Highlights from MACPAC March Public Meeting

Overview: On March 2, 2023 the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public meeting. Presentation slides and the agenda for this meeting can be found on MACPAC's website.

Session 1: Additional Analyses of Potential Recommendations for Countercyclical Disproportionate Share Hospital (DSH) Allotments

Presenters:

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

Background

- Disproportionate share hospital (DSH) payments are impacted by economic recessions. During a downturn, the number of uninsured patients increases, leading to higher levels of uncompensated care. At the same time, a state's financial situation can worsen, giving it less ability to fund its share of DSH payments.
- In 2021, MACPAC recommended Congress create a countercyclical funding mechanism for the Medicaid Federal Medical Assistance Percentages (FMAP) to help states fund Medicaid during a recession (increasing the federal match during periods of high unemployment). However, a higher FMAP has the perverse effect of reducing the total DSH funds available to states, since DSH payments are capped by a fixed federal allotment. A higher overall FMAP results in a state drawing down its federal allotment faster, which reduces total DSH spending.
- At the September public meeting, MACPAC Commissioners discussed potential policy options for ensuring DSH payments are responsive to changing economic conditions. Commissioners expressed support for a change similar to that included in the American Rescue Plan Act (ARPA), which enhanced the FMAP for DSH payments, but also increased federal DSH allotments to ensure no reduction in total DSH spending. At the October public meeting, Commissioners expressed interest in expanding their recommendation beyond recessions to a more general recommendation that would ensure that federal DSH allotments are not reduced as an FMAP changes, regardless of macroeconomic conditions.
- This session explored a potential policy recommendation on an economic condition-neutral DSH policy and its fiscal implications.

DSH Payments

- The Commission has sought to improve DSH payments with the goals of creating a relationship to a state's measures of need and avoiding disruptions in funding for DSH hospitals.
- A permanent ARPA-like policy (agnostic of macroeconomic conditions) would benefit states with increasing FMAPs. These states are generally seeing increases in their number of non-elderly low-income individuals, and given their increasing FMAPs, will draw down their federal DSH allotments faster without a policy change. .

Changes in DSH Funding Under Different Policies, FYs 2014–2019

Change in state FMAP	Number of states	Average percent change in federal DSH allotment		Average percent change in total available state and federal DSH funding	
		Without adjustment	With ARPA-like adjustment	Without adjustment	With ARPA-like adjustment
Increased FMAP	24	7.5%	11.3%	3.9%	7.5%
Decreased FMAP	11	7.5%	5.8%	9.3%	7.5%
No change to FMAP	16	7.5%	7.5%	7.5%	7.5%

- As the above chart shows, under a permanent ARPA-like policy, states seeing an increased FMAP would have a higher amount of DSH funding available than they would without a policy change. States experiencing a decreasing FMAP would receive a lower amount of funding than previously. In the years 2014-2019, 24 states saw FMAP increases overall, 11 saw FMAP decreases, and 16 saw no change to their FMAP.
- During periods of normal economic growth, an ARPA-like policy would not increase federal spending. This is because reduced spending on states with decreasing FMAPs would roughly equal the increased spending on states with increasing FMAPs. During recessions, an ARPA-like policy would see an increase in federal spending commensurate with FMAP increases, since all states would theoretically see an increased FMAP. Additionally, a permanent ARPA-like policy would prevent reductions in total DSH funding when the FMAP is manually altered by Congress (e.g. in 2011 when Lousiana saw an FMAP increase after being hit with natural disasters). A permanent ARPA-like policy is seen as less administratively burdensome.
- ***Temporary Adjustment Policy Option:*** *Congress should amend Section 1923 of the Social Security Act to increase federal DSH allotments during economic recessions so that total available state and federal DSH funding is the same as it would have been without the application of a countercyclical FMAP. If Congress makes future changes to improve the correlation between state DSH allotments and measures of need for DSH payments, this countercyclical adjustment should be applied after making these changes.*
- ***Permanent Adjustment Policy Option:*** *Congress should amend Section 1923 of the Social Security Act to permanently adjust federal DSH allotments so that total state and federal DSH funding is not affected by changes in the FMAP. If Congress makes future changes to improve the correlation between state DSH allotments and measures of need for DSH payments, the methodology should be based on total state and federal DSH funding.*

