Highlights from MACPAC January Public Meeting

Overview: On January 25 and 26th, 2024 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: Denials and Appeals in Medicaid Managed Care

Presenters:

- *Lesley Baseman, Senior Analyst*
- *Amy Zettle, Principal Analyst*

Background

In its ongoing examination of Medicaid managed care, the Commission focused on issues surrounding denials and appeals. MACPAC staff unveiled a draft chapter featuring seven proposals designed to enhance the appeals experience for beneficiaries and to heighten the monitoring, oversight, and clarity of denials and appeals. This chapter also reviews existing federal mandates governing the appeals process and the associated monitoring and transparency, while highlighting the latitude states have within these federal guidelines. Incorporating insights from previous Commission deliberations, a comprehensive review of state practices, interviews with stakeholders and state representatives, as well as feedback from beneficiary focus groups, the chapter identifies significant obstacles inherent in the current appeals process and the systems for monitoring and transparency of denials and appeals.

Current Federal Requirements

- MCOs are required to have an internal system to review appeals.
- Beneficiaries have statutory rights to appeal service denials by MCOs.
- Federal rules specify the requirements for service authorization and appeal processes.
- States must collect and monitor plan-reported data related to appeals.
- External quality review organizations must be involved in MCO oversight.

State Role

- States have some flexibility in modifying the appeals process, including timelines and ombudsperson services.
- States are responsible for monitoring and overseeing MCOs to ensure beneficiary access.
- Some states engage in more robust monitoring beyond federal requirements, like collecting denial data.

Current Challenges

- Beneficiaries express mistrust and frustration with the MCO appeals process.
- The process is perceived as challenging and burdensome.

- Issues exist with the timeliness and clarity of denial notices, as well as barriers to accessing continuation of benefits.
- Federal rules don't mandate states to collect data essential for assessing access to care, such as data on denials, use of continuation of benefits, appeals outcomes, and clinical appropriateness of denials.
- There's a lack of public reporting on plan denials and appeal outcomes.

Recommendations (see here for the full text and cost scoring)

- Independent External Medical Review: Amend the Social Security Act to establish an independent external medical review process for beneficiaries who have exhausted the internal MCO appeals process.
- Clarity of Denial Notices: CMS should issue guidance to improve the clarity and content of denial notices and share information on approaches MCOs can use to assist beneficiaries in filing appeals.
- Timely Denial Notices: CMS should require MCOs to offer beneficiaries the option of receiving electronic denial notices in addition to mailed notices.
- Continuation of Benefits: CMS should extend the timeline for requesting continuation of benefits while an appeal is pending and issue guidance to improve beneficiary awareness of this right.
- Monitoring and Oversight of Denials and Appeals: CMS should update regulations to require states to collect data on denials, beneficiary use of continuation of benefits, and appeal outcomes.
- Routine Clinical Appropriateness Audits: Congress should require states to conduct routine clinical appropriateness audits of managed care denials.
- Transparency of Denials and Appeals: CMS should publicly post all state Managed Care Program Annual Reports and require states to include denials and appeals data on their quality rating system websites.

Commissioners' Comments

In their comments, MACPAC Commissioners highlighted several key areas for further investigation and action in Medicaid managed care. They suggested a deeper exploration into the support system requirements for Managed Long-Term Services and Supports (MLTSS). The commissioners noted the challenge in making direct comparisons between Medicare Advantage and Medicaid denials due to inherent differences. They emphasized the need for more robust enforcement mechanisms from CMS and suggested future focus in this area. Additionally, there was a call for increased audits of MCOs. Regarding the proposed recommendations, some commissioners expressed opposition to the first recommendation concerning the cost implications of external medical reviews, especially considering potential overlaps with state fair hearings. This recommendation had an estimated cost of $500 million over 10 years.

However, they unanimously supported the other recommendations, despite a heated debate on the first. Lastly, the commissioners underscored the importance of standardizing the definition of a denial in the context of Medicaid managed care. Commissioners adopted the external medical review recommendation by a 13-3 vote and the remainder unanimously.

Session 2: Medicaid Self-Reported Disability Data Collection

Presenter:

- *Linn Jennings, Senior Analyst*

Background

During its current work cycle, MACPAC is concentrating on gathering data regarding primary language, proficiency in English, sexual orientation and gender identity (SOGI), and disability. These efforts aim to evaluate and mitigate health disparities. The focus in recent meetings has been on strategies for collecting Medicaid language data and SOGI information. The latest presentation highlighted insights into the collection of self-reported disability data. It revealed a lack of agreement among stakeholders on the most effective and meaningful disability data for addressing health disparities. Discussions also covered federal priorities for such data collection, current methods of gathering disability data in Medicaid, and important factors to consider in this process.

Findings

- Definitions of Disability
    - Various definitions exist, ranging from narrow (specific disabilities, eligibility for benefits) to broad.
    - The work focuses on three broad categories: functional disability, intellectual/developmental disabilities (ID/DD), and serious mental illness (SMI).
- Health Disparities
    - People with disabilities report poorer health, chronic conditions, unmet medical needs, and discrimination in healthcare compared to those without disabilities.
    - Disparities are more pronounced for disabled individuals intersecting with race, ethnicity, and other demographics.
- Federal Priorities
    - CMS's revised framework emphasizes disability data for health equity, expanding demographic data collection, and increasing healthcare accessibility.
    - The National Institutes of Health recognized individuals with disabilities as a population experiencing health disparities.

