

Highlights from MACPAC July Public meeting

Overview: On July 27th, 2022 the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public virtual meeting. This summary includes highlights from the meeting's only session, focused on the expiration of the Public Health Emergency (PHE). Presentation slides and the agenda for this meeting can be found on MACPAC's [website](#).

Session 1: Medicaid and the Public Health Emergency (PHE)

Presenters:

- *Martha Heberlein, Principal Analyst*

Background

- With the eventual end of the Public Health Emergency (PHE), states will lose their enhanced Federal Matching Assistance Percentage (FMAP) and begin again the process of redetermining Medicaid eligibility for millions of Americans.
- Given the uncertainty of the PHE's end, MACPAC conducted interviews with five states to assess their preparedness for Medicaid redeterminations.
- Between March 2020 and March of 2022, enrollment in Medicaid and CHIP has increased by 24%.
- The number of individuals who will disenroll at the end of PHE is highly uncertain, and has been estimated to be between 5 and 14 million people.
 - Impacts on enrollment are uncertain. One study found that almost 60% of children losing Medicaid are eligible for CHIP, and another 10% are eligible for premium tax credits on the exchange.
- Enhanced FMAP money has had varying impacts on state budgets, from equal to state costs of the additional enrollment in states such as New Hampshire, Nevada and Oregon to about six times state costs in Alabama and Mississippi. Overall, states have received approximately \$100.4 billion through the enhanced FMAP, more than twice state spending on increased enrollment.
- While the enhanced FMAP was intended to provide budget relief to states, no state has reported a budget deficit in 2022 and many budgets have long been fully recovered from the pandemic.
- CMS has been hosting monthly calls and releasing detailed information to help states prepare for the end of the PHE.

Findings

- State stakeholders said that the uncertainty about the exact ending of the PHE has hampered their ability to plan. The constantly shifting end date of the PHE consumes state resources. States worried that enrollees may become desensitized to warnings about the PHE ending if they continue to receive them for months on end.
- States have, however, used the PHE period to focus on modernizing and streamlining eligibility systems.
- States vary in their transparency on unwinding plans, but many states have broadly engaged stakeholders in the process.
- While Medicaid plan trade groups and the National Association of Medicaid Directors has endorsed a 120-day notice of the end of the PHE, states interviewed felt that they could begin the unwinding process with 60-day notice. However, if they were given more time, states could make longer term improvements to eligibility processes.
- States interviewed indicated they will take the full time allowed (14 months) when the PHE ends due to the backlog. One state noted that states may be covering some ineligible people for at least 10 months.

- States are less concerned now than they were in 2020 about covering ineligible people without the enhanced FMAP, given the improved budget situation.
- States are more concerned with flexibility to administer their eligibility programs and not as concerned about the continuation of the enhanced FMAP. They generally favor decoupling the enhanced FMAP from the end of the PHE.

Next Actions

- MACPAC will host a panel with states and beneficiary advocates at the September meeting.
- Staff will continue to monitor CMS and state actions.

Commissioners' Comments

- Commissioners expressed interest in CMS releasing the data it collects from states during the renewal process, something it has not yet committed to do. Commissioners were highly concerned about beneficiaries' loss of eligibility for procedural reasons, as well as the ability of states to ensure seamless transitions into marketplace coverage. A commissioner floated potentially issuing a recommendation at some point favoring a more gradual phase down of the enhanced FMAP, so that states had more budgetary flexibility, but nothing concrete about next steps was decided. Commissioners noted Kentucky and Oregon exploring implementation of a Basic Health Plan covering those making under 200% of the federal poverty level (FPL) but ineligible for Medicaid as another potential option to ensure continuity of coverage. MACPAC staff will continue monitoring the state preparation period.

Highlights from MACPAC September Public meeting

Overview: On September 15th and 16th, 2022 the Medicaid and CHIP Payment and Access Commission (MACPAC) held its September 2022 public virtual meeting. This summary includes highlights from all 8 meeting sessions. Presentation slides and the agenda for this meeting can be found on MACPAC's [website](#).

Session 1: Background on Medicaid race and ethnicity data collection and reporting

Presenters:

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

Background

- MACPAC's June report to Congress described state Medicaid approaches for promoting health equity, particularly the importance of quality race and ethnicity data.
- Linn Jennings and Jerry Mi presented background on how Medicaid collects race and ethnicity data as a prelude to further discussion at the October meeting on data collection.

Data Collection Standards

- Promoting racial health equity is a Biden administration priority, and CMS recognizes the importance of complete, high-quality data.
- Currently, major concerns in data collection include the inconsistent collection of race and ethnicity data across federal and state-level data sources, high rates of missing data, and small sample sizes. This can lead to an inaccurate understanding of health disparities.
- In 1977, the Office of Management and Budget (OMB) established the first federal minimum standards on race and ethnicity data. These were eventually updated to



include five race categories and two ethnicity categories. These standards applied to CMS as a federal agency, but not state Medicaid programs. This remained the case until the Affordable Care Act required uniform data collection standards across CMS and Medicaid and CHIP programs. However, these standards were interpreted to only apply to HHS-sponsored national population health surveys, not all kinds of data collected by Medicaid programs.