<u>Commissioners' Comments</u>
Commissioners broadly (with some dissension) supported the permanent ARPA-like policy. Many viewed the benefits of reduced administrative burden and stronger relationship between DSH payments and a state's actual need as steps in the right direction. Commissioners expressed interest in increased scrutiny of hospitals, with some suggesting that hospitals are being paid money by Medicaid with little oversight and accountability. In particular, imposing an "efficient and economically run" payment standard requirement on hospitals was suggested, like the standard already applied to nursing facilities. States interviewed as stakeholders were generally comfortable with the ARPA-like policy approach already recommended by MACPAC. After some language tweaks, Commissioners are expected to vote to approve the permanent DSH funding recommendation at their next meeting.

Session 2: Considerations for Providing Pre-Release Medicaid Services to Adults Leaving Incarceration

Presenters:

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

Background:

- Analysts continued their work in drafting potential considerations for providing pre-release medicaid services to adults leaving incarceration. For previous MACPAC discussions on this section, please read here.
- Analysts are continuing to watch for further CMS guidance and additional Section 1115 waivers. Following their presentation today, analysts will return in April with a draft discussion chapter for inclusion in their June report to Congress.
- The inmate payment exclusion currently prevents Medicaid payment for services delivered to incarcerated enrollees. Many states are trying to improve outcomes for justice-involved populations, including temporarily suspending Medicaid benefits rather than full termination upon incarceration, as well as providing state funded in-reach services.
- So far, only one state (California) has been approved for a 1115 waiver demonstration to provide pre-release services. However, through their research, MACPAC analysts found 14 other states with 1115 waiver requests currently pending CMS approval.

California Section 1115 Demonstration:

- With CMS approval, California is set to receive federal matching funds for a targeted set of pre-release services provided up to 90 days of pre-release. CMS has noted that additional approved waivers will closely align with the demonstration approved in California.
- California's demonstration is limited to adults and youths in state prisons and local jails who meet specified health-related criteria. Excluded from this demonstration are individuals in federal prisons, as well as children and foster care populations. Also approved in their waiver is funding for one-time transitional investments such as, data system updates and cross-sector collaboration.
- The demonstration includes an implementation plan that will lay out how California plans to operationalize Medicaid coverage and delivery of pre-release services. The federal match allowed is contingent on California implementing their plan and achieving a certain set of milestones.

- California is expected to closely monitor and evaluate their demonstration and report quarterly and annually to CMS.

Potential Implementation Considerations for Future Waivers: While conducting their analysis, MACPAC analysts worked with state officials and key stakeholders to gather feedback on potential areas they hope to be included in potential waivers.

- Cross agency collaboration: Clear and constant coordination between Medicaid and correction authorities. This includes engagement with state departments of corrections and local authorities who oversee jails.
    - Promoting cross-agency collaboration: This includes convenings, technical assistance, and support for administrative capabilities.
- Data Sharing and Infrastructure:
    - Ensuring data information is being exchanged between Medicaid and state/local corrections authorities. It was noted that this will be costly and time-consuming but necessary for achieving the best outcomes.
    - Sharing patient information between corrections and community health providers. Suggestions included utilization of electronic health records and the use of health information exchanges. Stakeholders voiced the concerns that patient data is currently limited, if available at all, and there is currently no capacity for corrections and community providers to share it when it exists.
    - Potential establishment of systems for Medicaid billing –which will require additional support and staff resources.
- Providers:
    - Clear determination of who will provide the pre-release services. In California's demonstration, either community based or carceral providers can provide these services and they do not have to be Medicaid enrolled.
    - Consider looking at the capacity of community-based providers to support individuals post-release.
- Maintenance Effort:
    - Reviewing the role of Medicaid versus state and local correctional authorities. State and local correctional authorities must be able to provide health care services to incarcerated individuals. In California's demonstration, the state is required to reinvest the matching funds when services are already provided by a carceral authority.
- Monitoring and Evaluating:
    - Strengthening monitoring and evaluation is important for pre-release services and in doing so, has the potential for enhanced monitoring and policy-specific guidance.

