Highlights from MACPAC March Public Meeting

Overview: On September 21 and 22nd, 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: Denials and Appeals in Medicaid Managed Care (Monitoring and Oversight)

Presenters:

Lesley Baseman, Senior Analyst

Amy Zettle, Principal Analyst

Background

- MACPAC has identified denials and appeals of care in managed care as an area for exploration. At this meeting, staff presented four potential policy options for improving monitoring and oversight. In November, staff will present the results of a beneficiary focus group and will also present appeals process improvement policy options. Commissioners are hoping to better understand the extent to which Medicaid beneficiaries are experiencing denials and filing appeals, how these denials and appeals are monitored, and whether beneficiaries find the appeals process to be accessible. Recommendations will be voted on at the January 2024 MACPAC meeting.

Current Policy and Potential Levers

- Currently, there are no federal requirements for states to collect and monitor data on denials, continuation of benefits, or appeal outcomes. Current federal requirements are therefore insufficient for giving a detailed view of access issues in managed care. Of particular concern is that there is no federal requirement for a clinical audit of denials based on lack of medical necessity.
- External quality review organizations (EQROs) similarly don't measure clinical appropriateness of denials when reviewing MCO performance.
- A Health and Human Services Office of the Inspector General (OIG) report found that only 13 states conduct some clinical audits. Similarly, only 14 states publicly report data on appeals and denials, and there is no federal requirement to this effect.
- The Managed Care Program Annual Report (MCPAR) requires some reporting of appeals, but does not report data on appeal outcomes. Additionally, it is not readily available publicly. MACPAC staff could only identify one state's report.
    - **Policy Option 1:** CMS should establish data reporting requirements for denials and appeal outcomes. This includes:
        - Issuing guidance to states for collecting and monitoring denial and appeal data;
        - Providing technical assistance;
        - Requiring states to collect data on denials (including number and type) and appeal outcomes

    - **Policy Option 2:** CMS should require states to audit denials that are based on lack of clinical appropriateness. This would entail:
        - Requiring states to conduct routine clinical audits on a subset of denials
        - Establishing more requirements and releasing guidance on how clinical appropriateness should be assessed
        - Requiring that the findings of audits are public
    - **Policy Option 3:** CMS should publicly release MCPARs and require these to include new data on denials, appeals outcomes, and the clinical appropriateness audit results.
    - **Policy Option 4:** CMS should include denials and appeals data on its quality rating system (QRS) website. This would allow beneficiaries useful information when selecting an MCO.
- MACPAC staff emphasized that states are responsible for oversight of their managed care plans and ensuring that beneficiaries have access to appropriate care, and can act in the absence of CMS action. States currently have plans out of compliance with existing federal regulations on this issue that they can hold accountable.

Commissioners' Comments

Commissioners supported all four policy recommendations. They emphasized the need for transparency from states on what actions they are taking on this issue. Commissioners noted that most denial decisions are not appealed (over 97%), so understanding the issue holistically through all four recommendations instead of simply focusing on appeal outcomes is important. Having a coherent definition of what a denial is is also important, since many are partial denials and some are less sinister than others (e.g. denial because of the improper submission of a form). Denials due to lack of medical necessity are of the most concern to commissioners, and they suggested that when a state overturns a decision, examining why that happened could be useful. MACPAC commissioners emphasized the important role that plans play in the Medicaid system and wanted to seek a collaborative approach to improving the system (and to avoid creating a "misleading headline"). Commissioners also noted an exploration of the role of artificial intelligence (AI) in evaluating claims could be beneficial in the future.

Public Comment

Dr. Arvind Goyal, the Chief Medical Officer (CMO) of Illinois Medicaid, spoke about this issue. Dr. Goyal indicated that providers and patients have been incredibly frustrated with MCO denials, and often tell him that "this wouldn't happen if I was on fee-for-service." Dr. Goyal called attention to a profit motive that MCOs might have in denying care, saying they have an incentive to do so. Dr. Goyal pushed for more aggressive recommendations, saying that the care of beneficiaries is suffering due to denials "as we speak," and that "downcoding" treatment (e.g. refusing inpatient hospital treatment in favor of observation status) is a major issue. Dr. Goyal called for more stringent guidelines on what types of services can be denied in the first place.

