adults are poorer than the general population with a median income of around $19,000.
- MACPAC analysts worked with The Academy of Health and 16 states to conduct analysis and gather states' feedback on Medicaid coverage for incarcerated populations.

Gaps in Coverage

- Adults in the criminal justice system report high rates of physical and behavioral health conditions, as well as other disabilities.
- In an analysis from 2016:
    - More than half of state prisoners reported having a chronic physical health condition and one in five said they had an infectious disease;
    - More than half indicated some type of mental health condition and nearly half met standard criteria for substance use disorder (SUD);
    - Of state prisoners, nearly half of the total population reported having at least one disability. That is a very high proportion in comparison to only 15% of the general population.
- Gaps in coverage: A major issue is the delay in coverage once leaving incarceration. While a majority of states interviewed by MACPAC analysts reported the ability to reinstate suspended benefits within a day of release, other states reported a delay in reinstatement of between 2 to 60 days, a very wide range.
    - While incarcerated there is limited access for individuals to medication assisted treatments (MAT) and less than half of state prisoners with serious mental health disorders reported receiving any type of treatment.
    - Between 2015 and 2019, nearly a third of Medicaid beneficiaries under community supervision reported unmet mental health needs. Within that group, black prisoners were more likely to not receive any treatment compared to their white counterparts.

State Strategies

- The health needs of adults in criminal justice programs are starting to push states to think about ways to improve transitions and outcomes for their incarcerated populations.
- All of the 16 participating states that MACPAC interviewed reported suspending Medicaid coverage, rather than terminating, for individuals who are incarcerated.

- Reactivation of Medicaid benefits post-incarceration is dependent on the frequency of data sharing and whether that process is conducted manually or automatically.
- Some states reported that the cost of data infrastructure improvements and the difficulty of anticipating release dates are significant barriers to timely reactivation.
- To ease reentry, some states have funded in-reach programs that include enrollment assistance and discharge planning, sometimes including partnerships with MCOs. The most successful programs target services to specific populations, such as prisoners with SUD conditions. However, these initiatives are limited because of a lack of federal Medicaid funding due to inmate exclusion.
- Currently, 13 states (AZ, CA, KY, MA, MO, MT, NJ, NY, OR, UT, VT, WA, WV) are seeking modification of the current inmate exclusion. It is important to note that no state is requesting a full waiver of inmate exclusion and currently there are no states with an approved waiver.
- The image below shows all pending state Medicaid section 1115 demonstrations noting key characteristics.

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Characteristics of Pending Medicaid Section 1115 Demonstrations to Waive the Inmate Exclusion, as of October 27, 2022

Characteristic	States
Eligibility	
All adult inmates	4 states (OR, VT, WA, WV)
Adult inmates with certain medical diagnoses	8 states (AZ[1], CA, KY, MA, MT, NJ, NY, UT)
All youth	4 states (CA, MA, OR, WA)
Benefits	
Full benefits	4 states (MA, OR[2], UT, VT)
Limited benefits	9 states (AZ, CA, KY, MT, NJ, NY, OR[2], WA, WV)
Duration of pre-release coverage	
30 days	8 states (AZ, KY[3], MA[4], MT, NY, UT, WA, WV)
60 days	1 state (NJ)
90 days	3 states (CA, OR[5], VT)
36 months	1 state (KY[3])
Throughout incarceration	2 states (MA[4], OR[5])

- Despite current state efforts to implement demonstrations, the uncertainty around the timing of release makes it difficult to align re-enrollment dates.
- MACPAC analysts did note that they are expecting an update on inmate exclusion from CMS any day now with further guidance. They requested that Commissioners suggest additional issues they wish to explore before this topic is brought back in December for a panel discussion.