<u>Commissioners' Comments</u>

Commissioners voiced their overall support for efforts to improve healthcare for the incarcerated population and noted that this topic fits well with the Commissioners' work to improve continuity of care. A few commissioners questioned why dental coverage was not included anywhere in the presentation of this issue. Analysts noted that unfortunately the majority of states seeking waivers are only requesting flexibility to offer specific services and did not find any state with dental requests. However, they did acknowledge the importance of dental coverage and will look for anything they can find in their further research. Commissioners emphasized the importance of looking at the role that community-based organizations can play, especially with respect to addressing social determinants of health (SDOH).

Session 3: Update on Unwinding the Continuous Coverage Requirements and Other Flexibilities

Presenter:

- *Martha Heberlein, Principal Analyst and Research Advisor*

Background

- Following previous discussions on the unwinding process following the end of the Public Health Emergency (PHE), a MACPAC advisor provided a brief background on where things currently stand. See previous MACPAC discussion here.
- Under the Families First Coronavirus Response Act (FFCRA, P.L.116-127), states were eligible to receive a 6.2% point increase in the federal match if they did not disenroll individuals during the PHE.
- However the correlation between the end of the continuous coverage requirement and the PHE created immense uncertainty and affected planning efforts for states. However, implementation of the Consolidated Appropriations (CAA) Act of 2023 made numerous changes to the provisions originally set in the FFCRA.
- With the CAA in place, continuous coverage will now end on March 31, 2023. Following its discontinuation, states will have 14 months to complete all pending actions and have 12 months to initiate the renewal process.
    - Under the CAA, in order for states to still receive the enhanced match rate through the remainder of 2023, states must: comply with existing requirements regarding the renewal process, at least more than one attempt to ensure current beneficiary contact , and conduct outreach following returned mail renewals.

Interview findings:

- Process initiation: States have been working with CMS in preparation for unwinding the continuous coverage requirements for quite some time.
    - There seems to be an overall sense from states that they have solidified their plans and a few states have already begun the redetermination process. There has been a communication shift in some states, changing the tone from updating contact information to informing enrollees that the renewal process has begun.
- States have been seeking updated contact information throughout the PHE, but new requirements included in the CAA could affect existing processes and systems. The highly anticipated volume of returned mail is posing a challenge to states and ongoing staffing concerns.
- Meeting reporting requirements: data concerning exchange enrollment has shown to be more challenging for states to report on.
- Workforce constraints: a majority of states are looking at multiple strategies to address the ongoing staffing constraints. Both CMS and states are also frantically trying to juggle multiple priorities that include phasing out other flexibilities.

Next Steps:

- MACPAC analysts are continuing to monitor state progress throughout the unwinding period. They anticipate further state-level information (e.g., implementation dates, timelines) to be available sometime in April. *Note: CMS released a list of timelines for state implementation of unwinding-related Medicaid renewals the day after MACPAC's meeting.*

<u>Commissioners' Comments</u>

The Commissioners thanked the MACPAC analysts for their continued research on the unwinding process and thought the presentation accurately depicted the overall message heard during their unwinding panel back in January (see here). There was discussion on the return

mail issue that states are facing and curiosity about what happens when mail is returned after the eligibility window closes. MACPAC analysts will continue to follow this closely and will report new findings to the Commission.

Session 4: Focus Group Findings: Experiences of Full-Benefit Dually Eligible Beneficiaries in Integrated Care Models

Presenters:

- *Tamara Huson, Analyst*
- *Kirstin Blom, Policy Director*

Background:

