Highlights from MACPAC December Public meeting

Overview: On December 8 and 9, 2022 the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public virtual meeting. Presentation slides and the agenda for this meeting can be found on MACPAC's website.

Session 1: Possible recommendations for improving Medicaid race and ethnicity data collection and reporting

Presenters:

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

Background

- MACPAC has been exploring ways to improve Medicaid race and ethnicity data collection and reporting, recognizing the importance of quality data to health equity.
- As a part of their focus on health equity, improving the usability of this data is also a key priority of the Biden administration. In particular, the Biden administration wants to increase the usability of federally collected race and ethnicity data by identifying data inadequacies and supporting agency efforts to improve data quality.
- States have broad flexibility to determine which race and ethnicity categories to collect on their applications, and submission of such information on an enrollment form is not a requirement for Medicaid eligibility. Every state currently collects race and ethnicity data during enrollment. However, state collected data on self-identification may be more granular than the federal categories and not easily reportable to the Transformed Medicaid Statistical Information System (T-MSIS). Also, many stakeholders identified beneficiary reluctance to report their race/ethnicity due to concerns about how the information may be used as a barrier.
- MACPAC conducted interviews with stakeholders, including Managed Care Organizations (MCOs), state officials, the Center for Medicare and Medicaid Services (CMS) and application assisters to gauge race and ethnicity data collection in Medicaid. This has led to draft recommendations for Commissioner review.
- CMS has identified additional barriers to data quality through its data quality atlas database, which assesses the completeness of race and ethnicity data by looking at the percentage of records with non-missing values, as well as how aligned data is to the American Community Survey (ACS), an in-depth survey conducted by the Census Bureau.
- MACPAC staff prepared two draft recommendations for Commissioner review, hoping that if adopted would lead to improved usability of such data.

Draft Recommendations

- **Recommendation 1:** The Secretary of the U.S. Department of Health and Human Services (HHS) should update the model single, streamlined application to include updated questions to gather race and ethnicity data. These questions should be developed using evidence-based approaches for collecting complete and accurate data. The updated application should include information about the purpose of the questions so that the applicant understands how this information may be used. HHS should also

direct the Centers for Medicare & Medicaid Services to update guidance on how to implement these changes on a Secretary-approved application

    - **Rationale:** Updating the model application would help address some of the challenges with collecting complete race and ethnicity data, and would improve applicants' comfort with providing sensitive information about themselves.
- **Recommendation 2:** The HHS Secretary should direct the Centers for Medicare & Medicaid Services to develop model training materials to be shared with state and county eligibility workers, application assisters, and navigators to ensure applicants receive consistent information about the purpose of the race and ethnicity questions. The training should be developed with the input of states, beneficiaries, advocates, and application assisters and navigators, user tested prior to implementation, and adaptable to state and assister needs.
    - **Rationale:** Providing those interacting with beneficiaries at time of enrollment training on how to ask for race and ethnicity data would address some of the challenges faced when collecting information from applicants, because it would reinforce to both the potential beneficiary and enrollment assister the importance of race and ethnicity data collection.

Commissioners' Comments

Commissioners were broadly supportive of both recommendations, which they felt were good first steps in the effort to improve race and ethnicity data collection. Commissioners noted that data is often incomplete for the LGBTQ and disability populations, and that while the recommendations may not go far enough, they are a good beginning. They will likely be adopted at the January MACPAC meeting, and included as a chapter in the March 2023 report to Congress.

Session 2: Potential nursing facility payment principles and recommendations

Presenters:

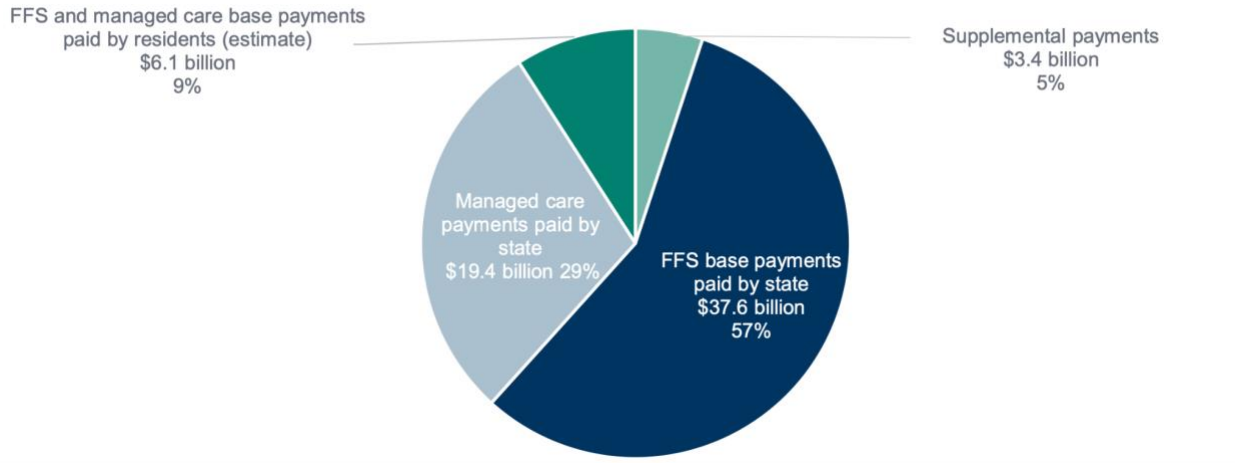
- *Drew Gerber, Analyst*
- *Rob Nelb, Principal Analyst*