<u>Commissioners' Comments</u>

Commissioners discussed several different ideas for analysts to think about before this topic is brought back in December. These included differences in policies between expansion and non-expansion states as well as looking more into the history of inmate exclusion, why it was enacted, and what has changed since this limitation was adopted. A few Commissioners highlighted the need to better understand and racial disproportionality among the incarcerated population, as well as clarifying and distinguishing jail and prison, as they believe these as very different forms of incarceration and should not be lumped together. MACPAC analysts will compile the Commissioners' feedback and bring this topic back for a panel discussion in December.

Session 3: Monitoring the unwinding of the Public Health Emergency

Presenter:

- *Martha Heberlein, Principal Analyst and Research Advisor*

Background

- MACPAC has been continually focused on state unwinding efforts, hosting sessions in its July and September meetings examining the readiness of states.
- As enrollments have grown, concerns have been raised by advocates about states' capacity to complete redeterminations with available resources. Interviews with stakeholders have highlighted the importance of data in understanding each state's level of preparation.
- This session examined the types of data collected during the redetermination process, and how it can be used to better assess how the redetermination process is working.

Data

- During the unwinding:
    - Renewal distribution reports summarize state plans for prioritizing and processing renewal. These are submitted to CMS.
    - Baseline and monthly unwinding reports track pending and completed eligibility and enrollment actions, including application processing, renewal outcomes and Medicaid fair hearings. These are also submitted to CMS.
        - *It is unclear if either of these reports will be released to the public.*
    - States report on performance data in 11 topic areas, including many related to eligibility and enrollment processes. CMS releases monthly reports on a subset of these metrics, with a three-to six-month lag.
- States already collect significant amounts of data for their program management purposes, but the public availability of this data varies widely by state. As of September, seven states indicated affirmatively that they would have dashboards or public data on the unwinding process.
- Qualitative data is also important, and inconsistent procedures for collecting it (e.g., varying levels of state engagement with MCOs and application assisters) can hinder efforts to understand more anecdotal concerns that can be measured before quantitative data is available.

Summary: PHE Unwinding Monitoring Data

Type of Data	Public Availability	Timeline
Federal level		
Renewal distribution report	?	N/A
Baseline unwinding report	?	N/A
Monthly unwinding reports	?	N/A
Performance indicator data	Some	3-6 month lag
T-MSIS	Yes	8 month lag
State level		
Enrollment data (46 states)	Some	Unknown
Other data	Some	Unknown
Qualitative		
Personal stories	Yes	Unknown

- The table above captures the varying types of data collected once the unwinding period begins, and the levels of availability of each to the public at large.
- MACPAC's December meeting will focus on easing transitions in coverage at the end of the public health emergency (PHE). In the meantime, Commissioners can consider whether they want to weigh in on ways to improve data collection.

Commissioners' Comments

Commissioners noted that if states are lagging on existing data reporting, we should be mindful of asking for more data. One Commissioner suggested that the most important data to focus on improving and making public is call center statistics and the share of procedural dis-enrollments, which would indicate people are being removed from eligibility due to a failure of outreach and not technical ineligibility. Overall, Commissioners repeatedly emphasized the importance of data transparency, as well as the importance of releasing as much data as possible to the public so that all stakeholders can monitor the redetermination process. MACPAC staff will consider drafting potential recommendations to be agreed to by Commissioners that focus on encouraging transparency and coordination.

Session 4: Proposed eligibility, enrollment, and renewal rule: Summary and areas for potential comment

Presenters:

- *Martha Heberlein, Principal Analyst and Research Advisor*
- *Kirstin Blom, Acting Policy Director*

Background

- CMS has proposed a new eligibility, enrollment and renewal rule.
- This is the first substantial change to the enrollment and renewal process since the implementation of the Affordable Care Act (ACA). These were modeled after many optional "best practices" used in some states.
- The rule aims to make the administration of Medicaid simpler, promote program integrity, and ensure that those eligible for public assistance can get it.