- Integrating care for those dually eligible for Medicaid and Medicare ("duals") is a key topic of interest to MACPAC.
- In 2020, 12.2 million individuals were enrolled in both programs. Typically, Medicare is the primary payer for acute and post-acute care, while Medicaid is the secondary payer and wraps around Medicare. Medicaid plays a key role in paying for long term services and supports. Division of coverage between the two programs can result in uncoordinated care and improper cost shifting.
- Integrated care is intended to align delivery, payment and administration of Medicaid and Medicare, which may improve care and reduce costs. As of 2020, just over 1 million duals received coverage through what qualifies as a highly integrated model.
- Types of integrated care models:
  - Medicare-Medicaid plans (MMPs) provide all services through a single plan and are paid with capitation.
  - Dual eligible special needs plans (D-SNPs) provide Medicare coverage and can coordinate or cover Medicaid depending on the type of plan. Some are coordination-only (CO D-SNPs), and only coordinate Medicaid services. Others are highly integrated or fully integrated (HIDE/FIDE SNPs) and cover some or all Medicaid services and are therefore more integrated.
  - One state, Washington, uses a "managed fee-for service" (FFS) model that uses health homes for integrated care.
- MACPAC is interested in feedback from dually eligible beneficiaries in these plans about how satisfied they are with their coverage and access to care. It contracted with the National Opinion Research Center at the University of Chicago to conduct focus groups with people in integrated plans. Ten focus groups were conducted virtually between November 2022 and January 2023, with one held in Spanish. Additional in-depth interviews were conducted via phone due to difficulties recruiting focus groups. Overall, 55 beneficiaries were interviewed. The focus group included 21 people enrolled in CO D-SNPs and 34 in plans with higher levels of integration to help better understand the impact of increased integration.
- Beneficiaries came from four states, chosen for diversity in socioeconomic status, politics, integration models, rurality (percent living in non-metro areas) and population. The chart below shows the states chosen and the various models offered. Note: New York's MMP plan is the fully integrated duals advantage plan for the I/DD population.

States	Plan types					State population (millions)	Rurality[1]
	FIDE SNP	HIDE SNP	MMP	Managed FFS	CO D-SNP		
Nebraska		X			X	2.0	34.9%
New York	X	X	X[2]		X	19.8	7.0
South Carolina			X		X	5.2	14.5
Texas		X	X		X	29.5	10.8
Washington		X		X	X	7.7	10.2

Findings

- *Enrollment Experiences:* Participants described receiving assistance from brokers, the internet and family and friends in enrolling. There was no notable difference in enrollment experience between those in higher vs. lower levels of integration. Of most importance when enrolling was the ability to keep primary care providers, access to specialists, and cost.
- *Access to Providers:* Most participants were more concerned about access to Medicare-covered services such as primary care, urgent care and specialty care. Participants reported easy access to primary care and said that they had a primary care provider. Participants indicated they rely on urgent care, and wanted it to be easily accessible. There was no appreciable difference across the levels of integration in access to providers, most beneficiaries reported that they did not have difficulty finding specialists accepting new patients. Rural patients did report more access issues. Participants with mental health care needs expressed more concern over provider access and cited long wait times and high turnover as issues.
- *Care Coordination:* Half of focus group participants reported having a dedicated care coordinator. This varied widely by state and by plan– generally, the less integrated the plan, the less likely a beneficiary was to have a care coordinator. Experiences with care coordination were mixed– many with coordinators employed by the state (instead of the plan) reported higher satisfaction. Many reported frequent care coordinator turnover.
- *Medicaid Benefit Coverage:* Multiple participants noted turnover of home health aides as a challenge. Many people were generally thankful for transportation benefits.
- *Experiences with Health Plans:* Interactions with the plans largely centered around the customer service line. Very few participants were familiar with the ombudsman process, or the appeals and grievance process. Participants reported receiving accidental unexpected medical bills, but had a positive experience working with plans to resolve them.
- *Overall Satisfaction:* Beneficiaries were generally satisfied and most did not report unmet needs. More participants reporting unmet needs were enrolled in higher levels of integrated plans. Integrated plans received a slightly larger range of ratings on a 1-5 star scale, reflecting a broader range of opinions. Those with higher levels of care integration were more likely to have a relationship with their care coordinator.

<u>Commissioners' Comments</u>

Commissioners expressed support for this research, and emphasized the ongoing importance of interviewing beneficiaries. Commissioners suggested that this research illustrates the benefits of integrating care for duals, and will include the summary of the findings in the June report to

Congress. Commissioners cautioned against making judgements from the slight overperformance of the less fully integrated plans. Many of the more fully integrated plans (e.g. the New York MMP for I/DD) serve some of the most in need beneficiaries in the entire Medicaid program. Those in highly integrated plans may have more interaction with the plan, thus inadvertently exposing faults that may not be apparent to someone in a less highly integrated plan. Commissioners also agreed that care coordinators employed by the state are more effective than those employed by plans. States, they suggested, are advocates for patients while plans could be more preoccupied with utilization management.

