Highlights from MACPAC April Public meeting

Overview:

On April 13th and 14th, 2023, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its April 2023 public virtual meeting. This summary includes highlights from all eight meeting sessions, as well as their votes on recommendations for their June report to Congress. Presentation slides and the agenda for this meeting can be found on MACPAC's website.

Session 1: Recommendations for automatic adjustments to disproportionate share hospital allotments

Presenters:

- *Aaron Pervin, Principal Analyst and Contracting Officer*
- *Rob 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. A variation of this recommendation (*referred to below as recommendation 2*) was advanced at the March meeting. Under this 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.
- This session provided an overview of the total of four DSH recommendations set to be included in the June report to Congress, their implications, and their final language for Commissioner approval. All recommendations further MACPAC's goal of ensuring adequate DSH funding during economic downturns.

Recommendation 1

- *In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship*

between total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas

- **Rationale:** This updates MACPAC's 2019 DSH recommendation language to reflect the goal of changing the calculation of DSH allotments to a total funding basis. Since the number of non-elderly low-income individuals in a state is correlated with uncompensated care, this proposed recommendation being "recommendation 1" reflects the Commission's view that rebasing DSH allotments on measures of need is most important.
- **Implications:** Generally, this is not projected to impact federal spending overall, but could result in states with lower FMAPs (meaning wealthier states) receiving less DSH money than they do under current policy.

Recommendation 2

- *Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital funding is not affected by changes in the federal medical assistance percentage.*
- **Rationale:** As the aforementioned "ARPA-like" approach discussed at the March meeting, stakeholders preferred this specific policy approach for rebasing DSH payments when it was implemented during the pandemic because it preserved funding for DSH hospitals and was easy for states to implement.
- **Implications:** Overall, this is also not projected to impact federal spending overall, but could result in states with lower FMAPs (meaning wealthier states) receiving less DSH money than they do under current policy. Providers would see the same amount of DSH funding, ensuring consistency.

Recommendation 3

- *Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:*
    - *An eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;*
    - *An upper bound of 100 percent on adjusted matching rates;*
    - *An increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and*
    - *An exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or based on allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group).*
- **Rationale:** This is a more technical change, and represents an amendment to MACPAC's original 2021 recommendations that supported a countercyclical funding mechanism for Medicaid writ large to include recommendation 2. Including DSH allotments within the model would ensure that DSH funding is preserved when an economic recession is triggered.
- **Implications:** While a countercyclical funding mechanism for Medicaid is projected to cost the federal government an additional $70 billion in FY 2023-2024, the Congressional Budget Office (CBO) projects that the DSH provision's inclusion will have a minimal impact on federal spending. The availability of a predictable source of funding would help states delay or avoid provider payment cuts due to declining state resources, and the maintenance of effort requirement recommendation MACPAC already adopted in 2021 would support health systems by minimizing coverage loss.

Recommendation 4

- *To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare and Medicaid Services (CMS) compare DSH allotments to total state Medicaid assistance expenditures in a given year before finalizing DSH allotments for that year.*
- **Rationale:** This policy was put in place when DSH spending was 15 percent of Medicaid spending, in order to slow DSH spending growth. However, DSH spending is now only 3 percent of Medicaid spending, and this policy no longer has a practical effect on DSH allotment calculations. Removing the requirement would finalize DSH allotments in a timelier manner and encourage states to send out DSH payments to providers faster, since states often fear payment recoupments due to miscalculations.
- **Implications:** This would have no overall fiscal implications, except to give states and providers greater certainty.

Commissioners' Comments

Commissioners supported all recommendations and voted to approve their inclusion in the June report to Congress.

Session 2: Integrating care for dually eligible beneficiaries: Different delivery mechanisms provide varying levels of integration

Presenters:

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

Background

- In 2022, the Commission recommended that states be required to develop a strategy to integrate coverage for full benefit dual-eligible ("duals") individuals (those eligible for both Medicaid and Medicare). Better integration of care for these individuals is a longstanding MACPAC goal. Since then, several pieces of legislation have been introduced in Congress incorporating this goal.
- Included in the June report to Congress will be a chapter on the various strategies for care integration, and feature findings from a focus group MACPAC conducted with dual-eligible beneficiaries on their experiences, something that was presented at the March meeting. MACPAC staff presented an overview of the chapter.