Session 2: Medicaid Demographic Data Collection

Presenters:

Linn Jennings, Senior Analyst

Background

- In its most recent report, the Commission evaluated the effectiveness of collecting race and ethnicity data within Medicaid. In MACPAC's March 2023 Congressional Report, they advised revising the standard application questions concerning race and ethnicity and creating training resources to boost response rates. Besides these suggestions, the Commission also recognized the necessity for further efforts in gathering and disclosing more demographic information. Building on this foundation, MACPAC plans to concentrate on collecting data related to limited English proficiency (LEP), sexual orientation and gender identity (SOGI), and disability status.

Uses of Medicaid Demographic Data

- Program administration:
    - Culturally competent application and educational materials
    - Identifying potential service needs and accommodations
    - Using correct name and pronouns in communications
- Identifying and assessing disparities:
    - Better understanding health disparities
    - Measuring population-specific healthcare needs and outcomes
    - Identifying inequities in access
    - Assessing compliance with civil rights rules
- Currently, Medicaid administrative data and federal surveys include some demographic data, but this is highly limited. Data collection efforts are inconsistent in their inclusion of questions on LEP, disabled and sexual minorities. Federal minimum standards for collecting this data have not been established.
- HHS has developed a model application, which includes questions about primary language, but not other categories. However, states are able to make their own applications with CMS approval or to add to the model application. Below indicates the number of states that ask about various categories:
- CMS and the Biden administration have made data collection a priority, viewing it as critical to advancing health equity.
- Going forward, MACPAC plans to conduct stakeholder interviews and state surveys on demographic data collection efforts. These will be presented at upcoming meetings.

Commissioners' Comments

Commissioners expressed enthusiasm for this work, but cautioned against making Medicaid applications longer and more difficult to complete. Regarding SOGI populations, Commissioners expressed interest in better data on use of the HIV prophylactic PReP and gender affirming care utilization.

Session 3: Panel Discussion: Unwinding the Continuous Coverage Requirement

Panelists:

Kate McEvoy, Executive Director, National Association of Medicaid Directors

Allison Orris, Senior Fellow, Center on Budget and Policy Priorities

Daniel Tsai, Deputy Administrator and Director, Center for Medicaid and CHIP Services

Background

- As Medicaid's continuous coverage requirement phases out, states are now renewing and removing individuals from their rolls. CMS has offered further guidelines and shared initial data on this process. The panel discussion aimed to shed light on the ongoing developments, the obstacles encountered by states and beneficiaries, and the monitoring efforts by CMS. MACPAC featured a panel on redeterminations with representatives from NAMD (McEvoy), CMS (Tsai), and a beneficiary advocate (Orris).

Kate McEvoy (NAMD)

- Medicaid Directors are enjoying a strong working partnership with CMS, with transparency underlying everything they do.
- Data on who is losing coverage is critical; for example better age stratification and post dis-enrollment data is seriously lacking nationally.
- The primary focus of Medicaid Directors is connecting individuals to coverage, in whatever form that might be.
- Directors are interested in doing everything possible to retain children on the rolls. Due to the recent ex parte renewal issue, states have worked closely with CMCS and eligibility vendors to find a “forensic solution” to the problem and rectify the issue as quickly as possible.
- NAMD has been convening not only Medicaid Directors but also finance staff and operations staff from states to share best practices on redeterminations. NAMD just hosted a forum in Denver solely focused on redeterminations.
- Medicaid Directors have been working through nontraditional partners, like local YMCAs and community groups, to spread the word about redeterminations.
- More protections from disenrollment for Medicaid beneficiaries interacting with the program are needed. Even in states with high ex parte renewal rates, there have been heightened levels of procedural disenrollment. Integrating Medicaid eligibility systems with other programs can help.
- States support Congress extending the enhanced FMAP given the additional compliance responsibilities imposed by CMS and the Consolidated Appropriations Act (CAA).