Session 5: Panel on State Flexibilities to Coordinate Care in the Absence of Full-Risk Capitation

Presenters:

- *Sean Dunbar, Principal Analyst*

Panelists:

- *William Halsey, LCSW, MBA, Deputy Director of Medicaid and Division of Health Services, Connecticut Department of Social Services*
- *Juliet Charron, MPH, Medicaid Division Administrator, Idaho Department of Health and Welfare*
- *Ashley Berliner, MPA, Director of Healthcare Policy and Planning, Vermont Agency of Human Services*

Background

- While the majority of Medicaid beneficiaries are enrolled in managed care plans, some states still choose a fee-for-service (FFS) or alternative arrangement for most or all Medicaid beneficiaries.
- Panelists from three states with limited managed care described their delivery systems and how they approach care coordination for beneficiaries without the managed care model.

Panelists

William Halsey (CT)

- Connecticut used to have managed care. At first, providers and patients complained about insufficient access to dental and behavioral healthcare. Lawmakers in 2006 carved these services out of managed care and into a FFS arrangement. However, after controversy around whether managed care organizations were "transparent" enough about their costs, the state eliminated the program in 2012.
- There is not currently an appetite to return to a managed care arrangement. Instead, the state contracts with Accountable Service Organizations (ASOs). These ASOs manage the Medicaid program, and do many of the same things as MCOs (e.g. provider relations and utilization management). However, they do not pay claims and they do not assume any risk for the beneficiary. ASOs have financial incentives for performance and help run a fully integrated claims system with one fee schedule. ASOs are also used for implementing new policies.
- Connecticut has had some trouble collecting data with its ASO system. There is a difficulty in understanding access, and potential shortfalls. In order to understand feedback from beneficiaries, the state has leaned heavily on a consumer advisory council set up by each of the ASOs. The state is also looking to do a comprehensive rate study in the near future.

Juliet Charron (ID)

- Idaho is mostly in FFS, but dual-eligibles are in MCOs and there is a standalone behavioral health plan. The state used to use primary care case management (PCCM) but stopped after realizing the model was not containing enough costs. Instead, it has created a brand new value care organization model. Providers in this program are held to cost targets and assume some degree of risk. This new model focuses mostly on acute care and does not include long term care, pharmacy, dental and non-emergency medical transportation. The new experiment in this value based care model is barely a year old, yet many in the Legislature are intensely pushing for a shift to full managed care. The Legislature is extremely concerned about the growth of the Medicaid program, driving their push for more cost certainty. Juliet has been making the case for more time for the value-based model.
- Idaho is a very provider centric state, and providers play a key role in all aspects of the policymaking process. Juliet has had experience working in very managed care heavy states (Arizona and Texas), and readily conceded that FFS has many shortcomings. For instance, she finds it difficult to do oversight of providers with her limited staff. MCOs are more equipped, she believes, to oversee providers and drive quality improvements through targeted initiatives. As an example, Idaho has extremely low screening rates for cervical cancer. An initiative improving screening rates is more difficult to implement under the current system than it would be with a managed care organization. In response to a Commissioner's question, Juliet mentioned the flexibility of MCOs to address social determinants of health, including by providing housing supports, as something she would want to replicate.
- Idaho is trying to integrate more of a consumer voice into its Medicaid program, but leans heavily on its medical care advisory committee. Oftentimes, the state has a difficult time differentiating complaints and feedback between paid provider advocates and actual Medicaid beneficiaries. It is difficult to get beneficiaries, many of whom need to volunteer their limited free time, to give honest feedback and the state is always being inundated with feedback from provider groups.
- The state's new dual-eligible managed care program has been going extremely well. MCOs have been highly responsive to the nursing industry and have worked very well with everyone. If more managed care comes to Idaho, there could be a greater willingness on the part of providers to engage given this positive experience.