- Medicaid Disability Data Collection Method
    - Uses various sources, leading to inconsistent disability information across states.
    - Medicaid claims data can identify individuals with disabilities through diagnosis codes.
- Disability Survey Data
    - Surveys vary in measures of self-reported disability, often with small sample sizes.
    - Functional disability, ID/DD, and SMI are the main categories assessed in surveys.
- Purposes of Data Collection
    - Primarily for programmatic needs like eligibility determination and service needs.
    - Research use of data is less common, with states needing guidance on collecting demographic data, especially SOGI data.
- State and Beneficiary Burden
    - Challenges include CMS approval processes, applicant understanding of data use, and translation requirements.
    - Application length and data system updates add to the burden.
- Data Quality Considerations
    - Self-reported data is preferred but requires question standardization and opportunities for updates.
    - Data privacy and representativeness are key concerns.
- Summary of Demographic Findings
    - States primarily collect demographic data for programmatic purposes.
    - Interest in using demographic data for research is growing, especially for SOGI data.

Next Steps

- Presentation of a draft chapter in April for the June report to Congress.
- Focus on key themes and messages, especially regarding disability data collection.

Commissioners' Comments

Commissioners emphasized the significance of self-reporting disability status, advocating for its increased adoption to better understand and address health disparities. They also highlighted the necessity of cross-tabulating data to deepen insights into equity issues. Overall, the Commissioners expressed strong support and enthusiasm for the ongoing work in this area, recognizing its potential impact on improving healthcare equity and outcomes for individuals with disabilities.

Session 3: Policy Options for Improving the Transparency of Medicaid Financing

Presenter:

- *Rob Nelb, Principal Analyst*

Background

Continuing from their December 2023 meeting, which introduced discussions on Medicaid financing transparency, MACPAC's latest presentation focused on policy options to enhance the clarity of Medicaid's financing methods and amounts. Given Medicaid's joint funding by state and federal governments, with states sourcing their contributions from various channels like state funds, healthcare taxes, and local government funds, each policy option was appraised on three fronts: its usefulness in analyzing Medicaid's net payments, its comprehensiveness in covering all Medicaid financing and provider payments, and the degree to which it minimizes administrative burdens for states, providers, and CMS.

Existing Requirements:

- In the context of Medicaid financing methods and amounts, states must address five key funding questions during changes to Medicaid state plans or managed care-directed payments. However, these responses are not publicly accessible.
- For certain taxes, additional documentation is required at initial approval. At the state level, tax amounts are reported on Form 64.11 as mandated by law, yet these data, meant for informational purposes, seem incomplete.
- Regarding provider-level financing, there are no existing requirements. States may include some provider taxes in upper payment limit demonstrations, and CMS sporadically collects detailed financing information during financial reviews.

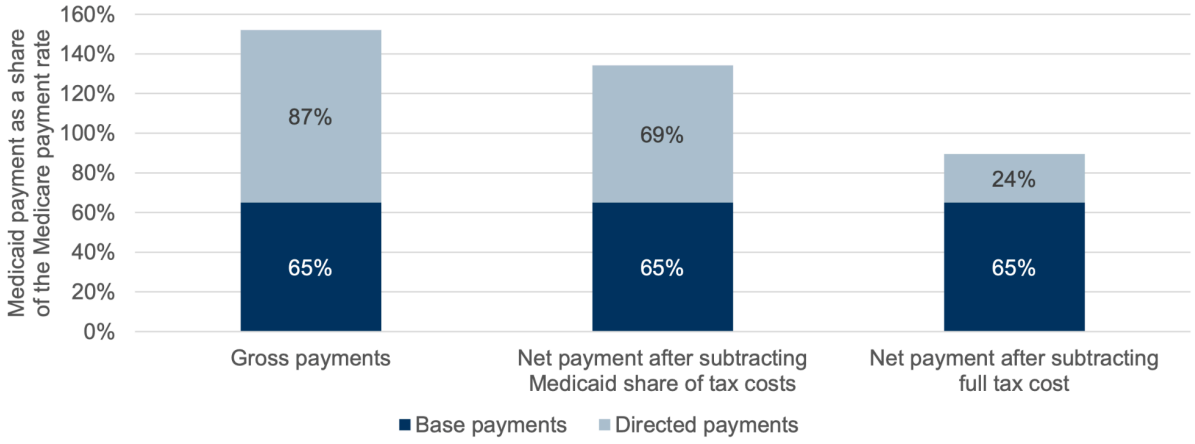
Policy Options and Evaluation

- 1A: Proposes public access to CMS's Medicaid funding responses. It's useful for financing insights but not comprehensive due to complex state data. Low administrative burden with current data, but adding a report could increase it. Focuses on financing transparency.
- 1B: Requires states to report all Medicaid financing methods publicly. Offers a complete financing view, useful for policymakers. Increases state administrative workload with additional reporting needs.
- 2A: Expands CMS Form 64.11 to include more financing types and data accuracy controls. Offers a broader view of state financing, with low administrative impact. Doesn't require tracking of financing sources for each payment.
- 2B: States to detail non-federal share sources on Form 64.11. Enhances transparency of state financing with a comprehensive funding view. Increases administrative burden due to detailed reporting.