Allison Orris (CBPP)

- Overall, far too many people who are eligible for Medicaid are falling off the rolls.
- Many states are not applying federal rules on ex parte renewals properly, and rates of ex parte renewals are still too low.
- 7 in 10 terminations are procedural in nature, a percentage that is still far too high.

- State advocates and community groups have done a great job keeping beneficiaries up to date and helping them complete paperwork.
- States that have done a good job engaging beneficiaries include Kentucky (did a beneficiary town hall) and West Virginia (has convened an inter-agency working group on redeterminations to quickly address issues).
- States should listen closely to the lived experiences of those on Medicaid and use these perspectives to strengthen their procedures.
- MACPAC has a strong voice and should aggressively advocate for better eligibility and enrollment processes.

Dan Tsai (CMS)

- CMS's priority is connecting as many people to coverage (of whichever type that may be) as possible.
- The CAA has given CMS unprecedented tools for tracking this process, and as a result we have learned a lot about aspects of the Medicaid program that had been overlooked.
- CMS takes oversight of states "incredibly seriously," and hopes to hold beneficiaries harmless when addressing issues.
- CMS is committed to addressing the ex parte renewal issue, and has released a list of states that improperly disenrolled children.
- Managed care has a great potential to reach beneficiaries, and is often being underutilized. States should give MCOs as much authority as possible to contact their members.
- Plans need to do more "chasing down" of individuals to stay enrolled, and should think creatively beyond "generic" fairs and flyers. Already, plans have plenty of levers available to them and can do more to utilize them.
- In recent memory, this is the strongest that the interests of plans and the administration have been so closely aligned.
- CMS is working on posting disenrollment data required by the CAA a lot quicker, instead of the months long lag currently.
- Early marketplace transition data is coming soon, allowing us to assess how many people are finding alternative coverage.
- Long term, states should move to a more user friendly eligibility and enrollment system for beneficiaries that isn't "paper-based."

Commissioners' Comments

Commissioners praised the panelists for their work on the redetermination process and emphasized the importance of continuity of coverage. A Commissioner noted that AHIP has commissioned a study in progress from the National Opinion Research Center (NORC) to assess how beneficiaries are being contacted by their plans and which managed care flexibilities are working. Commissioners also discussed the issue of churn, and whether reinstated beneficiaries are being placed into fee-for-service or their old MCO. When states switch people between their original MCO to FFS this causes issues for the providers (who need to switch who they bill), plans and the beneficiary unnecessarily. Commissioners continued to mention the high rates of procedural disenrollments, saying that they are surprisingly high in MCO heavy states, with one

Commissioner suggesting that MCOs are not doing enough to keep members on the rolls and suggesting it might be helpful to hear from them directly to better understand what they are doing and any barriers they face in helping members renew their coverage. Commissioners suggested hearing more from beneficiaries who have gone through redetermination about their experiences with continuity of coverage and care.

Session 4: Ex parte expert roundtable

Presenter:
Martha Heberlein, Principal Analyst and Research Advisor

Background

To extend Medicaid coverage for beneficiaries, states are initially required to verify continued eligibility using existing agency data, without needing additional information from the individual. This process, known as an ex parte renewal, has gained attention as states get ready to phase out Medicaid's continuous coverage requirement. To explore the challenges and potential improvements in executing successful ex parte renewals, MACPAC collaborated with Mathematica to convene states, CMS, policy experts, beneficiary advocates and an IT system vendor. Key insights from this session were shared by the staff.

Findings

- States need to access a variety of data sources to successfully conduct an ex parte renewal.
- The main challenge states face is not technological, but rather ensuring that they are accessing as much quality data as possible. As an example, in states with no income tax, income data from the federal government must be used and can be out of date compared to what a state would have had.
- States should look at things they don't need to verify the value of and be more explicit with beneficiaries to reduce the burden. As an example, cars as a rule depreciate in value so beneficiaries should not have to report any increased value of automobiles to maintain their coverage.
- Ex parte renewals can be challenging for some populations, such as the disabled, since their eligibility criteria can be difficult to verify electronically. Integrating Medicaid eligibility systems with other benefit programs, and automating as much as possible, can create efficiencies in the process.
- Various stakeholders agreed that the policy measures identified below potentially help improve ex parte renewals.