Background

- Over the past three years, MACPAC has done long-term work examining Medicaid nursing facility payment policies to ensure they are consistent with the statutory goals of efficiency, economy, quality, and access. This work includes a compendium of state fee-for-service (FFS) payment methods, interviews with state officials, analyses of staffing challenges, and an analysis of payment rates relative to costs. These will be synthesized into a chapter to outline policy principles for states to consider when setting nursing facility rates and methods.

Past Findings

- Payments: MACPAC has found that 57% of nursing facility payments were in FFS, while another 29% come from MCOs. An additional 9% were paid by residents, and 5% were supplemental payments made by either MCOs or the state.



Payment sources for nursing facilities, nationwide

- Costs: MACPAC found that costs are an imperfect measure of payment adequacy, because if facilities don't have enough, staff they may be too low. However, because Medicare rates are not comparable, facility costs are one of the few benchmarks for payment adequacy available.
- Quality and access: MACPAC has found that higher direct care staffing hours per resident day (HPRD) is associated with better outcomes. States have a variety of tools to improve staffing, including increased payment rates, incentives to spend more Medicaid revenue on staff, and minimum staffing standards that exceed federal requirements. CMS is expected to issue a rule on federal minimum staffing standards. Medicaid-funded facilities have worse staffing rates, which can contribute to health disparities for people of color.

Policy Principles for Medicaid Payment Policy Addressing Staffing Disparities

- MACPAC is likely to include two policy principles on quality for states to consider in the chapter. They are:
    - Staffing rates for facilities that serve a high share of Medicaid-covered residents should be "no worse" than staffing rates in other facilities in the same area. Medicaid policy can be used to address these shortfalls.
    - Medicaid covered residents should have access to sufficient staff to meet their care needs. This concern is likely to be re-examined when CMS issues a long-awaited federal minimum staffing rule.
- MACPAC is also likely to include policy principles on efficiency, along with an example state model.
    - States with high payment rates and low staffing levels may be able to get better outcomes without increasing overall outlays by incentivizing facilities to spend more of their revenue on direct care staff.
    - Illinois had a successful data-driven state payment reform that MACPAC plans to highlight as a model, including via targeted rate increases to facilities that increased staff wages and identifying some therapy services being covered by Medicaid that should be covered by Medicare.
- MACPAC has long supported greater alignment of Medicare and Medicaid for dually eligible populations, and increased integration for these so-called dual-eligibles ("duals") can improve efficiency.

Recommendations

- In addition to policy principles, MACPAC plans on making recommendations in the chapter.
- **Recommendation 1:** To improve transparency of Medicaid spending, the Secretary of Health and Human Services (HHS) should collect and report facility-level data on all types of Medicaid payments for all nursing facilities that receive them, including resident contributions to their cost of care, in a standard format that enables analysis. In addition, HHS should collect and report data on the sources of non-federal share payments necessary to determine net Medicaid payment at the facility level.
    - Rationale: complete data on Medicaid payments to providers is needed to inform policy approaches. This is similar to a prior recommendation on hospital payments by MACPAC, which Congress implemented in part. Data on resident contributions to their care is also important yet often overlooked. This would require some additional administrative effort on the part of the federal government and states, but would potentially allow for more provider participation in the rate development process.
- **Recommendation 2:** To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals, the Secretary of Health and Human Services (HHS) should update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents and quality outcomes. HHS should provide analytic support and technical assistance to help states complete these analyses, including guidance on how states can accurately identify the costs of efficient and economically operated facilities with adequate staff to meet residents' care needs. States and HHS should make facility-level findings publicly available in a format that enables analysis.
    - Rationale: Current regulations require that states make annual findings that FFS rates are "reasonable and adequate," but this has not been enforced since the 1990s. State-level analyses are critical for an accurate assessment of rates. This has similar implications to Recommendation 1, in terms of provider participation and administrative effort.