- 3A: Requires provider-reported Medicaid financing on cost reports. Increases provider-level transparency, and potentially heightens insight and oversight. Adds reporting burden for providers.
- 3B: States to report financing in provider-level supplemental payment reports. Improves provider-level financing transparency, aiding in supplemental payment analysis. Could increase state administrative efforts.
- 3C: States to create new reports for provider-level financing data. Deepens provider financing transparency, likely enhancing understanding of funding mechanisms. Increases administrative load due to new report maintenance.

State Findings (Texas)

- Texas recently started collecting provider-level financing data, potentially serving as a benchmark for other states. This involves integrating publicly available data with other payment information, although it required a significant administrative investment. Challenges include aligning the timing of data collection with payment dates. The Texas report also details administrative fees retained by local governments from provider taxes, noting that out of $2.7 billion collected in FY 2022, $1.8 million (0.7%) was kept as a local administrative fee.
- To demonstrate the utility of provider-level financing data, an analysis was conducted using FY 2022 data for a public and private hospital in Texas. This involved examining managed care directed payment projections, where it was found that $274 million of the $4.7 billion in payments to hospitals (about 6%) was retained as an administrative fee by the managed care organization.



Graph illustrating payments for a private Texas hospital

Commissioners' Comments

Commissioners expressed concern about the administrative fees received by managed care plans. They also pondered the need to revise audit methods for these payments. They stressed the significance of net payment data and commended Texas for

collecting it at the provider level. Commissioners noted that while states favor funding Medicaid in the current way, providers are sometimes confused by the opaque payment mechanisms outlined. The enhancement of CMS's enforcement capabilities was also discussed as a priority, with plans to delve deeper into these topics in future meetings.

Session 4: State Medicaid Agency Contracts (SMACs): Interviews with Key Stakeholders

Presenter:

- *Drew Gerber, Analyst*

Background:

In this session, the focus was on Medicare Advantage dual eligible special needs plans (D-SNPs), which are tailored to serve beneficiaries eligible for both Medicare and Medicaid. These D-SNPs must comply with specific coordination requirements for Medicaid benefits and secure a state Medicaid agency contract (SMAC) to operate in a state. While federal regulations establish basic criteria for SMACs, states can impose additional stipulations to enhance integration. The discussion highlighted key findings from interviews conducted with state Medicaid officials in select states, federal representatives from the Centers for Medicare & Medicaid Services, and D-SNP health plan representatives. Topics covered included contracting nuances, the scope of SMAC authorities, data and reporting obligations, strategies for monitoring and oversight, as well as approaches for performance improvement and enforcement. To view previous MACPAC discussions and further background on SMACs, please read here.

Key Themes:

- Contracting Considerations:
    - Mandates for Contracting: CMS mandates a SMAC for Dual Eligible Special Needs Plans (D-SNPs) operations, but states don't need to engage with every plan.
    - States' Considerations for D-SNP Contracting: States evaluate the potential impact of a D-SNP contract on the integration of Medicaid and Medicare services. In the case studies, all states required a model of enrollment that is exclusively aligned.
    - Focus on Beneficiary Stability: A key priority for states is to minimize any disruptions to beneficiaries concerning their enrollment in plans.
    - Collaboration and Feedback from Health Plans: State officials regularly interact with D-SNPs to gather insights on upcoming modifications to SMAC requirements. Representatives from health plans expressed concerns regarding the alignment of SMAC approval processes with Medicare deadlines, highlighting the challenges in synchronization.

- SMAC Authority:
    - CMS Stance on State Requirements: Officials from CMS clarified that states have the liberty to set their own requirements in SMACs, provided these stipulations do not clash with federal legislation.
    - Varied State Perceptions on Flexibility: There appears to be a divergence in views among state officials regarding the extent of flexibility they possess in setting these requirements.
    - Operational Constraints Identified by States: States acknowledged that several factors restrict what they can realistically mandate in their SMACs, including limited staff capacity and familiarity with Medicare rules.
- Data and Reporting:
    - Mandatory Data and Reports in Case Study States: All the states involved in the case studies have established requirements for D-SNPs to submit data and reports on specific areas, including:
        - The process of appeals and grievances.
        - The composition and availability of provider networks.
        - Strategies and practices in care coordination.
        - Patterns in beneficiary enrollment and disenrollment.
    - Advantages of Strong State-D-SNP Relationships: States with robust partnerships with D-SNPs can solicit additional data that goes beyond the stipulations of the SMAC.
    - Challenges Highlighted by Health Plan Representatives: Representatives from health plans have identified several challenges in complying with data reporting mandates:
        - Delays in receiving necessary guidance from states.
        - The potential increase in administrative workload is due to unique operational demands from different states and issues arising from uncoordinated enrollment systems.
    - Value of Care Coordination Data: Both state authorities and CMS have acknowledged the importance of care coordination data in evaluating the overall health of programs and the performance of plans. This includes data on:
        - Health risk assessments.
        - Rates of individualized care plan completions.
        - Management of care transitions.
        - Discharge planning procedures.
    - CMS Data Submission Requirements for D-SNPs: CMS obligates D-SNPs to submit various data and reports for Medicare oversight purposes. While such data can be instrumental for states in assessing D-SNP performance

and care coordination effectiveness, states need to explicitly request this data in their SMAC to access it.
    - State Requirements and Capacity Concerning Medicare Advantage Encounter Data: Several states have mandated the submission of Medicare Advantage encounter data. Although currently limited in their capacity to effectively utilize these data, state officials have shown interest in enhancing their capabilities in this area.