- State Medicaid programs therefore have flexibility to determine if and how they collect race and ethnicity data during enrollment. A 2021 review of state Medicaid programs found that all states collect race and ethnicity data in accordance with federal standards, with some collecting more granular data than others.
- States are required to report all enrollment system data to CMS via the Transformed Medicaid Statistical Information System (T-MSIS), which means that every state reports some data via T-MSIS on race/ethnicity.
- Beneficiaries self-report their racial/ethnic categories, which makes having enough categories that allow them to fully express their identity very important.

Analysis and Next Steps

- MACPAC conducted a data quality analysis of state race and ethnicity data, examining the percentage of records with missing race and ethnicity values and the number of categories with more than a 10 percent difference from the 2019 Census Bureau American Community Survey (indicating a potential concern with data accuracy).
- Often, T-MSIS race/ethnic categories don't align with all of a state's race/ethnic categories, making data entry difficult
- MACPAC will present their findings from interviews with HHS, CMS, states, experts and managed care plans at the October meeting in order to discuss avenues for improvement of data collection in preparation for potential recommendations. Also discussed will be MACPAC's data quality analysis.

Commissioners' Comments

- Commissioners agreed on the importance of data collection practices in understanding equity challenges. One commissioner suggested examining states with the best practices, and discerning which lessons can be extrapolated to other states. Commissioners also inquired about data sharing across providers, plans, and Medicaid authorities. MACPAC analysts are asking stakeholders in interviews about this issue, and plan on presenting more detail on how well this happens at the October meeting. Commissioners noted CMS's recent health equity RFI, and suggested that this could be a good area for comment. Finally, Commissioners noted that disability status is an important area to explore and that the coming redetermination period could be a good opportunity for quality data collection by states.

Session 2: State processes and stakeholder engagement for unwinding continuous coverage requirement

Intro Presenter:

- *Martha Heberlein, Principal Analyst and Research Advisor*

Panelists:

- *Jami Snyder, Director, Arizona Health Care Cost Containment System*
- *Carl Feldman, Executive Policy Specialist, Pennsylvania Department of Human Services*
- *Jodi Ray, Director and Principal Investigator, Florida Covering Kids & Families*

Background



- Commissioners, policymakers, beneficiary advocates and others have raised concerns about the end of the public health emergency (PHE), given the sheer administrative burden of Medicaid redeterminations.
- In July, MACPAC held a special meeting to assess where states were in PHE unwinding preparation. States said that they were prepared for the unwinding, and that the tools provided by CMS had been helpful.
- MACPAC will be focused during its next few meetings on the “post-PHE” world, and how states are operationalizing their unwinding plans.
- This panel featured two state officials, alongside a beneficiary advocate.

Jami Snyder (AZ Medicaid)

- Arizona has continued to process redeterminations behind the scenes during the PHE like many other states. Likely disenrollments are split into two groups: those found to be factually ineligible (e.g. having too high an income) and those who fail to submit documentation necessary to make a determination.
- Over 600,000 enrollees (out of a total of 2.4 million people currently on Arizona Medicaid) may fit into this latter group. Arizona has been partnering with MCOs and providing them data so that they can proactively reach out to these beneficiaries. MCOs have also been asked to share information with providers and the Indian Health Service.
- It will likely take 12 months to process all redeterminations. This estimated time has gone up as the PHE has dragged on. To increase efficiency, Arizona is completing renewals at the household level (redetermining an entire household at once), and aligning renewals with SNAP recertifications.
- Disenrollments of those deemed factually ineligible are being prioritized.
- The group of people needing to submit documentation has dropped, indicating initial outreach is working.
- Arizona has prioritized using ex parte renewals.
- CMS flexibility in allowing plans to market a corresponding marketplace product to beneficiaries is “appreciated.”

Carl Feldman (PA Medicaid)

- PA Medicaid has identified 525,000 factually ineligible individuals for quicker disenrollment.
- PA’s PHE unwinding process will occur between 6 and 12 months. Without additional federal funding beyond the quarter in which the PHE ends, PA will be forced to expedite its unwinding due to budget uncertainty.
- Distributing the redetermination work evenly is important to avoid workforce burnout and errors. Medicaid renewals will be aligned with SNAP renewals to minimize duplicative work.
- Pennsylvania has increased the flow of letters and communication to beneficiaries, including new reminders about the 90-day reconsideration period post-disenrollment.
- Constant communication with managed care plans and community partners is vital. Pennsylvania has not suffered the workforce challenges of other states, and 93% of its eligibility workforce is intact.
- PA’s ex parte renewal rate is low because of the way its integrated eligibility system is structured.

Jodi Ray (FL Beneficiary Advocate)

- Florida has not shared its plans for redeterminations, and the beneficiary advocacy community is disappointed with the state.
- In particular, there is significant concern that the state is not equipped to help people transition seamlessly to new coverage.