Commissioners' Comments

Commissioners expressed general support of the recommendations. Commissioners noted the fact that Medicaid funded nursing facilities disproportionately house people of color, putting them at enhanced risk of adverse health outcomes caused by poor staffing. CMS's impending staffing rule will need to be analyzed closely to make sure it enhances the program goal of quality, which to Commissioners was most important. MACPAC staff plan to incorporate Commissioners' feedback from the session into a draft chapter.

Session 3: Required annual analysis of Disproportionate Share Hospital allotments

Presenter:

- *Aaron Pervin, Senior Analyst*

Background

- MACPAC is required by statute to report on disproportionate share hospital (DSH) payments to Congress. This is separate from current work MACPAC is doing on countercyclical DSH payments.
- States are required to make supplemental payments to hospitals to offset uncompensated care. These are known as DSH payments
- Currently, 8.3% of the U.S. population is uninsured, and this is highest in states without Medicaid expansion, and among the Latino population.

- Currently, a state's DSH payments are capped by a set federal allotment. These were temporarily increased during the COVID-19 public health emergency (PHE), as a result of the American Rescue Plan Act (ARPA). However, they are scheduled to be reduced in federal fiscal year (FY) 2024, which begins October 1, 2023.

Analysis

- In FY 2020 (the year of the analysis), hospitals reported $42 billion in charity care and bad debt. 51% of this was charity care for uninsured individuals, 16% charity care for insured individuals, and 34% bad debt expenses for both. Hospitals in expansion states reported half the charity care and bad debt of non-expansion states.
- Hospitals in the DSH program reported a $25 billion Medicaid shortfall, which meant that Medicaid only paid 88% of their costs. Base rates represented 78% of these payments, non-DSH supplemental payments paid 8%, and DSH payments paid 9%. The remainder (5%) was self-funded by beneficiaries. However, many states actually paid over 100% of Medicaid costs for DSH hospitals.
- Operating margins for hospitals during the pandemic were negative (meaning they lost money, even after DSH). However, many saw positive overall margins after receiving federal provider relief program money (part of the CARES Act).
- MACPAC is required to count the number of hospitals providing what it defines as "essential community services," or providers serving a large portion of low-income or uninsured individuals, and saw little change in the overall number nationwide.

Commissioners' Comments

Commissioners appreciated the staff's fact-finding efforts, and highlighted the ongoing work MACPAC is doing on countercyclical funding of DSH so that hospitals do not see a drop in overall funding during a recession. Commissioners also highlighted concerns about resources not reaching poorer safety net hospitals as intended, and instead being consumed by larger hospitals with more resources.

Session 4: Transitions in coverage between Medicaid and other insurance affordability programs

Presenters:

- *Linn Jennings, Analyst*
- *Rob Nelb, Principal Analyst*

Background

- MACPAC has been exploring the ramifications of the end of the public health emergency (PHE) and the Medicaid continuous coverage requirement. In this session, Commissioners focused on insurance affordability programs (IAPs) and transitions to coverage.
- The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has estimated that one-third of Medicaid beneficiaries who are likely to lose coverage at the end of the PHE may be eligible for subsidized coverage on the exchange.
- The Affordable Care Act (ACA) sought to improve transitions between health programs (e.g., Medicaid, Basic Health Plans (BHPs), CHIP, exchange plans) but as previous MACPAC work has demonstrated, very few beneficiaries who lose coverage move seamlessly into other coverage.

Process of Coverage Transition

1) If an individual is eligible for another IAP, the Medicaid agency transfers the individual's account information to the program. Some states have fully integrated eligibility systems, but some do not. States without an integrated system have difficulties in transferring information.

2) If there is not enough information to determine eligibility, the program is required to send the beneficiary a notice seeking additional information. This presents a challenge and additional barrier.
3) The applicant submits the additional information.
4) Eligibility is determined for the new program. This can be complicated: Medicaid, CHIP and BHPs determine eligibility at a point in time, while the exchange determines income on an annual basis.
5) Individuals must now select a plan, something that can be difficult when presented with many options. Some states are trying auto-enrollment strategies for Medicaid, CHIP and BHPs, but cannot do the same for exchange plans. Managed care plans that offer plans on the exchange as well can help beneficiaries enroll but cannot direct them to specific plans.
6) Many IAPs require premium payment to effectuate enrollment. Some states (e.g., New Mexico) are trying to offer premium assistance plans and pay the first premium in order to hasten enrollment.
7) Each IAP determines the start date of coverage– Medicaid can provide retroactive coverage, while CHIP and BHPs can provide coverage from the date of application. Exchange plans generally start the month after an individual applies.
8) States with integrated eligibility systems can more easily coordinate the end of Medicaid coverage and the start of the other IAP.