Recent Developments

- CMS has emphasized to states the need to conduct ex parte renewals at an individual instead of household level.
- The agency plans to offer more technical assistance to states.
- MACPAC staff will publish an issue brief in the coming weeks with detailed findings from the roundtable.

Commissioners' Comments

Commissioners who attended the roundtable praised its depth and actionable ideas for improving ex parte renewals. Commissioners also expressed hope that the ex parte renewal process could be improved for certain populations, like those not eligible on the basis of income, to make it less likely they are disenrolled.

Session 5: Hospital Supplemental Payment Work Plan

Presenters:

Rob Nelb, Principal Analyst

Aaron Pervin, Principal Analyst and Contracting Officer

Background

- The presentation provided an overview of MACPAC's strategy for scrutinizing various kinds of Medicaid supplemental payments made to hospitals. This strategy is rooted in the Commission's criteria for assessing how these payments align with legal mandates concerning cost-effectiveness, efficiency, quality, and accessibility. The presentation touched upon aspects like the methodologies used for hospital payments, how these payments are directed towards specific hospital services, and the general rates of hospital payments.

Overview

- Overall, supplemental payments are a large share of Medicaid's hospital spending. Currently, 22% of Medicaid hospital spending is in directed payments through managed care, 38% via managed care base payments, 19% through FFS base payments and another 21% through various supplemental payments including uncompensated care pool payments, disproportionate share hospital (DSH) payments and upper payment limit (UPL) supplemental payments.
- The following table offers an overview of the cost and purpose of various supplemental payments to hospitals. Note: DSRIP refers to "delivery system reform improvement payments," GME refers to "graduate medical education."

Type of supplemental payment to hospitals	Total spending, FY 2021 (billions)	Number of states reporting spending, FY 2021	Intent of payment implied from federal rules			
			Reducing Medicaid shortfall	Paying for unpaid costs of care for uninsured individuals	Quality improvement	Support for specific types of hospitals
DSH	$14.1	48	✓	✓		
UPL	$15.4	32	✓			
Uncompensated care pool	$6.1	7	✓	✓		
DSRIP	$4.1	7			✓	
GME	$3.4	36				✓
Directed payments[1]	$47.9	35	✓		✓	

- Use of supplemental payments varies widely by state. Some states spend barely any portion of Medicaid funds on these payments, while others spend up to 30% of their total Medicaid benefit spending.
- New data collection requirements are being implemented by CMS, per the 2021 CAA. This requires that states report provider level data on non-DSH supplemental payments. Data is not yet available. Currently, data is aggregated by class of provider and is lacking on provider contributions to the non-federal share (as occurs in some states).
- MACPAC plans to develop a compendium of supplemental payment methods and identify payments that advance goals including supporting providers, offsetting Medicaid shortfall and supporting certain types of hospitals.

Policy

- States have significant flexibility in designing their own payment methods, often influenced by Medicaid financing.
- Some supplemental payments to physicians at academic medical centers indirectly benefit hospital systems. This could be an area of concern. About half of the states make around $1 billion annually in physician supplemental payments. However, data is lacking to understand the extent to which these payments support hospital systems.
- Plans are in place to link new non-DSH supplemental payment data with existing hospital-level DSH data.
- The Commission advocates for targeting DSH payments to hospitals serving a high share of Medicaid and uninsured patients. Preliminary data from four states shows that many, but not all, supplemental payments target hospitals with high Medicaid use. Some hospitals with large rural populations are also benefiting, even though they don't care for many Medicaid beneficiaries.
- Which hospitals to prioritize for supplemental Medicaid payments can be assessed on various factors like Medicaid use, unpaid care costs, finances, and community demographics. Wide variations in targeting policies may be due to local needs or state financing methods.
- A technical expert panel will be convened for further analysis. The aim is to understand how payment rates differ by state and compare to other payers like Medicare. Payment rates show significant variation both within and across states.
- *Areas for Consideration:*
    - How should we account for supplemental payments not intended to pay for the Medicaid shortfall?
    - How should we interpret payment rates without data on provider contributions to the non-federal share?