- Florida has one of the lowest ex parte renewal rates in the country, which drains administrative resources and leads to churn. CHIP and Medicaid program systems cannot share some information, which increases the administrative burden.
- The state will be using artificial intelligence (AI) to text message and email beneficiaries. They are also increasing reliance on technology such as an AI assisted chat box to assist with the renewal process.
- There is a concern that the state's outreach efforts will be ineffective given the varying English proficiency levels of Florida's Medicaid population.
- Florida has not adopted many "best practices" of other states, including heavy engagement with MCOs.

Commissioners' Comments

- Commissioners asked about what the states are doing when there are indications that beneficiaries have moved, such as returned mail. Both Jami Snyder and Carl Feldman replied that their states are taking a more active role than they had in the past to address returned mail. In Arizona, all contracted health plans are becoming "community assister organizations," so they can help individuals remain on the rolls more directly. Commissioners emphasized the importance of transparency, highlighting the varying levels of communications from states on unwinding plans. Commissioners also asked Jodi, the beneficiary advocate, for one takeaway she could provide on what would help beneficiaries most immediately, to which she replied that engagement of community-level stakeholders was most critical. MACPAC will continue highlighting the PHE unwinding.

Session 3: Improving rate setting and risk mitigation in Medicaid managed care

Presenters:

- *Sean Dunbar, Principal Analyst*

Background

- As a part of the Commission's broader work on managed care oversight, MACPAC staff investigated rate setting and risk mitigation practices in state MCO contracts during the Commission's last report cycle.
- Staff conducted several studies on managed care rate setting and CMS's available oversight tools. These included stakeholder interviews.
- CMS is preparing to issue two rules with implications for managed care rate setting.
 - One rule focuses on defining access
 - One rule addresses in lieu of services (ILOS) and directed payments
- These rules offer MACPAC the chance to comment on numerous policy areas, which analyst Sean Dunbar presented for Commissioner discussion. In other areas unlikely to be addressed soon by CMS rulemaking, MACPAC can still offer commentary.

Policy Areas Likely to be Considered through Rulemaking

- CMS is considering adding further clarity to treatment of ILOS in capitation rates. Currently, many ILOS are considered value added benefits and can only be funded through the nonmedical portion of the capitation rate. CMS is getting an increasing number of questions from states on these services, driving the need for further clarity. States are also interested in addressing social determinants of health (SDOH) concerns via ILOS payments.
- Directed payments too often have an unclear link to quality and access goals, while complicating rate review and approval. MACPAC received feedback from MCOs that they often have no ability to review rate assumptions in advance, and actuaries rarely

review directed payments. CMS is looking to issue rules around the approval process for directed payments.

- Accounting for access in rates is an area of interest to stakeholders and MACPAC. Currently, plans and actuaries feel as though they have limited tools to address access and current access metrics (e.g. time and distance) are out of date.

Policy Areas Unlikely to be Considered in Rulemaking

- While CMS is unlikely to use its rulemaking authority to address expedited or midyear rate review/changes, these topics could be ripe for MACPAC comment if Commissioners can agree on a set of recommendations to improve the process. Plans expressed concern about the future use of retroactive risk corridors as was done during the pandemic, as well as a desire for greater transparency in general during rate setting. CMS would like the ability to approve or disapprove parts of rates (known as partial deferral authority), however it has determined that this requires a statutory change. This authority was requested in the President's 2022 budget. Stakeholders interviewed were split on whether this would be helpful.
- Retroactive risk mitigation tools are controversial; plans found them disruptive while states found them helpful.
- Transparency in rate setting was popular with plans, which said that it better allowed them to meet state program goals.
- MACPAC staff would like to know, for both the areas that are likely to come up in rulemaking and those that are not, which policies Commissioners would like them to do a deeper analysis of for potential comment or policy recommendations. In particular, is the Commission interested in pursuing a potential recommendation on partial deferral authority?

Commissioners' Comments

- Commissioners expressed skepticism of recommendations on retroactive risk corridors. This was agreed to be dropped from further study. Commissioners split on partial rate deferral authority, with some wondering if it was necessary. MACPAC staff will study it more and bring back findings to a future meeting. All Commissioners agreed that there should be recommendations on rate transparency. Commissioners also expressed interest in access requirements, including rethinking time and distance standards and assessing rural access and access across state lines.

Session 4: Principles for assessing Medicaid nursing facility payments relative to costs

Presenters:

- *Drew Gerber, Analyst*
- *Rob Nelb, Principal Analyst*

Background

- Medicaid is a primary source of coverage for long term nursing facility residents (those staying over 100 days). Most of these residents are dually eligible for Medicare and Medicaid, and Medicare Part A covers their first 100 days of care and Medicare Part B covers many therapy services.
- Since 2019, MACPAC has been assessing nursing facility payments, with a special focus on fee-for-service (FFS) payment models and ways to promote adequate staffing, including via feedback from a technical expert panel on the data collected.
- Now, MACPAC staff is synthesizing its findings into a report that outlines policy principles for states to consider.

Findings

- Medicaid-covered residents are generally lower cost than Medicare ones.