Monitoring and Oversight:

- CMS is responsible for ensuring adherence to Medicare regulations, whereas state agencies focus on managing Medicaid services, especially with regard to long-term services and supports. States utilize various data and reports to supervise D-SNPs, but limitations in staff capacity often mean that these reports are primarily evaluated for their punctuality, completeness, and correctness. The ability to use data for thorough oversight is constrained by this limited capacity, making states hesitant to impose additional data requirements unless they are confident in their ability to manage them effectively. Typically, small, dedicated teams lead these oversight efforts, often with assistance from other divisions within their departments and agencies. Data concerning appeals, grievances, and care coordination are frequently employed to pinpoint issues in plan performance.

Performance Improvement and Enforcement:

- States have a variety of tools at their disposal to guarantee compliance with State Medicaid Agency Contract (SMAC) requirements by plans. These enforcement mechanisms include:
    - The implementation of corrective action plans.
    - Levying fines and monetary penalties.
    - The use of public data dashboards to display plan performance transparently.
- However, it was noted that only a few states incorporate financial incentives for D-SNPs in their SMACs. This is mainly due to constraints in resources and the absence of definitive quality benchmarks. Additionally, CMS emphasizes that for enforcement tools to be optimally effective, they should be explicitly included within the SMAC framework.

Next Steps:

- The analysts suggested potential areas to expand their focus following the presentation, depending on the interest shown by Commissioners, and will return in March with potential policy options.

Commissioners' Comments

Commissioners emphasized that bolstering state capacity is crucial for managing dual-eligible individuals, pointing out that only a few states are currently proactive in this area. There's a need for a deeper understanding at both the beneficiary and state levels of the impact, particularly regarding the financial implications for states, which may not fully grasp the total expenditure on individuals eligible for both Medicare and Medicaid. Acknowledging the topic's complexity, it was noted that efforts to advance SMACs are still emerging. Commissioners expressed gratitude for the work done so far and suggested that further research be undertaken to consolidate and communicate information on state strategies for integrated care, to increase awareness among states about alternative approaches they could adopt. Additionally, they recognized the importance of educating states about effectively exercising their SMAC authority to maximize the utility of these contracts for improving outcomes.

Session 5: Findings from Expert Roundtable on Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services

Presenters:

- *Melissa Schober, Principal Analyst*
- *Rob Nelb, Principal Analyst*

Background:

- Medicaid aims to align healthcare service payments with efficiency and quality while ensuring adequate provider participation for beneficiary access. MACPAC and Mathematica's collaboration for a literature review and expert panel discussion offered insights on how Medicaid's physician payment rates impact beneficiary access, identifying future research areas for MACPAC.
- Physicians are less likely to accept Medicaid patients than those with Medicare or private insurance. A 2017 MACPAC analysis showed variation in Medicaid acceptance rates across provider types and locations, with higher rates in community health centers and lower in psychiatry. Despite these disparities, Medicaid beneficiaries report unmet health needs at rates similar to low-income individuals with private insurance.
- States have considerable discretion in setting Medicaid payment rates. In 2019, physician fee-for-service rates were about 72 percent of Medicare's. States can make supplemental payments, and Managed Care Organizations (MCOs) have payment flexibility. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) receive payments based on cost evaluations. The ACA temporarily aligned Medicaid primary care payments with Medicare rates in 2013-2014. CMS introduced minimum payment requirements in Section 1115

demonstrations in 2022, focusing on primary care and behavioral health. Proposals in 2023 include annual payment analyses and managed care improvements like beneficiary surveys and wait time limits.

Literature Review: Physicians cite low Medicaid reimbursement as a reason for not accepting new patients. MACPAC's 2022 proposal for a new access monitoring system covers provider availability, service utilization, and beneficiary experiences. Mathematica's review of 44 studies post-2013 showed mixed results regarding the impact of payment rates on access.

- MACPAC engaged with Mathematica to evaluate 44 studies from peer-reviewed sources, all published after 2013, to further understand the impact of Medicaid payment rates on healthcare access. This review included six robust quasi-experimental studies on the primary care fee increase under the ACA, which found inconsistent results. One significant research effort by the Agency for Healthcare Research and Quality indicated no notable shift in physician engagement with Medicaid. Conversely, two analyses by the National Bureau of Economic Research suggested that the temporary fee hike had a beneficial impact on service utilization and the access reported by beneficiaries. While there are only a few studies that examine the administrative burden associated with Medicaid, a recent notable study utilized claims denial data to demonstrate a higher burden compared to other programs.

Expert Roundtable: Mathematica convened a panel of experts to deliberate on the outcomes of the research and to contemplate directions for further studies. This panel was composed of officials from federal agencies, scholars from academic institutions, and evaluators from state Medicaid programs.

- Key themes:
    - Tension between goals of expanding the number of providers participating in Medicaid and expanding access among providers who already participate
    - Data collection and research challenges
    - Variations by practice and organizational characteristics
    - Need to better understand the role of managed care
    - Need to refocus analysis on beneficiary needs and experiences
- Competing Goals of Medicaid Payment Policy: Medicaid fee enhancements improved access to existing providers more than attracting new ones. The panel discussed the trade-offs in resource allocation and the lack of frameworks for evaluating these options.
- Data Collection and Research Challenges: The Transformed Medicaid Statistical Information System (T-MSIS) could address past research limitations, but data

quality and managed care payment data availability are issues. Methodological challenges remain due to concurrent policy changes.