    - What federal policy concerns are raised by variations in payment methods and targeting?
- MACPAC will continue working on hospital payments, and complete a payment rate analysis before the next meeting cycle. In December, staff will present the statutorily required DSH report.

Commissioners' Comments

Commissioners emphasized the importance of understanding Medicaid supplemental hospital payments, given their complexity. As a Commissioner noted, oftentimes providers don't realize they are being fairly compensated (often above Medicare) because of the complexity of Medicaid's various payment arrangements. Commissioners emphasized that more attention needs to be paid to quality, and payments should be more accurately tied to adequate measures of this. Commissioners expected more transparency to result from additional non-DSH reporting requirements, but highlighted the need for more data on how these payments work.

Session 6: Review of Proposed Rule on Nursing Facility Staffing and Payment Transparency

Presenters:

Drew Gerber, Analyst

Rob Nelb, Principal Analyst

Background

- The proposed rule on nursing facility staffing and payment transparency was initiated in the wake of the COVID-19 pandemic. President Biden announced in March 2022 that new minimum staffing standards would be proposed based on an updated staffing study. The focus of nursing facility staffing primarily involves direct care staff, including registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides (CNAs). Higher staffing hours per resident day (HPRD) have been associated with better health outcomes.
- CMS currently requires nursing facilities to have RNs or LPNs available 24 hours a day, an RN available 8 hours a day, and a full-time director of nursing. This equates to 0.3 HPRD for a 100-bed facility.
- In 2021, MACPAC reviewed state policies to improve nursing facility staffing levels, including state minimum staffing standards. 38 states and DC currently have higher standards and 11 states and DC exceed 3.0 HPRD.
- Facilities serving a higher share of Medicaid-covered nursing facility residents typically have lower staffing levels.

Rule

- The proposed rule is intended to increase transparency in Medicaid nursing facility payments, costs, and ownership, and requires states to conduct

assessments of their Medicaid nursing facility payments relative to costs, quality outcomes, and health disparities.

- New annual state reports of the share of Medicaid payments spent on compensation for direct care workers and support staff at the facility level would be required four years after the rule is finalized. The requirement would apply to both nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IID). However, ICF/IID providers are not subject to new minimum staffing requirements.
- Proposed standards:
    - 0.55 HPRD for RNs and at least one RN on site 24 hours a day
    - 2.45 HPRD for CNAs
    - No specific standard for LPNs
- CMS estimates that 75% of facilities would need to increase their staffing to comply with the new requirements, at an estimated cost of $40.6 billion over 10 years. Medicaid's estimated share of these costs is $26.9 billion over 10 years. CMS estimates $2.5 billion in savings to Medicare from reduced hospital use.
- The rule does not require states to change their payment rates or methods, but it does propose annual reporting requirements on various financial metrics.
- The rule also seeks to improve Medicaid payment transparency. It proposes that states report annually on Medicaid nursing facility payments, costs, and other financial metrics.
- There are questions about whether staffing standards should be adjusted for patient acuity. Technical challenges also exist in determining staffing costs for Medicaid-covered residents, especially when staff serve multiple patients.

Commissioners' Comments

The MACPAC commissioners expressed strong support for commenting on the proposed CMS rule. They emphasized the need for transparency in understanding where Medicaid dollars are going, particularly in the context of nursing homes. A commissioner highlighted the importance of understanding the actual costs involved, including staffing and real estate overhead. Another commissioner stressed the need to focus on quality-adjusted care and to understand how Medicaid dollars are being spent on the actual care of residents versus other expenses like real estate. A commissioner highlighted the increased cost to Medicaid while Medicare saw savings, saying it shows "misalignment" between the two programs. The commissioners also discussed the challenges of staffing according to the acuity or medical needs of residents. They agreed that more comprehensive data is needed to make informed decisions and that states could play a role in providing this data.