- States make base payments and supplemental payments to nursing facilities. Payments must be consistent with “efficiency, economy, quality and access” (statutory requirement).
- MACPAC convened a technical expert panel to examine payments and the reliability of federal data sources to measure Medicaid payments
- In the 24 states with managed long-term services and supports (MLTSS), MACPAC found that FFS rates and managed care payment rates are similar.
- Nationwide, MACPAC found that 10% of nursing costs on average are paid by contributions from the patients’ assets.
- There is wide variation across states in the percentage of a facility’s costs that are paid by Medicaid.
- Facilities with higher staffing rates paid their workers a higher wage. However, there was no clear relationship between Medicaid payment rates and staffing. Facilities with lower staffing had higher margins, since they were spending less on staff.
- CMS is exploring adding staffing requirements via the rulemaking process, which could alter the staffing dynamic.
- Overall, data is unreliable and data collection standards need to be strengthened.
- Potential recommendations center around improving data collection on all Medicaid payments that providers receive, requiring states to regularly assess payment rates and outcomes, and allowing the testing of new models for integrating further integration of care for dually eligible patients.

Commissioners’ Comment

- There was strong interest by Commissioners in the intersection of Medicaid payment and nursing home quality. Commissioners expressed a concern that raising payment rates doesn’t always translate into higher quality care, particularly among for-profit operators looking to cut staff. Commissioners noted that the proliferation of supplemental payments has added complexity to the process and decreased transparency. Commissioners also called for more data on whether for-profit facilities are more likely to have lower levels of staffing. It was noted that for-profit facilities are more likely to serve Medicaid beneficiaries, and the recent trend in private equity consolidation in nursing home ownership was met with concern. There was broad agreement on the potential for recommendations around cost transparency and data collection. Also, commissioners discussed potentially commenting on the personal care allowance, the amount of money they can keep after contributing to their care.
- Next steps are draft recommendations within a chapter for the next report to Congress.

Session 5: Countercyclical disproportionate share hospital payment policies

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 higher unemployment).

- These recommendations excluded DSH, because DSH is capped by a fixed federal allotment. A higher overall FMAP results in a state drawing federal funding at a faster rate, but doesn't change the total amount it is eligible to receive.
- During past economic downturns, Congress has implemented countercyclical DSH policies to cushion the blow of increased uncompensated care.
 - 2009 American Recovery and Reinvestment Act (ARRA): increased federal DSH allotments by a fixed amount without enhanced FMAP for DSH payments
 - 2020 Families First Coronavirus Response Act (FFCRA): enhanced FMAP for DSH payments, but no change in DSH allotments
 - 2021 American Rescue Plan Act (ARPA): enhanced FMAP for DSH payments, and increased DSH allotments while requiring states to increase their DSH spending

Countercyclical DSH policy	Support for hospital uncompensated care	Support for states	Administrative simplicity of setting DSH allotments
Increased FMAP, but no increased allotment (FFCRA policy)	Reduces total DSH funding	Yes	Same as FMAP
No increased FMAP, increased allotment (ARRA policy)	Increases total DSH funding	No	Would require consideration of factors other than FMAP
Increased FMAP and increased allotment (ARPA policy)	Same total DSH funding, likely more net payments for public hospitals	Yes	Same as FMAP

- DSH payments are often financed through provider taxes and intergovernmental transfers from public hospitals
- The benefits of the increased FMAP often accrued to states rather than providers. Many states did not ease the provider tax burden even with the enhanced FMAP, so providers did not see that much of a benefit.
- Analysts also examined the administrative simplicity of the three proposals. The ARPA policy was favored, given its relative administrative simplicity and the likelihood of increased funding for hospitals.

Commissioners' Comment

- Commissioners supported an ARPA-like approach, and the staff will prepare recommendations for a future meeting. An ARPA-like approach could be implemented as an addition to the Commission's current countercyclical funding recommendation for Medicaid as a whole.

Session 6: Medicaid coverage of monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease

Presenters:

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

Medicaid Drug Rebate Program (MDRP) Background

- MACPAC analyst Chris Park provided background on the Medicaid Drug Rebate Program (MDRP), which governs what drugs are covered on Medicaid. Under MDRP, all drug manufacturers must provide rebates in exchange for their products to be recognized for the federal Medicaid match. Generally, states cover participating manufacturers' products, but have the ability to limit the use of a particular drug through utilization management tools such as prior authorization or preferred drug lists.
- Once a manufacturer's product has been approved by the FDA and entered the market, under the MDRP, the state is required to cover all of their participating products.



However, plans sold on health insurance exchanges and Medicare Part D plans must comply with applicable minimum requirements for drug coverage, but are still allowed to exclude coverage of some drugs. Those plans also have 90 to 180 days following a new manufacturer's release of a product to evaluate before making a decision on coverage.