- Variations by Practice Characteristics: Safety-net providers predominantly care for Medicaid patients, but research on practices serving more Medicaid patients is limited. Region and specialty-specific participation rates vary, necessitating further research into underlying causes and the role of mid-level providers in access.
- Role of Managed Care: The link between payment rates and access in managed care is unclear, with most research based on fee-for-service rates. Managed care's flexibility in reducing administrative barriers and the need for new network adequacy measures were discussed.
- Refocusing on Beneficiary Needs: Physician participation rates in Medicaid alone are insufficient for assessing access. Policymakers should consider access and beneficiary experience, with future research focusing on specific groups with unique healthcare needs.

Next Steps:

- MACPAC plans to publish a brief summarizing literature review findings and roundtable themes. Staff are seeking feedback on key themes (below) to guide MACPAC's future focus areas.

Themes and Potential Future Work

Theme	Potential work
1. Tension between expanding provider participation and improving access to safety-net providers	Expand on MACPAC's existing payment and access frameworks to include considerations for sites of care
2. Data challenges	Continue to examine T-MSIS and monitor new access rules
3. Variations by practice type	Further explore FQHC payment policy
4. Role of managed care	Examine how managed care rates relate to FFS, administrative burden, and network adequacy requirements
5. Refocusing on beneficiary needs	Apply payment and access frameworks to a subpopulation with unique needs

Commissioners' Comments

The Commissioners discussed the various metrics currently in use, and the potential inclusion of appointment wait times as another measure, particularly in light of the pending Managed Care rule that addresses this issue. They also discussed the methodology for incorporating consumer perspectives as they continue to explore the

first theme. Additionally, there was an expressed desire to intensify the focus on data challenges related to T-MSIS under the second theme, along with a suggestion to better integrate the viewpoints of state stakeholders into the discussion.

Session 6: Medicaid Coverage of Physician-administered Drugs

Presenter:

- *Chris Park, Policy Director*

Background:

The upcoming wave of costly specialty drugs, notably those involving cell and gene therapies that necessitate administration by a healthcare professional, is expected to significantly influence Medicaid expenditures on drugs. Until now, the majority of research into Medicaid's drug benefits has centered on pharmacy-dispensed medications, with scant public data on the mechanisms state Medicaid programs employ to fund and regulate physician-administered drugs (PADs). In the recent session, analysts laid the groundwork for the distinct policies governing PADs within Medicaid as opposed to those for drugs provided via pharmacies. MACPAC analysts shed light on the specific complexities encountered in overseeing PADs under the medical benefit. They also presented a synopsis of their investigative findings regarding the use and costs of PADs within Medicaid, drawing upon data from the Transformed Medicaid Statistical Information System.

Medicaid Drug Rebate Program (MDRP):

- In the Medicaid Drug Rebate Program (MDRP), drug manufacturers are required to offer rebates as a condition for their products to qualify for federal Medicaid matching funds. While states are typically obligated to include a manufacturer's drugs that participate in this program, they retain the authority to regulate their use through mechanisms such as prior authorizations and preferred drug lists (PDLs). The category of 'covered outpatient drugs' within this context is specific—it usually refers to drugs that necessitate a prescription for dispensation, have received approval from the Food and Drug Administration (FDA), and are produced by manufacturers that have entered into a Medicaid rebate agreement.

Statutory Rebates:

- The statutory rebates in the Medicaid Drug Rebate Program are determined based on the average manufacturer's price (AMP). For single-source and innovator multiple-source drugs, often referred to as brand-name drugs, the basic rebate is the higher amount between 23.1 percent of the AMP or the difference between the AMP and the drug's best price. These drugs are also subject to an additional rebate if there is inflation in price, as well as an alternative rebate for any line extensions. In the case of non-innovator multiple-source drugs,

commonly known as generic drugs, the basic rebate stands at 13 percent of the AMP, with an additional rebate applied for price inflation. Before January 1, 2024, the total rebate that could be claimed was capped at 100 percent of the AMP.

Supplemental Rebates:

- States have the authority to secure additional rebates from drug manufacturers, which go beyond the mandatory federal rebates. These supplemental rebates are negotiated by states as a means to incentivize manufacturers, ensuring their products are included on a state's Preferred Drug List (PDL) or are subject to fewer usage restrictions. Similarly, Managed Care Organizations (MCOs) have the power to independently negotiate rebates with manufacturers that are akin to the supplemental rebates arranged by the states.

Payment to Pharmacies:

- In the fee-for-service (FFS) model, payments made to pharmacies consist of two parts: the ingredient cost, which is meant to compensate the pharmacy for the purchase price of the drug, with states required to pay based on the drug's actual acquisition cost (AAC); and the dispensing fee, which is for covering the professional services involved in dispensing the medication. Managed Care Organizations (MCOs) generally adopt a similar payment framework, which also includes ingredient cost and dispensing fee. However, MCOs may employ a pharmacy benefit manager (PBM) to negotiate the terms of payment with individual pharmacies and are not obligated to base payments on AAC. Additionally, beneficiaries might be responsible for cost-sharing payments.