Key Elements

- The rule aligns Medicare Savings Program eligibility with the Medicare Part D Low Income Service (LIS) program, given the overlap in beneficiaries.
- All states must have an asset verification system (AVS) to verify assets via electronic data matching. States must use electronic data before requesting additional information from an individual.
- Non-Median Adjusted Gross Income (MAGI) populations were left out of previous Affordable Care Act (ACA) implementing regulations. Their eligibility processes must align now with that of the MAGI population. As an example, they must have a pre-populated renewal form if ex parte renewal was initially unsuccessful (something already required for MAGI population).
- The rule imposes minimum requirements for states to determine eligibility at application and to respond to requests for additional information.
- The rule outlines steps to be taken when returned mail is received (e.g., checking additional data sources).
- States must establish interagency agreements to include procedures for seamlessly transferring individuals between Medicaid and CHIP, and are required to send a combined notice when an individual is determined eligible for one program but not another.

- States are prohibited from establishing “lock-out” periods for CHIP beneficiaries when past due premiums are paid and a beneficiary attempts to re-enroll.
- States are prohibited from having a “waiting period” in which a child must be without employer sponsored insurance for a certain period of time before enrolling in CHIP.

Commissioner Comments

Commissioners are extremely supportive of the rule, which builds off many of the specific recommendations and concerns that MACPAC has shared over the years on easing administrative burden for beneficiaries and states. Commissioners’ comments focused around another CHIP provision, which some Commissioners believe should be changed to allow families the ability to enroll in CHIP before pre-paying premiums, giving them more financial flexibility. Comments are due by November 7th, and MACPAC staff will work on finalizing a final comment letter incorporating MACPAC’s relevant previous work and recommendations, as well as their suggestions for improving CHIP program access.

Session 5: Potential changes to the consideration of access in actuarial soundness

Presenter:

- *Sean Dunbar, Principal Analyst*

Background

- During the September public meeting, MACPAC explored the rate setting process and how to account for access in rate setting. Staff presented findings from stakeholder interviews and opened up the floor for input by Commissioners.
- With anticipated rulemaking on MCO access from CMS in the next few months, there is potential for MACPAC to issue recommendations and eventually comment on the rule.

Findings

- No specific requirements exist for how states should account for access in rate setting, whereas other components of rate setting have very specific definitions (e.g., risk sharing, medical loss ratios).
- Actuaries lack guidance on how to calculate whether underlying data represents adequate access, and have little oversight over directed payments.
- Actuaries have little to no role in reviewing the reasonableness and appropriateness of directed payments, so they cannot assess access holistically when reviewing the underlying rates.
- There are inconsistent/vague definitions of access, and this coupled with the lack of actuarial oversight leads to it being overlooked.
- Access program goals are often pursued by states outside of the rate setting process

Areas for Consideration: Are current actuarial soundness requirements related to access sufficient?

- Should CMS consider approaches that better determine how rates meet network adequacy and access to care standards for the purposes of actuarial soundness?
- What should CMS take into account as it considers new requirements for access measures with respect to rate setting?
- Should additional changes be made to directed payments to address findings related to access and actuarial soundness?
- What are the potential implications of making changes to requirements for compliance with actuarial soundness standards?

Commissioners’ Comments

Commissioners suggested that perhaps CMS should require a dedicated section of rate certification that includes an analysis of access adequacy. They also said states should be encouraged to communicate more information to actuaries, including sharing past MCO corrective action plans with these actuaries when they are evaluating new rates. Access and rate development are currently going through different channels when states are working with CMS, and this needs to be fixed. There should also be information sharing with actuaries, focused on requiring the "connecting of dots" on data that is already required to be reported. The Commissioners had a lengthy discussion of how to draw more providers into the Medicaid program, including whether paying higher rates to providers would solve the access issue. Some Commissioners were adamant that paying commercial rates to providers would solve access issues, cautioning against incremental efforts to bring in more Medicaid providers through complicated and temporary payment schemes. Some Commissioners also said that MCOs need to be held accountable to ensure that any additional payments fully benefit providers rather than accrue to their bottom lines. These Commissioners argued that Medicaid paying less than other providers is a fundamental source of disparities. Other Commissioners agreed, but said that payment rates do not provide the whole picture, and there are a variety of reasons some providers do not serve Medicaid patients. All agreed that current actuarial soundness requirements on access are not sufficient, and that CMS should consider approaches that better determine how rates affect network adequacy. When the rule is released, MACPAC will revisit for potential comment.