- Included under the MDRP are rebates set in place that are based on the average manufacturer price (AMP). Those rebates differ for brand and generic drugs.
 - Brand drugs: basic rebate calculated as the greater of 23.1% of AMP or AMP minus best price. Best price is defined as the lowest price available.
 - An additional inflationary rebate is applied if the increase in a drug's AMP exceeds the rate of inflation over time.
 - Generic drugs: basic rebate is 13% of AMP with no best price provision.
 - An inflationary rebate can be applied, and until January 1, 2024, the total rebate a state receives on a drug cannot exceed 100% of AMP. After January 1, 2024, the cap will be lifted and the total rebate can exceed 100%.
- States can negotiate supplemental rebates with manufacturers in addition to the federal rebates. Manufacturers can provide rebates to ensure that their products are included on a state's preferred drug list.
- Physician-administered drugs are typically prescribed and administered by a health care provider and are unique in that their inclusion in the MDRP depends on how the state pays for the drug. If the state pays for the drug as part of a bundled service, then it can be claimed in the statutory rebate. But, if the state makes a direct payment for the drug, separate from other services, it can be claimed in the rebate.
- Under Medicare, prescription drugs are covered under Part B and D. MACPAC analysts only focused on Part B in their presentation:
 - Covers drugs that typically are not self-administered by a patient and instead are included as part of a physician's service in an outpatient setting. Part B drugs are paid at 106% of average sales price and generally beneficiaries have a 20% co-insurance.
 - Services covered are only those deemed reasonable and necessary. Therefore, for drugs, this means Part B generally covers FDA-approved drugs for on-label indications and other approved uses.

FDA approval of drugs:

- The FDA has a few different ways that they can go about approving drugs.
 - The traditional pathway mandates manufacturers demonstrate that the drug provides clinical benefit.
 - Accelerated approval pathway allows the FDA to grant approval based on whether the drug shows an indication of some clinical benefit.

Aduhelm and anti-amyloid monoclonal antibodies for the treatment of Alzheimer's disease:

- In June of 2021, the FDA granted accelerated approval of Aduhelm for the treatment of Alzheimer's disease. This approval was granted against the recommendation of the FDA's advisory board, which argued there was insufficient evidence of a clinical benefit because of conflicting results in two trials presented for consideration. Additional concerns voiced by the board included, safety concerns and an overly broad indication of individuals with Alzheimer's. There was also apprehension over the price of Aduhelm. Initial Aduhelm treatment averaged over \$56,000 a year, per patient; however the manufacturer lowered the price to \$28,000 in December 2021.
- The population for treatment for drugs like Aduhelm is large, over six million people in the U.S. are estimated to have Alzheimer's disease. Of those six million, a large majority



of those individuals are 65 and older, so they're most likely to be covered by Medicare. With the current price, Medicare Part B spending and beneficiary cost sharing is estimated to be \$1.5 billion per year for every 50,000 beneficiaries who receive the treatment.

- Because of the large concerns about the treatment's effectiveness and potential costs, many stakeholders requested that CMS initiate a NCD (national coverage determination) to narrow its use. A final decision was made in April 2022 that allowed coverage of Aduhelm—under a coverage with evidence development (CED) policy—which allows Medicare recipients to access Aduhelm if they are part of a CMS-approved study that includes data collection. The CED applies to the entire class of anti-amyloid monoclonal antibodies and three more in this class of drug are under development.

Implications for Medicaid:

- With the FDA's approval of Aduhelm, states are now required to cover Aduhelm and any future drugs in that class, once approved. For non-dually eligible Medicaid beneficiaries, a state must cover all medically accepted indicators but could implement prior authorization to manage utilization. For dually eligible beneficiaries, coverage is limited to the terms of the Medicare NCD.
- According to statute, a drug not covered under Part B is covered under Part D. Since Medicaid does not pay for Part D drugs, Medicaid is not a payer of a last resort when Aduhelm (or drugs of that class) are not covered under the NCD.

Number of Medicaid Enrollees with Diagnosis of Alzheimer's Disease or Mild Cognitive Impairment:

- MACPAC conducted an analysis of 2019 Medicare and Medicaid data to estimate the potential number of beneficiaries with mild cognitive impairment or Alzheimer's disease who may qualify for treatment with Aduhelm or other anti-amyloid monoclonal antibodies. Their analysis compared low and high population estimates. The low estimate included individuals with both a diagnosis of Alzheimer's and a mild cognitive impairment, and the high estimate looked at individuals with either a diagnosis of Alzheimer's or a mild cognitive impairment.



Number of Medicaid Enrollees with Diagnosis of Alzheimer's Disease or Mild Cognitive Impairment, CY 2019

Group	Low population estimate (both Alzheimer's disease and mild cognitive impairment)	High population estimate (either Alzheimer's disease or mild cognitive impairment)
Non-dually eligible	1,027	59,564
Dually eligible	23,530	649,753
Full dual	21,764	599,875
Partial – QMB	891	26,090
Partial – Other	875	23,788
Total	24,557	709,317

Notes: QMB is Qualified Medicare beneficiary. Dually eligible status was assigned using dual-eligible indicators from Medicare eligibility records. Low population estimate includes individuals who had at least one claim with a diagnosis of Alzheimer's disease and one claim with a diagnosis of mild cognitive impairment during the year. High population estimate includes individuals who had at least one claim with a diagnosis of Alzheimer's disease or one claim with a diagnosis of mild cognitive impairment during the year. Because we used only diagnoses from Medicare fee-for-service claims to identify the relevant conditions, the count of dually eligible beneficiaries is understated.
Sources: MACPAC, 2022, analysis of T-MSIS data as of December 2020 and Medicare data from the Medicare Enrollment Database, Common Medicare Environment, and Medicare Common Working File.