Delivery Systems in Fee-for-Service (FFS) States:

- Although use of managed care by dually eligible beneficiaries is growing, most still receive coverage of their Medicaid services through FFS. About half of states do not enroll this population in Medicaid managed care
- In September, MACPAC heard from Medicaid officials in two states and the District of Columbia, all of which use FFS for their duals population, about their flexibility for coordination. A summary of this session can be found here. Takeaways from this will be included in the chapter. The District of Columbia has recently begun to integrate duals into managed care. Panelists highlighted state capacity (such as a lack of Medicare expertise on staff) and protecting consumer choice as key priorities to address when considering integration.

Delivery Systems through Managed Care

- The chapter will also describe 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.
- CMS has finalized a rule that eliminates MMPs and makes D-SNPs the preferred model for integration. This transition will be complete by 2025.

Leveraging State Medicaid Agency Contracts (SMACs)

- In its June 2021 report to Congress, the Commission described how states could maximize integration in their D-SNPs through their SMACs.
- States can include provisions in their D-SNP contract to require higher levels of integration. The chapter will re-emphasize this point.

Beneficiary Experiences

- The chapter will include results from the focus group MACPAC conducted on dual beneficiaries. These are detailed in Viohl & Associates' March MACPAC report, but will emphasize key themes including
    - Enrollment experiences
    - Access to providers
    - Care coordination
    - Coverage of additional benefits
    - Experiences resolving issues with health plans
    - Overall satisfaction with integrated care

Commissioners' Comments

Commissioners are broadly supportive of MACPAC's continued work highlighting the benefits of integrated care for duals. One commissioner noted the trend towards managed care with approval, and suggested that managed care flexibilities for care coordination were better. Commissioners were careful to note that some beneficiary experiences with a lack of providers did not mean dissatisfaction with integrated care, and that significant provider shortages threaten access to care for all beneficiaries independent of delivery method.

Public Comments

Nicholas Wilhelm spoke on behalf of the Medicaid Health Plans of America (MHPA). He stated that MHPA supports MACPAC's goal of further integrating care for dually eligible individuals, and has identified workforce shortages and non-interoperable data exchange as two roadblocks to this goal. States, plans and CMS need to work better on data exchange in order to facilitate appropriate care delivery and improve enrollment in integrated care models. In particular, MHPA recommends the creation of a standardized information system for states. The healthcare workforce shortage is also a serious issue. Providers are moving away from insurance based payments, and this poses a risk to integrated care models. In order to address this, MHPA encourages MACPAC to recommend investments in the workforce and eased barriers to

telehealth (particularly with cross-state licensure). Finally, states should consider removing barriers to family members serving as paid caregivers.

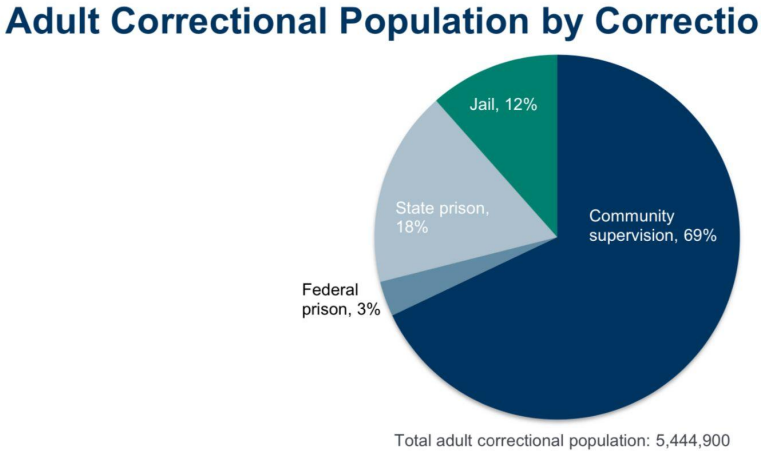
Session 3: Access to Medicaid coverage and care for adults leaving incarceration

Presenters:

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

Background:

- For a more detailed summary of previous discussion on access to Medicaid coverage and care for adults leaving incarceration, please go to our website.
- The chart below shows the adult correctional population by correctional status (2021), which includes people in community supervision.