Monitoring

- There is little data on how successful coverage transitions are– states are required to submit information to CMS on the number of account transfers to other IAPs but not whether the individuals ultimately enrolled. This leaves plenty of uncertainty around how well coverage transitions are occurring. Exchanges also do not regularly share information with Medicaid agencies, a further complication.
- According to a MACPAC analysis, of the 24.6% individuals who applied for exchange coverage during the 2019 open enrollment period, only 14.8% were determined eligible, 11.4% selected an exchange plan, 10.6% paid a first month's premium, and 9.1% enrolled. This illustrates the many barriers and steps people must take in ensuring continuity of coverage.

Commissioners' Comments

MACPAC plans to continue monitoring the unwinding and examining transitions to coverage. Commissioners noted their concerns with how inflation may impact the qualification for IAPs, given that inflation adjustments may alter the incomes required to take advantage of IAPs. Commissioners also emphasized that children are most at risk of losing coverage, and the focus should be on ensuring seamless transitions for them. Commissioners also expressed concern about checking income eligibility at a point in time instead of over an annual basis, as this could negatively impact seasonal workers. Commissioners indicated interest in a letter to the administration encouraging more data transparency. A public commenter, a healthcare policy analyst speaking about her personal experience, shared a story of a relative on Medi-Cal (California Medicaid) who experienced a significant gap in coverage between leaving an MCO and joining an exchange plan, indicating how much work needs to be done.

Session 5: Recent developments in Section 1115 demonstration waivers and implications for future policy

Presenter:

- *Moira Forbes, Principal Policy Director*

Background

- CMS has recently approved several innovative Section 1115 waiver demonstrations that allow states to test new approaches to Medicaid and population health. Importantly, these include interventions focused on population health. MACPAC is providing an overview of these new waivers and recent trends in waiver policy.
- Section 1115 waivers must be budget neutral, feature a public input process, and require periodic reporting.

Current Waivers

- Almost every state has an 1115 waiver, and many have multiple. CMS has approved seven comprehensive waivers in 2022 and has more pending.
- Recent waivers featuring innovative practices to improve the delivery of Medicaid services include MassHealth (MA), Oregon Health Plan (OR) and Arizona Health Care Cost Containment System (AZ). These waivers feature innovative uses of Medicaid money to address social determinants of health (SDOH) by providing medically tailored meals, housing supports, and other assistance.

Budget Neutrality

- CMS has recently reversed Trump era guidance that limited the amount of savings that could be carried forward, which had the effect of making it harder to be "budget neutral."
- CMS is now also designating certain spending as "hypothetical" and exempt it from budget neutrality requirements.
- In 2005, CMS allowed states to use federal matching funds for "designated state health programs," which are state-funded programs that did not previously qualify for federal Medicaid match, with the effect of freeing up state funds for demonstration expenditures.

SDOH Trends

- Recent approvals have allowed states to address food insecurity and housing instability for high-need populations that have specific risk criteria. For example, CMS has allowed states to pay for assistance in finding and securing housing but has generally stopped short of allowing Medicaid to pay rent.

Continuous Eligibility

- States have the option to provide 12 months of continuous eligibility to children in Medicaid and CHIP. Recently, CMS has used waivers to also extend additional flexibility to states seeking continuous eligibility for children up to age 6 and 12 months of continuous eligibility for foster care youth and homeless/justice involved individuals.
- These new waivers feature robust reporting requirements, including mandatory evaluation plans describing the specific goals of new initiatives along with assessments on how each approach meets the demonstration's goals.

Capacity Development and Payment Adequacy

- State Medicaid programs generally cannot use federal funds to explicitly bolster provider capacity. However, recent approvals have featured delivery system reforms focused on integrated care, as well as targeted investments in health-related social needs, behavioral health, and equity.
- Recent approvals have also featured a requirement from CMS to increase provider payment rates for primary care, behavioral healthcare, and obstetrics care to at least 80% of Medicare fee-for-service.

Commissioners' Comments

Commissioners expressed support for and interest in recent innovative waiver approvals. However, there seemed to be some confusion amongst the Commissioners about how "budget neutrality" works, and how the limitation is applied in practice. Commissioners were interested in how ambitious CMS will allow waivers to be, given recent trends. MACPAC will continue monitoring waiver approvals, particularly on SDOH, for future discussion.