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- Their analysis estimated anywhere between 1,000 and 60,000 non-dually eligible Medicaid beneficiaries that could be eligible for treatment. Given state's obligation to pay 20% co-insurance for full-benefit dually eligible beneficiaries, Medicaid could have a responsibility for about 22,000 to 626,000 individuals.



- Based on the number of non-dually eligible Medicaid beneficiaries with Alzheimer’s disease or mild cognitive impairment, states could spend anywhere from \$29 million to \$3.3 billion in gross drug costs. Those estimates were calculated by using the low and high averages of Aduhelm.
 - Low price of \$28,000 for Aduhelm– states are estimated to spend anywhere from \$29 million to \$1.7 billion
 - High cost of Aduhelm at \$56,000–states could spend between \$57 million and \$3.3 billion

Potential Policy Options

- The National Association of Medicaid Directors (NAMD) asked CMS to give states flexibility for applying the same coverage requirements as Medicare –limit use to participation in a clinical trial. However, given the MDRP coverage requirements are in statute, CMS does not have the executive authority to allow states to restrict coverage similar to Medicare NCD.
- It is possible that a beneficiary or drug manufacturer could challenge the state’s coverage criteria, leaving it up to the courts to decide.
- The Commission could consider recommending an amendment to the Medicare Drug Rebate Program allowing states to exclude, or restrict, coverage of a covered patient drug based on a Medicare NCD, including any CED requirements.

Commissioners’ Comments

Commissioners discussed in great lengths the Medicare guidelines and recommendations as it pertains to Aduhelm and other anti-amyloid monoclonal antibody treatments. It was made clear that their concerns are not focused on the merits of Aduhelm but instead on discussing the flexibility that should be allowed by states to follow certain Medicare guidelines. There was concern by some commissioners on the effectiveness of the drug and they voiced that instead of focusing on how much the medication costs, they should only be focusing on the effectiveness of it. It was clear from their discussion that more evidence is needed on Aduhelm and the Commissioners asked for MACPAC analysts to gather more information on the study of Aduhelm and agreed this is a topic they want to look into more.

Session 7.1: Review of proposed rule on core set reporting and Congressional request for information on long-term services and supports

Presenters:

- *Joanne Jee, Policy Director and Congressional Liaison*
- *Tamara Huson, Analyst*

Background

- MACPAC analysts provided background on the standardized measures for assessing quality of care for individuals enrolled in Medicaid and CHIP. As it stands, there are currently core sets for children, adults, health homes, maternity care, and behavioral health. Currently reporting by states is done on a voluntary basis, but as of January 1, 2024, reporting for child core sets and the behavioral health measures of the adult core set will be made mandatory.

Proposed Rule, Updates and Guidelines

- Issued in the proposed rule are a few key requirements for reporting on child core sets and the behavioral health measures of the adult core sets, as well as some of the health home core set measures. Those requirements are for all states, including Washington D.C., and some territories (Puerto Rico, US Virgin Islands, Guam) as well as any state



that has implemented health homes under Section 1945 and Section 1945A of the Social Security Act.

- The proposed rule requires the Secretary of the Department of Health and Human Services (HHS) to recognize and annually update the core sets in discussion with states and stakeholders.
- States will be required to adhere to the Secretary's guidelines for reporting on an annual basis. The guidelines issued by the Secretary will include information on specifications for measure calculations as well as requirements related to stratification of said measures.
- The rule requires states to report on children enrolled separately in Medicaid (including Medicaid-expansion CHIP), S-CHIP as well as a combined population from these programs. It was noted that the rule acknowledges the high churn in children going on and off programs and specifies that the Secretary will issue guidance on attribution of reporting for this population.

Potential areas for comment by the Commission

1. Phase-in: MACPAC's previous work regarding states' need for sufficient lead time to prepare for mandatory reporting.
2. Stratification: MACPAC's previous June report ([found here](#)) on the need to address health disparities and improve data collection.
3. State Burden: MACPAC's previous report in March ([found here](#)) described state burden and capacity constraints and considerations for mandatory reporting.
4. Technical Assistance Needs: MACPAC has reported on the technical assistance needs of states, including for FFS populations, EHR data, non-Medicaid data sources, EQROs, and behavioral health measures.
5. Adherence to guidelines: States will need guidance and technical assistance (TA) in a number of areas (a sentiment echoed by state officials in their discussions with MACPAC staff). Reporting on S-CHIP enrollees: Whether to report on children in S-CHIP separately or combined with Medicaid children. Currently states do not always report on children in S-CHIP.
6. Need for specific and timely guidance: MACPAC previously described states' need for early and clear guidance. Although the proposed rule provides some information about the framework, it does so at a pretty high level, with no clarification on when the guidance will be issued.

Commissioners' Comments

Commissioners discussed the need for an expedited release of guidance by the Secretary. 2024 is not that far away and states need to be well prepared to meet new requirements. In regards to stratification, the Commissioners agreed that they would like to see some more specificity in these rules. It was also noted that there is no such thing as perfect data, therefore there needs to be an end date provided so that states can move forward and release data for transparency with other states as well as the federal government. MACPAC analysts suggested multiple areas that the Commissioners could report back to the Secretary. Following the Commissioners' discussion, MACPAC analysts are to compile their suggestions and compose a draft letter ready for review before the October deadline.