Session 6: Trends in Medicaid drug spending and rebates

Presenters:

- *Chris Park, Principal Analyst and Data Analytics Advisor*

Background:

- Outpatient prescription drugs are an optional benefit that states provide and in most instances, can only be obtained by prescription and through pharmacies. These do not include drugs provided or billed as part of other services, such as inpatient stays.
- In FY 2021, Medicaid spent approximately $80.6 billion on outpatient prescription drugs and collected $42.5 billion in rebates, for a net total of $38.1 billion drug spending.
    - Net spending for outpatient prescription drugs represents slightly over 5% of total Medicaid benefit spending.
- There are two components that come into play for the amount Medicaid will spend for a particular outpatient prescription drug;
    - Payment from Medicaid to the pharmacy
    - Rebate to Medicaid from manufacturer
- Transactional Relationships
    - Between the manufacturer and pharmacy; the pharmacy purchases inventory from the wholesaler or manufacturer
    - State managed care organization (MCO) and pharmacy; MCO pays the pharmacy for cost of acquiring the drug and beneficiary may contribute to cost sharing (co-pays)
    - Drug manufacturer and state/MCO; manufacturer pays state/health plan statutory and supplemental rebates. The health plan may also negotiate its own rebates with the manufacturer.
- For payment under MCOs, typically they use a similar payment structure of ingredient cost and dispensing fee
    - Most MCOs use a pharmacy benefit manager (PBM) to negotiate payment terms with pharmacies, which may differ across pharmacies.

Medicaid Drug Rebate Program (MDRP)

- Drug manufacturers must provide rebates in order for their products to be eligible for the federal Medicaid match.
- Typically states cover participating manufacturer's products, once approved by the FDA, but can limit use (e.g., prior authorization, preferred drug list (PDL)).
- These rebates are separate from the state's payment to pharmacies.

Statutory Rebates

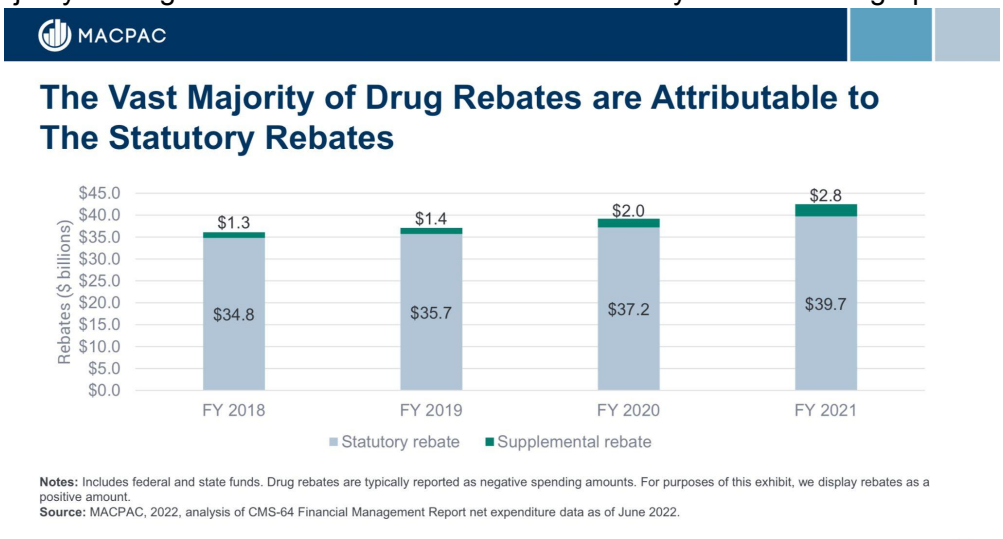
- Are defined rebates based on AMP
    - Single source and multiple source drugs (brand drugs)
        - Basic rebate calculated as greater of 23.1% of AMP or AMP minus best price
        - Additional inflationary rebate
    - Non-innovater, multiple source (generic drugs)
        - Basic rebate is 13% of AMP
        - Additional inflationary rebate
- Until January 1, 2024, total rebate amount cannot exceed 100% of AMP