Session 6: In-lieu-of services and value-added benefits: Implications for managed care rate setting

Presenter:

- *Sean Dunbar, Principal Analyst*

Background

- CMS will issue regulations on in lieu of services (ILOS), directed payments, and managed care generally in 2023. MACPAC is examining managed care rate setting in general and is looking at how much flexibility states have to offer ILOS and value-added benefits within current federal guidance on managed care. Staff conducted interviews with MCO and state stakeholders as a part of this effort. MACPAC may be interested in submitting a comment letter once the CMS rule is released.
- ILOS are defined as medically appropriate, cost-effective alternatives to approved state plan services, while value-added benefits (VAB) are non-medical services funded by health plans' administrative dollars. Utilization and costs of ILOS are considered in capitation rate development (and included in the numerator of a plans' medical loss ratio, or MLR). VABs are usually funded from health plan administrative dollars, so are not included in the capitation rate setting process (with some exceptions).

Findings

- CMS provides little insight into which non-medical services are permissible for ILOS, leaving many states without clarity when setting rates. However, states do feel like they have a bit more clarity on factoring in cost and utilization of medical ILOS into rates. Current actuarial standards have information on how actuaries should capture covered services.
- States are generally relying on VABs and excess profit investments (reducing MLR remittances) instead of increased use of ILOS. Those interviewed in states and plans expressed an interest in clarification about which VABs can be considered substitutes for state plan services, if any (thus turning the VAB into an ILOS).
- Interviewees consistently stressed the need for clarity on how ILOS can be factored into rate setting. Stakeholders also noted that states sometimes struggle in requiring MCO investment in SDOH services, notably since churn can affect savings from population health improvements and the perception that lower-cost ILOS can reduce capitation rates in the long term. States have reported an increased use of MLR remittances and required investments in VABs.

Areas for Potential Comment from MACPAC

- Should CMS consider providing new guidance on what distinguishes a service as ILOS or as a value-added benefit, as well as what types of non-medical ILOS could be quickly approved?
- Are there concerns regarding the widespread availability of ILOS that could be addressed by CMS?
- Should CMS provide more clarity on how non-medical ILOS and other SDOH-related services should be treated in MLR calculations?
- Is more clarity needed regarding the documentation of ILOS in rate certifications?
- Are there ways CMS can help states implement ILOS consistent with how states prefer to operate their Medicaid program

Commissioners' Comments

Once the managed care rule is released, Commissioners are very interested in exploring a potential comment emphasizing the need for clarity, particularly for non-medical ILOS. Commissioners mentioned the fact that ILOS are very taxing, administratively, for a relatively

small expenditure, and thus require evidence behind them. Commissioners also mentioned the need to capture more data on how ILOS currently in effect are working.

Session 7: Medicare-Medicaid plan demonstration transition updates and monitoring

Presenters:

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

Background

- CMS has finalized a rule that eliminates so-called Medicare-Medicaid Plans (MMPs) for dually eligible individuals, in exchange for integrated Medicare Advantage dual special needs plans (D-SNPs). This will be complete by 2025. MACPAC staff presented an update on the progress of this integration and the challenges faced by states via this ongoing integration, based on stakeholder interviews.
- MMPs largely featured either capitation models or managed fee for service models. However, after a decade of existence, research found that MMPs realized little savings to Medicare or Medicaid, saw mixed outcomes and low enrollment. However, MMPs were popular with beneficiaries.
- D-SNPs are a different type of duals plan and can have varying levels of integration. D-SNPs involve a health plan holding a separate contract with the state Medicaid agency and Medicare (CMS), while MMPs involve one three-way contract between state Medicaid, the plan and Medicare (CMS).
- This recent rulemaking (supported by MACPAC) that eliminates MMPs has required new D-SNPs to have an integrated appeals and grievance processes and a service area alignment with companion Medicaid plans.

Current Status

- States reported being in the early stages of planning for the transition but appreciated ongoing federal technical assistance. Some states expressed concern about the administrative burden this will require. States remain confident in their ability to create a smooth transition. Some things will not be transitioned into the new D-SNPs, notably the shared savings program (a program that allows providers to create an accountable care organization, or ACO).
- States plan to begin preparing procurements next year (2023) and expect to intensify stakeholder engagement.

Commissioners' Comments

Commissioners were grateful for the update on the process of MMP conversion, and plan to closely monitor the process. Commissioners expressed their longstanding commitment to as much integration as possible for dually eligible individuals and believe that this rule will result in improved coverage. Commissioners also stressed the importance of CMS assuaging any concerns that states may have about the process.