Session 7: School-based behavioral health services for students enrolled in Medicaid

Presenters:
Audrey Nuamah, Senior Analyst
Melinda Becker Roach, Principal Analyst

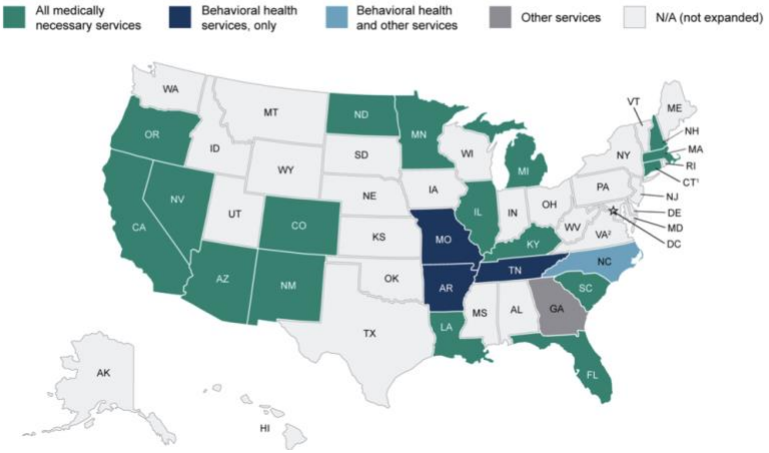
Background

- MACPAC staff presented information on school based behavioral health services for Medicaid-enrolled students.
- School-based services are delivered in schools by providers employed by a school or local education agency.
- The Individuals with Disabilities Education Act (IDEA) mandates public that schools provide students with disabilities with education and health care services, like speech or physical therapy. Medicaid is a primary payer for services included in an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).
- Schools can bill Medicaid for certain services identified in a student's IEP or IFSP. Common examples include speech-language/audiology, occupational/physical therapy and behavioral health.
- A CMS policy change in 2014 allowed states to expand coverage of school-based behavioral health and other services to students enrolled in Medicaid.
- The Bipartisan Safer Communities Act led to new guidance on Medicaid services and administrative claiming in schools, as well as $50 million in grants for states to implement or expand school-based services.

Key Issues

- States have flexibility in determining the types of providers that can bill Medicaid for school-based services, including school psychologists and social workers. To be eligible for Medicaid reimbursement, services must meet the state's definition of medical necessity.
- Claims for school-based services must list an ordering, referring, or prescribing provider who is state-licensed and enrolled in Medicaid.
- Since the reversal of the free care rule in 2014, 22 states have expanded coverage of school-based services, particularly focusing on behavioral health care.
- Medicaid usually pays for school-based services only after other insurance companies have paid. However, Medicaid pays for services that are part of a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) without first seeking reimbursement from other insurance companies. States can apply for waivers that would allow Medicaid to pay for all school-based services, but these waivers are rare.

Medicaid Coverage of School-Based Services Under the Free Care Policy Reversal, by State, July 2023



- Challenges include the need for parental consent for billing purposes and the complexity of coordinating between various agencies and regulations.
- In November, staff will discuss the results of stakeholder interviews and whether new federal guidance addresses key issues.

Commissioners' Comments

A commissioner highlighted that the issue disproportionately affects people of color and those from different cultural backgrounds due to a lack of understanding of their rights and the system. The need for equity across school districts was also stressed. Commissioners also discussed the challenges schools face in hiring and training the workforce for behavioral health services, and complying with administrative requirements. The issue of balancing medical necessity requirements with educational requirements was also raised. Commissioners were interested in case studies that could demonstrate the effectiveness of the 2014 rule change in delivering behavioral health services to children, especially given the current mental health crisis among youth. They also asked MACPAC staff to survey stakeholders about the possibility of involving managed care organizations in expanding school based provider networks.