Supplemental Rebates

- Can be negotiated with drug manufacturers in addition to the federal rebates; states can also join multi-state purchasing pools.
- Manufacturers pay these rates in exchange for their products to be placed on a state's PDL or to reduce restrictions on use.
- Under Managed Care:
    - MCOs can negotiate their own rebates with manufacturers, similar to state supplemental rebates.

Takeaways in drug rebates in FY 2020

- Majority of drug rebates are attributable to the statutory rebates. See graph below.



- Most brand drug rebates are based on best price calculations instead of the minimum basic rebate.
- Majority of brand drugs also received an inflationary rebate versus a quarter of generic drugs.
    - Inflation rebates significantly increased the total rebates for both brand and generic drugs.

- High-cost drugs tended to have lower rebate percentages than other drugs.

Commissioners' Comments
Commissioners discussed at great length the importance of this topic and asked a few clarifying questions as it pertains to the breakdown of rebates and generic dispensing rates. Commissioners also discussed potential ways to measure equity when looking at costs, specifically common risk adjustment models to get a better idea of equity. A few Commissioners voiced that this could be achieved by looking at T-MSIS data or by looking at specific classes of drugs and how they differ in spending costs. The Commission will receive a brief from MACPAC analysts with the requested new information on rebates and asked that analysts add descriptions to all graphs depicting rebate data.

Session 7: Panel on streamlining delivery of home- and community-based services

Intro Presenter:

- *Asmaa Albaroudi, Senior Analyst*

Panelists:

- *Henry Claypool, Policy Director, Community Living Policy Center, University of California, San Francisco*
- *Katie Evans Moss, Chief, TennCare Long Term Services and Supports (LTSS) Division*

Background:

- MACPAC analysts introduced two panelists for a discussion on streamlining the delivery of home-and community-based services (HCBS). The panelists discussed the challenges for Medicaid beneficiaries in accessing HCBS, ways in which states and the federal government could help address access barriers, and ways to simplify the administrative complexity around Medicaid HCBS.
- The panel was conducted in a Q&A format with participating panelists having time to answer each question.

Question 1: Do barriers to access exist? If so, what are they and do they differ by population?

Henry Claypool:

- There are many barriers that exist, listed in no order, they are:
    - Equity; barriers to HCBS exist across demographic groups that serve the entire population.
    - Workforce; HCBS is currently experiencing a crisis right now, specifically as it relates to HCBS beneficiaries actually receiving the help they need.
    - Housing; beneficiaries not having homes to adequately receive the care and help they need provided through HCBS programs.
    - Funding; the range of fiscal support invested in HCBS is significant, but is not uniform across states, and because of that, some states are less generous with their benefits..
        - Beneficiaries' personal need allowances do not match the actual expenses needed.
    - The three top populations are:
        - Behavioral health populations; with the IMD exclusion limiting available Medicaid spending that could be diverted to HCBS options.
        - Intellectual and Developmental Diseases (IDD); overall this population is well organized, with several community-oriented advocacy groups that focus on managing 1915(c) waivers.

        - Aged populations with severe disabilities; the majority of these individuals are enrolled in similar waiver programs and have the same services. However, in many states beneficiaries must go with needs unmet while they wait to reach the level of care required for enrollment.

Katie Evans Moss:

- In Tennessee they see all of the barriers that Mr. Claypool listed. In many parts of the state, beneficiaries are forced to wait until they qualify for institutional care to be able to access HCBS services.
- Immense waiting lists; TN was able to utilize ARPA funding to try and tackle this issue to the best of their ability, but it has not been fully addressed.
- Workforce challenges; they are unable to maintain enough direct support professionals as they are competing with other employers (e.g.,Target and fast food restaurants) that can pay more.