Session 8: Medicaid coverage based on Medicare national coverage determination: moving towards recommendations

Presenter:

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

Background

- Under the Medicare Part B statute, CMS may make a national coverage determination (NCD) about whether a service or prescription drug is "reasonable and necessary" and therefore covered. CMS may also link coverage to participation in a clinical trial (known as coverage with evidence development, or CED). However, due to the Medicaid Drug

Rebate program, state Medicaid programs do not have the same authority to restrict coverage or issue a CED like Medicare can.
- Medicare Part B concerns physician administered drugs, often those furnished in an outpatient setting.
- MACPAC is exploring a recommendation that would allow states the same authority to limit access to a drug, via a revision to the Medicaid Drug Rebate program statute.

Program
- Outpatient prescriptions are optional, but all states currently cover them.
- States must generally cover all of a manufacturer's products in their Medicaid drug rebate programs once approved by the FDA but can limit their use via prior authorization or a preferred drug list (PDL).
- This is more expansive than the requirements for exchange or Medicare Part D plans, which can exclude coverage of some drugs and take time to make coverage decisions.

Recent Updates
- Recently, the Alzheimer's drug Aduhelm was approved by the FDA. CMS issued a CED, meaning the drug would only be covered for those participating in clinical trials. However, state Medicaid programs must cover the cost of this drug for all eligible beneficiaries given the parameters of the drug rebate program, despite the drug's controversial efficacy, cost, and dangerous side-effects.
- Medicaid Directors have asked CMS for the flexibility to apply the Medicare coverage requirements to drugs, but CMS likely does not have that flexibility (it would require a statutory change).

Draft Recommendation
- Congress should amend § 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug based on a Medicare national coverage determination, including any coverage that includes an evidence development requirement.
    - Rationale: The recommendation would give states the flexibility to align their coverage with the federal government and align the time frames for Medicaid coverage decisions with Medicare Part D and plans on the exchange. Nothing would prohibit a state from providing broader coverage, but a state would have the flexibility to align itself with Medicare in the case of drugs like Aduhelm. Collection of data on the clinical benefits for Medicaid beneficiaries could be strengthened, and states could also obtain larger rebates in the case of lower-than-expected clinical benefit.
    - Implications: This change could relieve some budget pressure for states while not impacting the vast majority of drugs. Beneficiaries and drug manufacturers have opposed CED requirements in the past, but MACPAC staff believe that CED requirements could further incentivize manufacturers to demonstrate more clinical benefits.

Commissioners' Comments

Commissioners expressed support for the draft recommendation, although there was intense discussion. Commissioners noted that many low-income people are skeptical of research, and have been harmed by research experiments in the past. As a result, they may be hesitant to participate in a CED. Commissioners noted the trend of emerging drugs that are expensive and can have worrying side effects, and agreed that the Medicaid program must have tools to grapple with these new drugs. Commissioners argued that beneficiaries in the Medicaid program should have the same protections as those in Medicare, and therefore expressed support for CEDs.

Session 9: Highlights from MACStats 2022

Presenters:

- *Jerry Mi, Research Assistant*
- *Chris Park, Principal Analyst and Data Analytics Advisor*

Background

- MACPAC annually compiles the most current data available on Medicaid and CHIP into an end-of-year publication. Notable statistics are as follows, presented with limited Commissioner comment.

Statistics

- In FY 2021, 30% of the U.S. population was enrolled in Medicaid or CHIP for at least part of the year
    - 87.8 million in Medicaid
    - 8.6 million in CHIP

Full-Benefit Medicaid and CHIP Enrollment, Selected Months in 2013-2021 (millions)

Year	Number of Enrollees	Annual growth
July–September 2013 average	56.5	–
July 2019	71.6	–
July 2020	76.0	6.1%
July 2021	83.9	10.4%
July 2022	90.0	7.2%

Enrollment over time

- Medicaid made up 15.1% of state budgets in state fiscal year (SFY) 2020 (excluding federal funds), meanwhile elementary and secondary education made up 24.8%
- Medicaid and CHIP comprised 16.8% of nationwide health expenditures while Medicare represented 20.1%.
- Medicaid and CHIP enrollment grew 7.2% between July 2021 and July 2022.
- Over 70% of enrollees are in comprehensive managed care, accounting for 50% of Medicaid benefit spending.
- Just 5.4% of Medicaid enrollees used long term services and supports (LTSS), but they accounted for almost one third of Medicaid spending.
- Drug rebates reduced gross spending on drugs by 52.8%.
- 35% of those enrolled in Medicaid had family incomes below 100% of the federal poverty level (FPL), while 53% had incomes below 138%. 38 states have expanded Medicaid to cover up to 138% of the FPL.
- Children in Medicaid or CHIP were as likely to see a doctor as those with private coverage, and more likely than those without coverage.
- Children in Medicaid or CHIP were less likely than those in private insurance to have a "usual source of care," meaning a regular primary care physician, although a majority did.