Session 8: Engaging beneficiaries through medical care advisory committees (MCACs)

Presenter:

Audrey Nuamah, Senior Analyst

Background

- MACPAC contracted with RTI International to conduct a comprehensive study on the functioning and effectiveness of Medical Care Advisory Committees (MCACs) in all states and the District of Columbia.
- MCACs must include:

    - Physicians and health professionals who work with the Medicaid population
    - Members of consumer groups, such as Medicaid beneficiaries or consumer organizations
    - Director of the public welfare department or the public health department
- Interviews with stakeholders from six states were conducted to delve deeper into the challenges and barriers that beneficiaries face when participating in MCACs.
- The study found that there is a wide variation in how states have implemented MCACs, particularly in terms of membership criteria for beneficiaries and consumer groups.
- MACPAC has previously highlighted the need for diverse representation in MCACs, but the study found that only a few states have specific requirements or guidelines to ensure such diversity.
- CMS released a notice of proposed rulemaking (NPRM) that would change federal MCAC rules:
    - Rename MCACs to Medicaid Advisory Committees (MACs);
    - Expand the scope of topics to be addressed outside of health and medical care services;
    - Establish a Beneficiary Advisory Group (BAGs);
    - Require state agencies to publicly post information related to MAC and BAG activities.

Key Findings

- Beneficiaries and consumer groups who are part of MCACs generally feel that their input is heard by Medicaid agency staff. However, there is a sense of uncertainty about whether their feedback actually influences policy decisions.
- One of the key challenges identified is the lack of timely communication and responses from state Medicaid agency staff, which hampers effective participation.
- Beneficiaries often feel more empowered to discuss topics that directly relate to their personal experiences with Medicaid services but feel less comfortable when the discussion shifts to technical or complex policy matters.
- A significant number of states have vacancies in their MCACs specifically for beneficiary representatives, indicating challenges in recruitment and retention.
- To improve beneficiary participation, the study suggests several strategies, such as holding pre-meeting Q&A sessions to clarify agenda items, involving beneficiaries in the agenda-setting process, and providing easy-to-understand background materials to help beneficiaries prepare for meetings.

Commissioners' Comments

Commissioners discussed various aspects of engaging beneficiaries through MCACs. A commissioner suggested that there might be a selection bias in the composition of these committees, as certain types of beneficiaries are more likely to volunteer. The idea of learning from jury duty selection processes was floated, including offering some form of compensation for time and travel. Another commissioner emphasized the importance of including diverse voices, particularly those representing dual eligibles and different races and ethnicities. Commissioners also discussed the importance of transparency and accountability in the recruitment and application processes for these committees. Overall, the discussion indicated a need for more inclusive and transparent practices in MCACs.

Session 9: Medicare savings programs: Eligibility and enrollment

Presenter:

Kristin Blom, Policy Director

Background

- The session focused on Medicare Savings Programs (MSPs), which are state-run initiatives aimed at helping low-income Medicare beneficiaries cover their Medicare premiums, deductibles, and other out-of-pocket expenses.
- The four primary types of MSPs are Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled and Working Individuals (QDWI). The QMB program is the largest and offers the most extensive financial aid.

Program		Medicaid benefits	Income threshold as % of FPL	Helps pay for	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

- Legislative changes have had a significant impact on MSPs. For instance, provisions from the Affordable Care Act (ACA) have expanded eligibility criteria and simplified the enrollment process. Additionally, the growing popularity of Medicare Advantage plans has also influenced how MSPs operate, as these

plans often come with different cost-sharing structures and benefits that can affect MSP enrollees.

Key Issues

- As of 2020, about 10 million individuals who are eligible for both Medicare and Medicaid (known as "dual-eligibles") are enrolled in MSPs. Most of these enrollees are part of the QMB or SLMB programs.
- MSP enrollees are generally younger, more likely to be Black or Hispanic, and predominantly female compared to those who are only on Medicare.
- The session aimed to clarify various aspects of MSPs and to gauge the commissioners' interest in exploring policy options related to these programs. Future meetings will present potential policy recommendations for enhancing MSPs. Of particular concern will be ways to streamline enrollment.

Commissioners' Comments

The MACPAC commissioners discussed various aspects of MSPs, focusing on the challenges and opportunities for states. A commissioner emphasized the value of MSPs and expressed interest in updated enrollment data from the Urban Institute. The discussion also touched on the potential for states to use different income or asset limits in urban versus rural areas due to cost differentials. The conversation concluded with a call for more data to inform the discussion, especially given that enrollment has likely increased for various reasons since the last study in 2017.