Ashley Berliner, Vermont

- Vermont's entire Medicaid program operates under an 1115 waiver, and must be renewed every five years. Taking advantage of managed care's regulatory "free-for-all" of the early 2000s, the state essentially runs a public managed care plan. In doing so, it enjoys all the flexibility that CMS gives managed care states (e.g. doing in lieu of services) while maintaining full state control. According to Ashley, Vermont can "have its cake and eat it too."
- Ashley explained that the state sets a per member per month target on spending, and any money unspent is reinvested into the Medicaid program. This money would ordinarily be profits for MCOs, but instead is going to benefit the program and has funded innovative approaches including behavioral health treatment without an income threshold. Vermont also pioneered the use of Medicaid money to address social determinants of health. Over time, CMS has begun imposing more stringent rules on what Vermont can do with its program.
- The state is required to do external quality reviews, like any other managed care state. It has had trouble getting feedback from beneficiaries, and finds that those in home and

community based settings (HCBS) are often overrepresented in beneficiary advisory groups. The state has also struggled to wrap around services for dual-eligibles.
- Ashley acknowledged that the state's generally healthier population does not necessarily represent the experience of other states. However, she sees the state's lack of a profit motive in managed care to be a benefit.

Commissioners' Comments

With a common theme being the "unequal" regulatory playing field between managed care states and FFS states, many Commissioners expressed interest in a recommendation allowing FFS states to take advantage of many of the innovative flexibilities managed care states are able to use, particularly concerning SDOH. Commissioners were also interested in the treatment of dual-eligibles in FFS, mechanisms for beneficiary feedback, and quality measurement. A general consensus emerged that despite potential profit motives of managed care plans, states with managed care can more effectively implement changes, collect data, and hold providers and plans accountable. Commissioners expressed an overall interest in making recommendations to CMS on regulatory flexibilities that would allow FFS states a more "equal" playing field.

Session 6: Managed Care External Quality Review (EQR): Study Findings

Presenter:

- *Sean Dunbar, Principal Analyst*

Background

- Following recent work done by analysts presented in MACPAC's January meeting (see here), analysts shared recent findings from interviews with stakeholders and an environmental scan. MACPAC staff hope to get the Commissioners' feedback and if they would like staff to issue a brief of their findings.
- External Quality Review (EQR) is a statutory tool utilized by the federal government and states to actively engage in oversight of Medicaid managed care. There is a federal requirement for states to conduct annual reviews, external and independent, that covers all managed care types of plans.
- States are required to execute at least four mandatory activities (e.g., compliance reviews, validation of performance measures, performance improvement projects (PIPs), and network adequacy) but also have the option to pursue one or more optional activities (e.g., encounter data validation, focused studies).

Environmental Study:

- MACPAC partnered with Bailit Health to conduct a study of the EQR process and state practices. Included in their study was a federal policy review, environmental scan of 44 states and the District of Columbia, detailed review of five selected states, as well as interviews with CMS, state medicaid agencies and national experts.
- It was found that the link between EQR and quality strategies has been limited but is growing. There was no clear link found between EQR and the state managed care quality strategy. Historically a majority of states and External Quality Review Organizations (EQROs) do not try to align their EQR activities with the state quality strategy.
- States still use extensive flexibility within their current EQR requirements. It was found that the majority of states engage in at least one optional activity, while 10 states limit EQR to only mandatory options, and another 8 do all optional activities.
- Enhanced match is limited to only certain plan types even with the broader EQR requirements. States are required to conduct their EQR for all plan types, however they only receive the enhanced match for managed care organizations (MCOs). Their

environmental scan showed that only half of the states conduct EQR on a large number of non-MCO plans.

Findings:

- The EQR process is predominantly still focused on process measures, validation and compliance, as opposed to focusing on changes in performance and outcomes over time. Stakeholders expressed their need for the EQR process to place more emphasis on outcomes and comparability.
- There are currently no requirements in place for states to act on the findings and/or recommendations included in the Annual Technical Report (ATR), which results in drastic variations in states' use of EQR.
- EQROs have the potential to support states in their efforts to improve managed care quality through technical expertise and building responsive and collaborative relationships.
- There are still large challenges that exist with accessibility and usefulness of the annual technical report content. Even though states are required to publicly post their ATRs by April 30th each year, the reports are not easily accessible and can be hard to find. Because of the length of these reports, stakeholders voiced the concern that ATRs can be hard to fully absorb and are highly technical.
- CMS's role in the oversight of the EQR process appears extremely limited. In conducting their research, MACPAC analysts found little to no information available regarding CMS oversight. Stakeholders expressed the need for CMS to increase its presence in the EQR oversight process.