Question 2: What are the federal and/or state policy levers that could help address access barriers?

Henry Claypool:

- Workforce is the main barrier that needs to be addressed, this could be done by looking at ways to help pay for direct care workers as better wages are needed to attract and retain workers.
- Encourage more programs like Help at Home (in Colorado) that includes an enhanced match. Potentially providing tax relief for home care agencies.
- Also looking at waitlist management to support states in planning for the future.

Katie Evans Moss:

- Federal flexibility on requirements and institutional bias are two areas that need to be addressed at some point.
    - In TN they are seeing individuals go into institutional care, or nursing homes, who are then unable to afford to pay for their homes while receiving care.
- Possibly looking at value-based payment models, tying a portion of rates to outcomes.
- Enable a technology approach. For example, in TN they are currently unable to provide enough broadband (i.e., Wi-Fi) as it is not a reimbursable expense.

Question 3: What are the advantages and disadvantages of HCBS authorities?

Katie Evans Moss:

- From the perspective of Tennessee, their LTSS programs are managed through the state's 1115 waivers and have been for some time. However, they are currently working to integrate their 1915(c) waivers into their 1115 waivers, which are not included in Tennessee's capitation rates for MCOs. They are looking to merge both waivers so that HCBS will be managed by the state's MCOs.
    - This would promote the integration of BH and LTSS so that they can operate as a wraparound for primary Medicaid benefits and also help streamline coordination between the two types of services.

Henry Claypool:

- Mr. Claypool discussed his personal experience with his state's Medicaid program (as an aged adult with physical disabilities) and noted that his overall needs were well supported.
- Consumer advocacy groups should be utilized to greater extent in shaping HCBS programs so they better meet the needs of the individuals needing services.
- Variation by states on how they choose to structure their HCBS programs creates disparities across the nation, making it more challenging to implement policies that streamline service delivery.

Commissioners' Comments

Commissioners asked many questions of the panelists, specifically asking them what they see as the best outcome for the Commission's deliberations. Both panelists agreed that the HCBS delivery system is in crisis in terms of access to services and the need for more direct support for beneficiaries.They also agreed on the benefits of the waiver approach and the need for the Commission to consider providing specific guidance to CMS on how to improve the use of waivers. The Commissioners themselves agreed this topic is worthy of further research and conservation and that tackling issues one state at a time will not be an efficient approach to addressing delivery system challenges.

Session 8: Maintenance needs allowances for beneficiaries receiving home- and community based services

Presenters:

- *Asmaa Albaroudi, Senior Analyst*
- *Tamara Huson, Analyst*

Background

- MACPAC analysts were interested in exploring the cost for home-and community-based services (HCBS) beneficiaries to live in the community relative to their states' maintenance needs limits.
- Analysts' research updated a 2017 Urban Institute study that looked similarly at the maintenance needs allowance limits compared to relative household expenditures.
- Medicaid eligibility determinations for long term services and supports (LTSS) typically focus on the level of care (LOC) rather than on the specific clinical conditions.
- In order to access Medicaid funding, states must follow broad federal guidelines, but the functional assessment tools they use to determine functional eligibility and create a care plan may differ.
    - Functional criteria are typically defined by everyday activities that individuals are unable to do without assistance;
        - Activities of daily living (ADLs) such as eating, bathing and dressing; and
        - Instrumental activities of daily living (IADLs), like housework, grocery shopping, and medication management.
    - Majority of HSBC programs require an institutional LOC
- The financial eligibility criteria for HCBS includes both income and asset limits and states are able to disregard certain types of income.
    - Countable income is both earned income (e.g., wages) and unearned income (e.g., Social Security benefits, trusts). It also includes assets like cash or liquid resources (e.g., stocks and bonds).
- The special income level pathway, which MACPAC analysts chose to focus on for their research, is an optional eligibility pathway for individuals who have an income up to 300% of the Supplemental Security Income (SSI) benefit rate and who also meet LOC criteria for nursing facility or other institutional care. 42 states and DC use this pathway.
    - It typically utilizes the SSI asset limits of $2,000 for an individual and $3,000 for a couple.
- Maintenance needs allowances are the amounts that states allow individuals to retain after enrolling in Medicaid, intended to support community living.
    - These funds can be used to pay for room or board or other expenses such as utilities and range from $100 to $2,250 per month.