340B Program:

- The 340B program offers significant discounts on medications to designated healthcare facilities, such as Federally Qualified Health Centers (FQHCs). This program establishes a cap on the maximum amount that manufacturers can bill these entities, with the ceiling price being determined by deducting the amount of the federal Medicaid rebate from the average manufacturer's price (AMP). However, medications acquired for Medicaid beneficiaries through the 340B program do not qualify for federal rebates to avoid a situation where both discounts are applied to the same unit of drugs. Therefore, such drugs should be omitted from the state's rebate billing process. When operating under a fee-for-service (FFS) system, 340B pharmacies are reimbursed based on the drug's acquisition cost, which corresponds to the ceiling price.

Physician-administered Drugs (PAD):

- PADs are typically those that require administration by a healthcare professional in settings such as a physician's office or a clinic. Most PADs, apart from vaccines, are potentially eligible for the Medicaid statutory rebate, though eligibility hinges on the method of payment. When a state bills for a PAD as part

of a bundled service within certain healthcare settings, like during a clinic visit or a hospital stay, it is not able to claim the statutory rebate. However, if the state pays for the PAD separately from the bundled service, the statutory rebate can be claimed. A proposed rule from May 2023 suggests altering the definition so that even drugs included in a bundled payment could be deemed covered outpatient drugs, provided the drug and its specific cost are distinctly itemized on the claim.

- Payment for PADs have two components (1) cost of drug and (2) cost of administration and professional services

Methodology for drug cost	Number of states
ASP + 6 percent	23
Between ASP and ASP + 6 percent	11
ASP – other percent	2
Other benchmark (e.g., WAC, AAC, AWP)	14

Notes: ASP is average sales price. WAC is wholesale acquisition cost. AAC is average acquisition cost. AWP is average wholesale price. Many states utilize a lesser of methodology, which means that the state pays the lower of different formulas based on different benchmarks, for example, the state pays either ASP + 6 percent or usual and customary charges, depending on whichever is lower for that treatment. This table only counts a state once for its primary payment benchmark. Includes 49 states and the District of Columbia.
Source: MACPAC 2022, analysis of Medicaid state plans.

Coverage for Dually Eligible Beneficiaries:

- For individuals eligible for both Medicaid and Medicare, PADs would typically fall under the coverage of Medicare Part A for inpatient services and Part B for outpatient services. Most drugs covered by Medicare Part B are paid for at the average sales price (ASP) plus a 6 percent markup. Medicaid steps in to cover the cost of coinsurance or other cost-sharing components for drugs under Medicare Parts A or B; for instance, beneficiaries usually have a 20 percent cost-sharing responsibility for Part B drugs. When a state covers the cost-sharing for a Part A or B drug, it is eligible to receive the entire statutory Medicaid Drug Rebate Program (MDRP) rebate. However, Medicaid does not cover the cost of drugs that fall under Medicare Part D or any cost-sharing associated with them.
- The cost of PADs tends to be greater when billed under the medical benefit, often involving a markup on the acquisition cost. This can lead to wastage, particularly if the entire amount in a drug vial is not used during administration. Challenges also arise in claims processing for medical claims, which may result in less frequent use of utilization management tools. Furthermore, the cost and payment for PADs can differ depending on the healthcare setting where they are administered. Collecting rebates for PADs poses its own set of difficulties due to the absence of a designated National Drug Code (NDC) field on medical claim forms, discrepancies in the billing units used, and the fact that PADs included in bundled payments do not qualify for rebates. Additionally, there is often an

overlap between the medical and pharmacy benefits, complicating the management of these drugs.

PAD Utilization and Spending Analysis:

- There is limited publicly accessible data specifically detailing Medicaid's use and expenditure on physician-administered drugs (PADs). To address this gap, the analysis utilized data from the Transformed Medicaid Statistical Information System (T-MSIS) for the fiscal year 2021. This involved identifying PADs and their administration by using a list of procedure codes from Medicare Part B and PAD lists from five states. The study included both full-benefit Medicaid beneficiaries who were not dually eligible and those who were. However, it only accounted for drugs explicitly itemized on outpatient claims, specifically those with a drug-specific procedure code. Drugs potentially included in bundled payments, like inpatient hospital Diagnosis-Related Group payments, were not considered. Therefore, this analysis likely represents an underestimate of the actual utilization and spending on PADs. It's also important to note that the spending figures are gross amounts, calculated before the application of any rebates.

Commissioners' Comments

The Commissioners appreciated the presentation by the analysts and highlighted the importance of their work. They noted the crucial importance of the analyst's work and look forward to them coming back in March with the findings from their roundtable.

Session 7: Highlights from Duals Data Book

Presenter:

- *Gabby Ballweg, Research Assistant*

Background:

MACPAC analysts presented highlights from the 2024 Duals Data Book, which was conducted on individuals eligible for both Medicaid and Medicare, focusing on their demographic characteristics, eligibility and enrollment methods, service usage, and expenditure patterns. The book also shows the shifts in the demographics, spending, and service utilization of this group from 2018 to 2021. The research represents a joint effort between the Medicaid and CHIP Payment Access and Advisory Commission and the Medicare Payment Advisory Commission. The 2024 edition includes a fresh exhibit (Exhibit 13) that illustrates the intersection of Medicare and Medicaid managed care enrollments in calendar year 2021. This includes data on individuals enrolled in both Medicare Advantage and comprehensive Medicaid managed care, those who are part of both fee-for-service (FFS) and managed care systems, as well as those exclusively enrolled in FFS Medicare and FFS Medicaid.