Session 7.2: Request for Information on Disability Policies

Presenters:

- *Joanne Jee, Policy Director and Congressional Liaison*
- *Tamara Huson, Analyst*



Background

- On July 27, 2022, the House Energy and Commerce Committee minority staff issued a request for information (RFI) on, “Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion.” Included in the RFI were several questions related to how best to remove current barriers that limit meaningful community living for disabled people. MACPAC analysts requested feedback from the Commissioners for inclusion in their draft comment letter response to the RFI.
- The RFI listed three priority areas of concern:
 - a. LTSS access
 - b. Community accommodations
 - c. Barriers to integrated employment & estate recovery

Potential areas for MACPAC comment

- HCBS waivers/LTSS access:
 - In 2020, MACPAC analyzed Section 1915(C) and Section 1115 documents for all 50 states and D.C., which included potential areas for comment by the Commission as it relates to waiver waiting lists and their variation in size.
 - However, the length of each state’s waiting list does not accurately depict the measure of unmet needs for HCBS waiver services.
- Barriers faced by states when trying to increase access to HCBS: The RFI requested specific tools to improve states’ ability to expand access. MACPAC analysts highlighted a few potential areas:
 - Nature of HCBS benefits in Medicaid
 - Lack of executive and legislative champions, as well as state level advocates available to provide expertise.
- Estate recovery: In March 2021, MACPAC published a report to Congress on estate recovery that included three recommendations. In the RFI requested by the House Energy and Commerce Committee, their RFI specifically asks for feedback on MACPAC’s first recommendation on making estate recovery an optional benefit.
 - Congress should amend the Social Security Act, defaulting to estate recovery being an option, to help lessen the burden of estate recovery on beneficiaries and states.
 - Some beneficiaries postpone their Medicaid enrollment over worrying about estate recovery and losing their homes.
 - Estate recovery efforts are limited in some situations because of the large percentage of modest homes held by older adults.

Commissioners’ Comments

There was discussion by a few commissioners on the concern on length of waiting lists. LTSS waiting lists differ in age group, and other factors, and there was some hesitancy on whether the length of waiting lists is a legitimate concern. The Commissioners were reminded that the only ask of the House Energy and Commerce Committee was feedback and therefore the goal of the Commissioners is to reinforce the recommendations that they have already drafted along with highlights of their work. Overall, the Commissioners applauded the recommendations provided by MACPAC analysts and directed MACPAC analysts to go back and draft a comment letter in response to the RFI.

Session 8: Panel on integrating care for dually eligible beneficiaries in Medicaid fee-for-service (FFS)

Presenters:

- Drew Gerber, Analyst
- Kirstin Blom, Acting Policy Director

Panelists:

- Kelli Emans, Integration Manager, Home and Community Services Division, Washington Aging and Long-Term Support Administration
- Katherine Rogers, Director, Long-Term Care Administration, District of Columbia Department of Health Care Finance
- Olivia Alford, Director, Delivery System Reform, Office of MaineCare Services

Background

- MACPAC staffers provided a brief background on the Commission's recent recommendation to Congress (in June) asking for the Secretary of the U.S. Department of Health and Human Services to require states to develop a strategy for integrated Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries. MACPAC staffer Drew Gerber introduced three Medicaid state officials who presented on their experience implementing an integrated Medicaid and Medicare care model, in FFS states, for dually eligible populations, as well as any challenges faced.

Panel

- **Kelli Emans, Integration Manager for the Home and Community Services Division within the Aging and Long-term Support Administration in the State of Washington**
 - During initial implementation of an integrated model in Washington (2011) the state was predominantly a FFS state with respect to services provided to most its dually eligible population (both for Medicaid and Medicare).
 - In 2011, Washington was chosen to participate in CMS's Financial Alignment Demonstration program for dually-eligible Individuals, which provided them \$1 million in funding that was used to hire dedicated staff and work with stakeholders to develop their model.
 - The Washington Health Homes Model they developed is partly managed by the Washington Health Care Authority (HCA) and Department of Social and Health Services (DSHS) and is delivered at the community level.
 - The demonstration formally began in 2013, and they received a 90/10 match for eight quarters that helped sustain their program and continue to build it out. Over time, "shared savings" received from the federal government helped them to expand it. In 2016, their match was beginning to run out and they received their first "shared savings" check. Ms. Emans noted that as they started to receive shared savings, it allowed them to break even. Which then allowed them to turn to their state legislature and ask for continued support of their program.
 - As time went on, and shared savings continued to come in, they were able to not only break even, but more money was coming in, which allowed them to put that extra money back into their program, which Ms. Emans noted was crucial. Since 2018, with shared savings continuing to come in, Washington has received \$98.7 million in shared savings.
 - Ms. Emans attributed the success of their duals strategy to stakeholder engagement. This engagement included working with community-based organizations to achieve desired better outcomes and cost savings, integration of

services across medical and social services, and establishment of a single point of contact for enrollees.