Session 10: Panel on the role of Medicaid in improving outcomes for adults leaving incarceration

Introduction:

- *Melinda Becker Roach, Senior Analyst*

Panelists:

- *Vikki Wachino, Executive Director, Health and Reentry Project and Principal, Viaduct Consulting LLC*
- *David Ryan, Senior Policy Advisor to Sheriff Peter J. Koutoujian, Middlesex County, MA*
- *DeAnna Hoskins, President & CEO, JustLeadershipUSA*
- *Jami Snyder, Director, Arizona Health Care Cost Containment System*

Background:

- Following recent discussions from MACPAC's October meeting (see here), analyst Melinda Roach moderated a panel on the role of Medicaid in improving outcomes for adults leaving incarceration. The panel was conducted in a Q&A format with participating panelists having time to answer each question, with a few directed at specific participants.

Q1: Why is this an important issue?

- **Vikki Wachino**: The United States has the highest incarceration rate in the world, with more people going into custody than leaving. It is estimated that in one year, 5,000 individuals will leave incarceration while over a million will cycle through the prison system. Justice involved populations have significant healthcare needs, and some of the highest rates of severe mental illness and physical disabilities. Studies have shown that post incarcerated individuals are 40-100 times more likely to die from a drug overdose than any other group. Our system does very little for the post-incarcerated individuals and gives no support for individuals leaving incarceration.
- **DeAnna Hoskins**: There is no support for the population once they leave incarceration. Having worked directly with post incarceration populations, she discussed the major gap between incarceration and community. When people leave incarceration, they go back into a community that does not have the resources to properly help them transition. In some cases, an individual's medication is stopped once they leave, and they are unable to refill post incarceration and can easily be forced to fall back on old habits. The struggle for individuals to reintegrate is immense. They are not given the basic access and tools to become an effective member of the community.
- **Jami Snyder**: Echoed the points discussed by the other panelists. Emphasized the need to enhance continuity of care. In October, the State of Arizona received approval of their 1115 housing opportunity waiver, which will allow the state to fund six months of transitional housing with a focus on transitional housing post incarceration.
- **David Ryan**: Further emphasized the other panelists' points, especially on establishing continuity of care. Massachusetts is currently looking at studies and data pertaining to access to care upon re-entry back into the community. They are seeing an increase of incarcerated individuals with unaddressed mental health issues. Of note, over 50% of incarcerated individuals within the state are diagnosed with an SUD.

Q2: DeAnna, could you describe the reentry process from your personal experience? What, if any, factors affect coverage post incarceration?

- **DeAnna Hoskins:** She discussed how she had suffered from substance abuse issues and was removed from her community. However, after receiving treatment while incarcerated, upon her release and reintegration into her community, there was no continuation of services that she received while incarcerated. It was left up to her to try and seek coverage and support within her community. Now working directly in that field, she sees individuals leaving incarceration in the same boat that she was in– not having any direction or guidance upon release.

- She also emphasized that when she was incarcerated, the state took her children away. When talking about incarcerated individuals and continuation of care, you also must think about their families. When DeAnna was released from jail, her children were given back to her, but their continuation of care was disrupted because of DeAnna's disruption in coverage.

Q3: Jami and David, could you explain the efforts your states have undertaken to support adults leaving incarceration?

- **Jami Snyder**: In 2017, Arizona implemented an enrollment program that operates by exchanging data with the department of corrections in order to effectively suspend enrollment of coverage for individuals going into incarceration as well as reinstating it before departure. For individuals originally not enrolled in Medicaid, the state worked with correctional facilities to assist in applying for benefits before departure, and have achieved a 94% approval rate for those applicants.
    - For MCOs in the state, Arizona has very specific requirements that the MCOs connect with individuals coming back to their plan prior to departure to better coordinate care so they can access it quickly upon release. They also have implemented targeted investment programs that incentives providers to integrate care at the point of service.
        - Currently Arizona has 13 justice clinic sites across the state that operate as a full continuation of care post incarceration.
- **David Ryan**: Massachusetts is focused heavily on connecting post incarcerated individuals to community support immediately post incarceration. That support is both focused on medication assisted treatment (MAT) as well as post release navigation to help individuals seek employment and other types of support within the community.