Commissioners Comments

Commissioners provided overall support for MACPAC staff to compile an issue brief on their findings. Many found the disconnect of the EQR reviews to be extremely startling and wondered what, if any, impact these reviews really had. There was discussion to potentially look at states that are more effectively leveraging the EQR process to improve performance and outcomes, to better understand how they have accomplished this. The Commissioners agreed for MACPAC staff to compile an issue brief and see if there are potential opportunities for future recommendations.

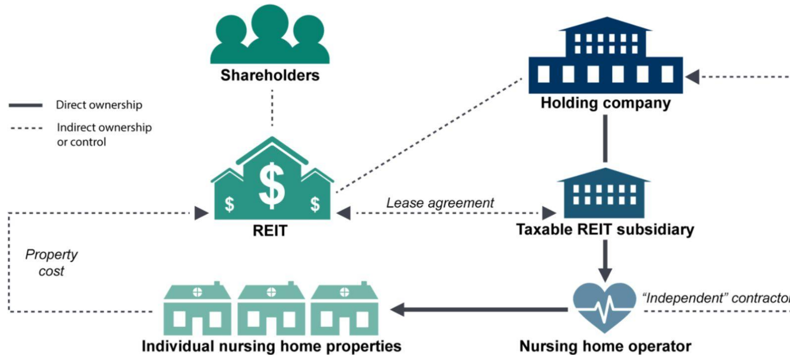
Session 7: CMS Proposed Rule on Disclosures of Nursing Facility Ownership

Presenters:

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

Background

- MACPAC analysts presented an overview of a recent proposed rule pertaining to disclosures of nursing facility ownership that would require nursing facilities to report whether private equity firms (PE) or real estate investment trusts (REITs) have ownership and/or a stake in the facility.
- Comments are due by April 14th, 2023. MACPAC analysts proposed gathering feedback and putting together recommendations for submission before MACPAC's next meeting.
- As of 2022, 72% of nursing facilities were for-profit and 66% of facilities were part of a larger chain.
    - In 2021, REITs held investments in 1,806 nursing facilities within the United States.
- Below is a graphic showing the complex ownership involved in REITs. The solid lines reflect direct ownership and the dotted lines show indirect ownership.



- Some stakeholders have expressed concerns that ownership by PE and REITs has the potential to reduce staffing levels and worsen health outcomes.
- It was noted that in some states, public hospitals also buy or lease privately owned nursing facilities so that they can receive Medicaid supplemental payments.
- There are current ownership disclosure requirements in place that require CMS to collect nursing facility ownership information (Section 6101 of the Affordable Care Act (ACA)). CMS also collects information on corporations that have at least a 5% ownership stake in Medicare-certified facilities in its Provider Enrollment, Chain, and Ownership System (PECOS).
    - Similar nursing facility data is collected for state Medicaid agencies.
- The proposed rule would add regulations to implement Section 6106 of the ACA and expand its scope of reporting. Expansion of PECOS data collection would include additional information about PE and REIT ownership. For Medicaid-only nursing facilities that are not enrolled in PECOS, they would need to submit ownership information in a state-prescribed format.

Potential areas for MACPAC comments:

- The proposed additional reporting requirements are in line with MACPAC's recent recommendations for CMS to gather and report data on nursing facility ownership in a standard format.
- One potential area of special concern relates to the lack of standardization of reporting for facilities that are only certified by Medicaid.

Commissioners' Comments

The Commissioners voiced overall support for providing comments. With regards to transparency around ownership, a few Commissioners want to encourage CMS to be as comprehensive as they can in collecting ownership information, especially when it comes to PE. MACPAC analysts will gather their additional feedback and information and draft comments for review by Commissioners before submission on April 14th, 2023.