- The state contracts with lead entities that are predominantly Area Agencies on Aging or other community-based organizations. These entities are responsible for administrative duties, data collecting, reporting and contract and payment of the care coordination organizations.
 - The care coordination organizations (CCOs), are on the ground, and work directly with beneficiaries. These CCOs are highly qualified and trained by the state to deliver Health Homes services. The purpose of Health Home is to serve as an intensive service delivery focused on actively engaging with clients on behavior change and integration of services on the local level.
 - Washington's intense and robust model is best suited for a targeted population. Their model uses a predictive risk modeling tool that looks at prospective clients' age, gender, and diagnosis to determine a medical risk score. Depending on the risk score, their tool allows them to identify who would most benefit from their high-intensity care coordination and where they are able to help reduce costs.
 - With the large success of their Health Homes Program, they are asking for approval from CMS to make their program permanent. Approval by CMS would ease administrative burden alleviate network instability caused from short-term extensions. Ms. Emans did note that while the managed care Financial Alignment demonstrations are phasing out, their Health Home Model will stay in place for the FFS duals population.
 - Since starting their model in 2013, there have been significant changes in the composition of their Medicaid and Medicare populations. Because of that, they are looking to add similar types of support to their D-SNP contracts with policy goal of including state-specific requirements for D-SNP's to offer Health Homes program.
- **Katherine Rogers, Director, Long-Term Care Administration, District of Columbia (DC) Department of Health Care Finance**
 - Most of DC's aged, blind and disabled populations (20-30% of Medicaid enrollment) are still in a FFS program.
 - In 2018, an internal Medicaid workgroup convened by the Department of Health Care Finance made recommendations for improving management of their remaining FFS populations. The internal workgroup found potential areas (behavioral health, duals populations and long-term care) where the Medicaid agency could do more to impact and improve care.
 - While DC has variety of different program-specific care management programs over the years, they have gradually increased their engagement with D-SNP health plans and MCOs to better leverage their care models to improve outcomes.
 - The agency started having quarterly meetings with the plans. Through these meetings, the agency decided to establish a multi-faceted strategy aimed at addressing such issues as coordination, integration and fragmentation (both opportunities and challenges), with the goal of moving towards a more comprehensive Medicaid managed care model.
 - DC has incorporated an 1115 behavioral health care delivery transformation initiative into its Medicaid state plan.

- A new PACE program will also be launched in January 2023 that is intended to provide a site-based approach to offering a full range of services (acute, primary, long-term services and supports) to its duals population.
- DC’s overall approach has been to work with existing programs and help enhance or expand their operations to cover more eligible beneficiaries and services. She emphasized that working with existing programs helped them to better engage with the thousands of people delivering services on the ground. For example, in 2020 they carved into their existing Medicaid managed care program non-dual adults with disabilities – primarily SSI eligible individuals.
- **Olivia Alford, Director, Delivery System Reform, Office of MaineCare Services**
 - Maine is demographically one of the oldest populations in the country—over 21% of their residents are over the age of 65. It’s also one of the most rural states. These two characteristics make it somewhat unique.
 - Maine’s Medicaid program is entirely FFS and they are focused on multi-payer alignment on alternative payment models rather than delivery system reform efforts. They are still focused on achieving financial alignment for their duals populations even though they haven’t been part of the federal alignment demonstration.
 - Like many other states, Maine is taking an incremental approach and is focused on working to integrate care through their D-SNP contracts (at the same time they are seeing growing enrollment).
 - In the last several years, they have implemented quarterly meetings with their D-SNPs, aimed at creating relationships and collaboration between one another on data collection and strategy. Through this collaboration, Ms. Alford highlighted three examples of their ongoing integration efforts:
 - D-SNP Coordination Requirements – they worked with the D-SNPs to improve coordination with their statewide Health Information Exchange admission, discharge and transfer notifications.
 - Alternative Payment Models – Maine has several alternative payment models in which an individual’s duals status directly impacts payment methodology and reimbursement. They officially aligned these models with Medicare and were able to create more visibility and incentives for integrating care for duals.
 - Integrated Care Strategy – Maine previously issued a request for information (RFI) on managed care strategies and potential alignment opportunities. Following their RFI, Maine is taking next steps in seeking a vendor to conduct an assessment on Maine’s strengths, weaknesses, opportunities and threats as they relate to duals and dually eligible integration. They are currently in the capacity building stage and are working to better understanding what resources they do and do not have.
 - Given what they’ve learned so far, it’s safe to assume that Maine will need flexibility and coordination with CMS and CMMI as they plan to roll out more models.

Commissioners’ Comments

Commissioners discussed the key takeaways from the panel and highlighted their previous recommendations on supporting states with funding to help build capacity and dedicated resources needed for duals integration, as well as their most recent recommending that states be required to develop a strategy. They emphasized the unique role states play and appreciated the chance to better understand what policy levers states still need and where exactly they need

more help and support for their integration efforts. The panelists supported the idea of states having a duals strategy going forward and the need for CMS to make it easier for states to integrate Medicaid and Medicare administrative requirements and financing. This issue was affirmed as a high priority for the Commissioners, and one they will continue to focus on.