Key Statistics, CY 2021:

- In 2021, beneficiaries fully eligible for both Medicaid and Medicare represented a significantly larger portion of Medicaid's spending compared to their share in enrollment – they accounted for 27% of Medicaid's spending, despite making up only 10% of its enrollment. Additionally, these dual-eligible beneficiaries were less likely to be enrolled in comprehensive Medicaid managed care for at least one month, with only 42% enrolled compared to 73% of non-dual eligible Medicaid beneficiaries. Furthermore, full-benefit dual-eligible beneficiaries using fee-for-service (FFS) were more likely to utilize institutional long-term services and supports (LTSS), with 15% using these services compared to just 4% of non-dual eligible Medicaid beneficiaries.

New Exhibit: Overlap Between Medicare and Medicaid Managed Care Enrollment, CY 2021:

- In the calendar year 2021, a quarter of dual-eligible beneficiaries were enrolled in both Medicare managed care and comprehensive Medicaid managed care for at least one month. The data also reveals a notable age-related trend: dual-eligible beneficiaries under the age of 65 were more likely to not be enrolled in managed care for any month compared to those aged 65 and older, with the figures being 33% and 25% respectively.
- Dual-eligible beneficiaries were more inclined to utilize institutional long-term services and supports (LTSS), accounting for a larger portion of Medicaid's total spending on these services compared to non-dual eligible individuals. Interestingly, the per-user spending for dual-eligible beneficiaries in fee-for-service (FFS) was $25,000 less. Additionally, a higher number of these beneficiaries utilized home- and community-based services (HCBS) through waivers rather than state plans. Compared to the previous year, 2020, there was an increase in the use of HCBS covered under state plans among both dual-eligible and non-dual eligible Medicaid beneficiaries.

Dually Eligible Trends, CY 2018–2021:

- The dually-eligible population grew at an average annual rate of 2.0%, reaching a total of 12.8 million individuals. During this period, the proportion of individuals with at least one month of enrollment in comprehensive Medicaid managed care saw a 7.5% increase. Meanwhile, Medicaid's average annual spending per beneficiary grew by 3.9%, with a notably higher growth rate of 8.5% per year for non-dual beneficiaries. Despite a decline in the percentage of beneficiaries utilizing services, there was an increase in per-user Medicaid spending on inpatient hospital services, institutional long-term services and supports (LTSS), and prescription drugs.

Commissioners' Comments

The Commissioners expressed their appreciation of the Duals Data Book and all agreed on the importance of the information it provides. Some also emphasized how significant the book is in regards to comparing the data over time to see where they have come and where they still need to go as it relates to improving the quality of care for dually eligible beneficiaries.

Session 8: Medicare Savings Programs (MSPs): Enrollment Trends

Presenter:

- *Kirstin Blom, Policy Director*

Background:

Medicare Savings Programs (MSPs) are designed to assist dual-eligible individuals with Medicaid and Medicare by covering Medicare premiums and cost-sharing. A study by the Urban Institute in 2017, commissioned by MACPAC, found that participation in these programs was around 50% in late 2009 and 2010, particularly in the MSPs with the highest enrollment. To gain a current understanding of MSP policy, MACPAC again partnered with the Urban Institute to examine enrollment trends using Medicare administrative data, focusing on the period from 2010 to 2021. This session provided a comprehensive overview of these trends, concentrating mainly on the Qualified Medicare Beneficiary Program and the Specified Low-Income Beneficiary programs, which together represent over 90% of MSP enrollees.

Types of MSPs:

- Qualified Medicare Beneficiary (QMB) Program
    - Enacted in 1986/1988, represents the largest portion of enrollment and most expansive enrollment and benefits.
- Specified Low-Income Medicare Beneficiary (SLMB) Program
    - Enacted in 1990.
- Qualifying Individual (QI) Program
    - Enacted in 1997, fully federally funded.
- Qualified Disabled and Working Individual (QDWI) Program
    - Began in 1989, paying Medicare Part A premiums for certain individuals under 65 years old.

MSP Eligibility and Benefits, 2023

Program		Medicaid benefits	Income threshold as % of FPL	Qualify for Medicaid payment of:	Federal asset limits	
					Individual	Couple
QMB	Only	Partial	At or below 100%	Medicare Part A and Part B premiums, coinsurance, deductibles, and copayments	$9,090	$13,630
	Plus	Full		Medicare Part A and Part B premiums, coinsurance, deductibles, and copayments All Medicaid-covered services	$2,000	$3,000
SLMB	Only	Partial	101% - 120%	Medicare Part B premiums	$9,090	$13,630
	Plus	Full		Medicare Part B premiums; Medicare coinsurance, deductibles, and copayments All Medicaid-covered services	$2,000	$3,000
QI		Partial	121% - 135%	Medicare Part B premiums	$9,090	$13,630
QDWI		Partial	At or below 200%	Medicare Part A premiums	$4,000	$6,000

CMS Rulemaking:

- The final rule on MSP eligibility determination and enrollment was published in September 2023. The rule codifies CMS guidance on using Social Security Administration (SSA) data for MSP applications and encourages states to align MSP eligibility processes with SSA requirements. States have until April 1, 2026, to comply with most provisions

Analyzing MSP Enrollment Trends: The methodology includes analysis of Medicare beneficiary summary files data from 2010 to 2021. Enrollment data is displayed across five MSP categories, excluding QDWI data due to small enrollment numbers