Analysis of Maintenance Needs Limits Relative to Household Spending

- MACPAC's methodology for this study replicated the previous study conducted by the Urban Institute but extended it with a sub-analysis of LTSS need. Their LTSS need population served as a proxy for HCBS need. Their study focused on financial resources and household expenditures relative to state allowance limits.
    - The study population included individuals 65+, community-based, with income no greater than 400% of the federal poverty guideline (FPG), without long-term care insurance, and complete ADL information.
- Study limitations:
    - Not limited to Medicaid-eligible individuals
    - HCBS eligibility: analysts were unable to identify if individuals were accessing or were eligible for HCBS
    - Small sample size: their population with LTSS needs served as a proxy for HCBS need, and the resulting LTSS need population was small
    - Other factors: Cost of living and number of dependents in a household were not captured in the analysis, which could affect household expenditures
- Study population:
    - Individuals with incomes at or below 400% of FPG had limited resources
        - Median annual income: $16,984
        - Median assets: $29,000
    - Participants with an LTSS need have less resources than those with no LTSS need
        - Median annual income (LTSS need): $12,738
        - Median annual income (no LTSS need): $17,370

- Findings:
    - Household expenditures: found 86.1% of spending was for essential expenditures (e.g., housing costs) and half of all households spent more than 82.9% of their income on essential expenditures.
    - State Allowance Limits: Roughly 40% of households spent more than their allowance limit on essential expenditures. Noteworthy is that in households with an LTSS need, almost half had essential expenditures that exceeded their allowance limit.
- Takeaways:
    - For community-based individuals 65 and older, most household spending was found to be essential expenditures compared to non-essential expenditures.
        - In certain households, essential expenditures exceeded allowance limits.
    - Their findings suggest that LTSS need may be one of several predictors that essential expenditures exceed states' spending allowances.
    - Given that MACPAC analysts were unable to conduct its analysis in a manner that made it Medicaid specific, there is still some ambiguity around the allowance limits and their role in meeting the needs of Medicaid beneficiaries in the community.
    - More research is needed to further understand how allowance limits are set and how they affect household spending for Medicaid beneficiaries, as well as their decisions on living in their community or in an institution.
- MACPAC analysts requested that the Commissioners offer their feedback and any potential areas of special interest for further exploration of this topic.

<u>Commissioners' Comments</u>

Commissioners all agreed that this was a topic worth further research. They discussed how many of them have given this topic much thought and would appreciate further research. Commissioners suggested looking more closely at how the cost of living is taken into account, as those numbers differ widely by state. A few Commissioners noted how it was unusual that previous data from the Urban Institute as well as the data presented by analysts used median instead of mean. The Commissioners voiced their desire to continue research on this topic with a focus in the next session on qualitative aspects and different approaches states are taking. .

Session 9: Potential recommendations for structuring disproportionate share hospital allotments during economic crises

Presenters:

- *Aaron Pervin, Senior Analyst*
- *Rob Nelb, Principal Analyst*

Background

- Disproportionate share hospital (DSH) payments are impacted by economic recessions. During a downturn, the number of uninsured increases, leading to higher levels of uncompensated care. At the same time, a state's financial situation can worsen and harm its ability to fund DSH payments.
- In 2021, MACPAC recommended Congress create a countercyclical funding mechanism for the Medicaid FMAP to help states fund Medicaid during a recession (increasing the federal match during periods of high unemployment). However, a higher FMAP has the perverse effect of reducing the total DSH funds available to states, since DSH payments are capped by a fixed federal allotment. A higher overall FMAP results in a state drawing down its federal allotment faster.
- At the September public meeting, MACPAC Commissioners discussed potential policy options for ensuring DSH payments are responsive to changing economic conditions. Commissioners expressed support for a change similar to that included in the American Rescue Plan Act (ARPA), which enhanced the FMAP for DSH payments, and increased DSH allotments while requiring states to increase their DSH spending.
- Given the fact that the FMAP changes as a state's median income changes, as a state becomes poorer and sees a higher FMAP, it has less federal DSH money.