Q4: Vikki, looking at state approval of 1115 requests, what are the main challenges and concerns coming from stakeholders?

- **Vicki Wachin**o: Services provided within prisons and jails are highly protected, and not easily accessible. A large part of the challenge is the diversity of settings and how one starts to think about improving standards of care in a correctional setting.
- They have talked with over 70 stakeholders and the overall recommendation was to establish a strategic approach to re-integration designed around the needs of the individual leaving incarceration.
- There's a need to establish a strong connection between behavioral health services and patient navigational support. There's also a need for some type of trauma informed care for both individuals and family members. All of the interviews conducted with stakeholders mentioned that once an individual left incarceration, no support was given to them, and it was on them to figure out next steps.
- There are severe implementation challenges and an inability to convene across sectors. It is vital that correctional departments, state healthcare agencies, and healthcare providers all have a seat at the table for these issues to be successfully addressed.
- Another need is better connectivity of between information systems and data systems across agencies, to better predict and align release dates to coverage dates.

Q5: Jami and David, are there any policy or operational issues related to prerelease coverage?

- **Jami Snyder**: Ensuring that we are attending to the needs of each individual, and their family, as they leave incarceration, as well as maintaining the tailored needs of the individual and making sure pre-release screening is done to establish eligibility.
    - That includes ensuring individuals are "document ready" when released back into the community so they can quickly pin down housing and other supports.

    - In Arizona, they currently exchange data with 5 of 15 counties. This is an area that still needs more work, and they are currently looking at different ways to increase access to services.
- **David Ryan**: Acknowledged that policymakers face a bit of a learning curve with all the different participating sectors and stakeholders and needs, such as provider education (differences between chronic issues, behavioral health, etc.).
    - This should include a focus on the specific workforce needed to help with these efforts.

Q6: DeAnna, what do you think should be top of mind for states?

- **DeAnna Hoskins**: Peer to peer support is something not supported with incarcerated populations. On the Medicaid side, there's a challenge with individuals not trusting the system (correctional departments, police, etc.,), and they're finding that most individuals don't access healthcare until they are incarcerated.
    - Overall, this has been treated as a "person problem," not a "system problem," but there needs to be more systems change that includes more work in communities to build trust.

Q7: What could Congress and the federal government do to improve health outcomes for adults involved in the criminal justice system?

- **DeAnna Hoskins**: In Ohio, there is a requirement that all individuals leaving incarceration obtain a 90-day supply of all medications they were on while incarcerated. This is done to ensure medical coverage post incarceration while they try to connect with a primary care physician.
- **Vikki Wachino**: Need to implement collaboration between all sectors at both the state and local level, possibly by looking at how to support healthcare providers and community providers, perhaps through new grant funding or examining how current grant funds are being spent.
- **Jami Snyder**: Echoed what the other panelists voiced. Also believes that the Department of Justice (DOJ) and CMS should work more closely. States are already working on better coordination and cooperation internally, but at the federal level more commitment is needed to ensure communication is happening and that states understand what tools and resources are available to them in addressing the needs of incarcerated individuals.

Session 11: Congressional request for information on data and recommendations to improve care for dually eligible beneficiaries

Presenter:

- *Kirstin Blom, Acting Policy Director*

Background:

- In response to a Congressional request for information (RFI) released by Senator Cassidy (R-LA) and five other bipartisan senators –due January 13, 2023 –on data and recommendations to improve care for dually eligible beneficiaries, MACPAC analysts provided three potential areas of comment by the Commision.
    - Requiring state strategies to integrate care:
        - MACPAC's previous work in their June report to Congress (Ch. 5, p. 107) recommended states be required to develop an integrated care strategy for their full-benefit dually eligible populations.
    - State capacity to integrate care; this is an ongoing theme in MACPAC's work in regard to integrated care. Currently states face barriers to integration and many states need a starting point.

        - Potential areas for comment from the Commission in relation to state barriers could be on competing priorities, limited staff capacity and resources, and lack of Medicare knowledge.
    - Consolidation for a unified program; the RFI asks for comment on whether there is a n need for a new, unified system of care and for any insights on what that should look like.
        - Potential areas for comment include goals of a unified program, administration, and state flexibility.

Commissioners' Comments

There was overall support from the Commissioner's on the areas of potential feedback presented by MACPAC analysts. A few Commissioners requested that MACPAC staff include a note in their response highlighting this as an ongoing area of interest by the Commissioners, and that if more help is needed down the road the Commission would want to offer its insights. Based on the feedback by Commissioners, MACPAC staff will now draft a response letter for review by the Commissioners before submission on January 13, 2023.