MSP Enrollment, CY 2010 to 2021

MSP	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Average annual growth, 2010 to 2021
Total	***7.2***	***7.5***	***7.9***	***8.1***	***8.3***	***8.5***	***8.7***	***8.9***	***9.1***	***9.3***	***9.7***	***10.0***	***3.0%***
QMB plus	4.8	4.8	5.0	5.1	5.3	5.3	5.4	5.6	5.6	5.8	6.1	6.3	***2.6%***
QMB only	1.0	1.2	1.2	1.3	1.4	1.4	1.5	1.5	1.6	1.5	1.7	1.7	***4.7%***
SLMB plus	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	***4.0%***
SLMB only	0.8	0.9	0.9	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	***2.6%***
QI	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	***3.0%***

Key Takeaways from Enrollment Analysis:

- The QMB plus program stood out significantly by encompassing 63% of the total MSP enrollment, surpassing the combined enrollment of all other MSPs. In contrast, the SLMB plus program, not considering the QDWI, recorded the least enrollment among the MSPs. During the 12-year span, the most significant increase in enrollment occurred in 2020, especially for the QMB plus and SLMB plus programs, which cater to beneficiaries with full benefits. The QMB-only program, targeting beneficiaries eligible for partial benefits, showed the most

consistent year-to-year growth, often exceeding 5%. This program also marked the highest average annual growth rate across all MSPs, at 4.7%.

Factors Affecting MSP Enrollment Growth:

- Several key factors influenced the growth in MSP enrollment. First, the implementation of the Patient Protection and Affordable Care Act (ACA) played a significant role. Also, there was a notable increase in managed care enrollment among dual-eligible individuals between 2013 and 2021. Specifically, Medicare managed care enrollment rose from 22% to 46%, and Medicaid managed care enrollment increased from 17% to 42%. In addition, federal and state initiatives significantly contributed to this growth. These initiatives included; additional funding for outreach as part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), continuous guidance from CMS on simplifying the enrollment process, and the states' expansion of income and asset thresholds used to qualify for MSPs.

Commissioners' Comments

There was a suggestion to explore potential opportunities for monitoring the SSA's role in this context, possibly to ensure that benefits are effectively coordinated. The Commission also expressed an interest in examining quality of care and access issues, with particular attention to the churn rates in Medicare enrollment, as understanding these rates could provide valuable insights into the stability and continuity of care for beneficiaries. They look forward to the analysts' continued work on this topic and to seeing their additional analysis in June.

Session 9: Panel on the American Rescue Plan Act (ARPA): Sustainability and Evaluation

Introduction:

- *Tamara Huson, Senior Analyst and Contracting Officer*

Panelists:

- *Jennifer Bowdoin, Director of the Division of Community Systems Transformation, Medicaid Benefits and Health Programs Group, Center for Medicaid and CHIP Services, CMS*
- *Alissa Halperin, Principal Consultant, Halperin Health Policy Solutions*
- *Bonnie Silva, Director of the Office of Community Living, Colorado Department of Health Care Policy & Financing*

Intro and Background

Tamara Huson introduced the panel, highlighting ARPA's enhanced FMAP for Home and Community-Based Services (HCBS). She noted that this represents the largest new federal investment in HCBS, with states having until 2025 to utilize these funds.

Panelists

- Jennifer Bowdoin from CMS shared that states are keen on sustaining workforce development activities under ARPA, with a particular focus on reducing waiting lists. She mentioned that activities requiring substantial initial investments, like IT upgrades, are likely to continue. Bowdoin emphasized the states' flexibility to modify their spending plans and CMS's commitment to providing technical assistance, including facilitating inter-state communication. She also discussed CMS's support for states in funding areas typically outside Medicaid's scope, like housing supports, and the plan to update Medicaid.gov with a comprehensive overview of state spending plans.
- Alissa Halperin, representing the ARPA technical collective, spoke about providing rapid, free technical assistance to states, funded by foundations like Millbank and Arnold Ventures. The collective's focus is on the sustainability of projects and bringing states together to share insights, particularly in the direct care workforce sector. She highlighted the challenges in identifying impactful initiatives and the importance of transparency and participant-centered approaches. Halperin also mentioned the ongoing struggle to convince legislatures to sustain investments.
- Bonnie Silva from the Colorado Department of Health Care Policy & Financing detailed their research-based approach, constantly evaluating what works. She discussed raising the base wage for direct workers, ensuring legislative commitment for ongoing funding before utilizing one-time funds. Silva stressed not waiting until the end of ARPA to sustain plans and being strategic about IT and workforce investments. She noted the time constraints as challenging, requiring quick hiring and project implementation. Silva suggested that fewer, more focused projects might have been more effective and highlighted the requirement for direct worker salary funding and the necessity of administrative reporting to ensure compliance.

Commissioners' Comments

The commission emphasized the crucial role of sustainability in state initiatives under ARPA, particularly lauding those states that secured recurring funding from the outset. They advocated for continued monitoring of this issue in partnership with organizations like NAMD and Advancing States. A significant focus was placed on tracking waiting lists and ensuring the long-term sustenance of individuals removed from these lists and added to waiver programs. The commission recognized the cost-saving aspect of HCBS and its potential to attract further investment, reiterating their commitment to examining the relationship between HCBS, payment, and access. The necessity for state Medicaid

agencies to collaborate with academic institutions for in-depth Medicaid studies was highlighted, with a strong emphasis on keeping the perspectives of the served populations at the forefront of these endeavors.