Potential Recommendations

- Commissioners are being asked to choose between two policy options. The first would be a temporary change, protecting DSH funding during economic recessions by having DSH allotments increase temporarily so that total funding is the same as it would've been without the increased FMAP. The second would be a more permanent change that would permanently preserve total DSH funding when a state's FMAP changes, regardless of macroeconomic conditions.
- Commissioners also reviewed proposed recommendations to adjust previous MACPAC recommendations on countercyclical Medicaid funding. This new recommendation asks Congress to amend the Social Security Act to include a countercyclical DSH funding mechanism so that total funding does not drop during a recession. The previous MACPAC countercyclical funding recommendations covered Medicaid, but not specifically DSH.
- Finally, MACPAC tackled the delays in finalizing DSH allotments that have impacted states' ability to spend all available funds. Because CMS is required to compare DSH allotments to total state Medicaid spending (federal allotments cannot exceed 12% of

total medical spending), allotment finalizations are significantly delayed since it takes two years to finalize necessary data. MACPAC is recommending the elimination of this requirement since it functionally serves no purpose as DSH payments now represent a low single digit percentage of state medical spending.

Commissioners' Comments

Commissioners focused debate around choosing between a temporary versus permanent fix for DSH funding. Most Commissioners favored the temporary fix, seeing wisdom in addressing DSH funding during recessions without more broadly overhauling the DSH funding mechanism. While some Commissioners expressed concern that any changes could reduce the incentive for states to expand Medicaid by potentially increasing DSH funding, MACPAC staff assured them that they did not think this would be the case given the amount of funding involved. Commissioners generally agreed on the wisdom of the latter two recommendations centered on revising previous MACPAC recommendations related to providing for a DSH funding countercyclical mechanism and reducing CMS's administrative burden. Staff will be presenting the final text of recommendations at a future meeting after reaching out to the Congressional Budget Office (CBO) for an official score on the draft recommendations.

Session 10: MACPAC response to request for information—Make your voice heard: Promoting efficiency and equity within CMS programs

Presenters:

- *Joanne Jee, Policy Director and Congressional Liaison*

Background

- In response to CMS's request for information (RFI) (due November 4th, 2022) on promoting efficiency and equity, MACPAC analysts provided potential two areas of comment for the Commission:
    - Advancing health equity
    - Impact of COVID-19 waivers and flexibility
- Advancing health equity:
    - To address health disparities and advance health equity, the Commission could provide feedback as it pertains to:
        - Collection and reporting of race and ethnicity data through improved data quality, further standardization of T-MSIS data, and stratification of core set measures.
        - Monitoring access to care; the need for an access monitoring system with a priority on populations known to experience access issues.
        - Feedback on enrollment and eligibility processes, opportunities for streamlining eligibility and enrollment processes (i.e., ex parte eligibility determinations).
- Impact of COVID-19 waivers and flexibilities:
    - Support for CMS's efforts to examine the impact of waivers in improving access to care, advancing health equity, and reducing beneficiary and provider burdens.
- MACPAC could also provide insights on the need for transparency of the RFI process, previously discussed in April (Session 2).

Commissioners' Comments

The Commissioners applauded analysts for their quick turnaround in providing an overview of all of MACPAC's previous work as it relates to CMS's RFI and noted how it is a great reminder of all the good work the commission has done in previous years. Given the deadline (November 4th) quickly approaching, the Commission agreed that they trusted the work analysts had done and approved their suggestions for what to include in the RFI response.