- The demographics of justice-involved adults show they are disproportionately low income, people of color. From data gathered in 2021, the imprisonment rate for black individuals was five times that of white individuals. Justice-involved adults typically are below poverty level and have substantial health related social needs (housing, employment, and nutrition), as well as significant physical and behavioral health conditions.

State Strategies:

- Access to Medicaid for justice-involved adults is an important source of medical coverage for them once released back into the community. Currently the inmate payment exclusion prohibits Medicaid coverage during incarceration. For adults enrolled in Medicaid their coverage is suspended upon incarceration, and the gaps in coverage present themself once released back into the community.
- A majority of the states interviewed by MACPAC analysts have already initiated efforts to improve care, however it was reported that it is difficult to maintain because of competing priorities within Medicaid agencies. All states interviewed suspend coverage while a beneficiary is incarcerated instead of terminating, to make it easier to resume coverage upon release.
- State strategies focus on:

    - Facilitating enrollment by suspending benefits instead of terminating them upon incarceration.
    - Providing reentry services through state-funded pre-release programs to evaluate the needs of beneficiaries and establish relationships with community providers.
- The state of California has implemented a new 1115 waiver that allows the state to receive federal matching funds for a specific target set of services provided up to 90 days pre-release.
    - There are currently 14 other states that have submitted similar waiver requests to provide Medicaid services pre-release.
- The implementation considerations presented by analysts were;
    - Cross-agency collaboration–establishing strong coordination between Medicaid and corrections.
    - Data-Sharing and infrastructure–implementation of cross-sector data systems in order to initiate pre-release coverage, promote care coordination, and support Medicaid billing.
    - Application to jails–the unreliable release dates and short stays make it challenging to determine the coverage window.
    - Providers–states need to regulate who will provide the pre-release Medicaid services.
    - Maintenance of effort–in the example of California's new waiver, they are required to reinvest Medicaid matching funds when pre-release services are already provided by a carceral authority.
    - Monitoring and evaluation–enhance monitoring by including beneficiary surveys and midpoint assessments to try and improve the lag in evaluation results. States could benefit from policy-specific consideration guidance.

Commissioners' Comments

Commissioners agreed about the importance of ensuring consistent pre-trial Medicaid coverage, and were excited by the inclusion of this chapter in the June report as well as the potential for future work on Medicaid coverage and incarceration. Commissioners focused on the difference between jail stays and prison stays. Since jail stays are far more unpredictable and short, many suggested that differentiating jails vs. prisons in research is important. California's recently approved waiver request will provide both data and a foundation for evaluating future efforts. MACPAC's chapter will be included in the June report to Congress.

Session 4: Access to covered dental benefits for adult Medicaid beneficiaries: Panel discussion

Introduction:

- *Audrey Nuamah, Senior Analyst*

Panelists:

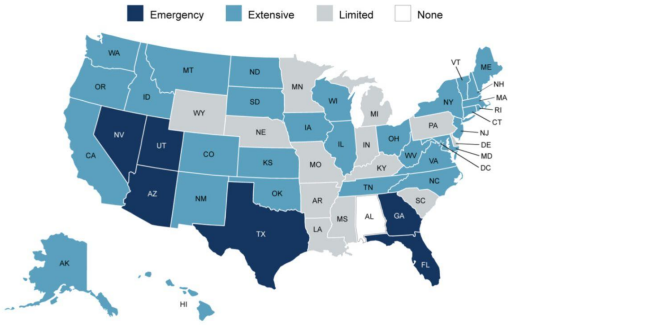
- *Brandon Bueche, Program Operations and Compliance Manager, Louisiana Department of Health and Hospitals*
- *Justin Gist, Dental Program Manager, Virginia Department of Medical Assistance Services*

- *Marko Vujicic, Chief Economist and Vice President from the Health Policy Institute at the American Dental Association*

Background:

- Poor oral health is an issue widespread among adults, specifically higher for low income populations. States currently have the option under Medicaid to cover dental for adults. That coverage falls under three categories; emergency, limited services, and extensive. The map below shows current state Medicaid coverage for adult dental services, as of 2023.

State Medicaid Coverage for Adult Dental Services



As of January 2023

- Previous MACPAC studies have found when comparing private insurance to those on Medicaid, that Medicaid adult enrollees are;
    - Less likely to have had a dental exam
    - More likely to delay dental care because of fear or other reasons
    - More likely to not receive dental care because of high costs
- A majority of the gaps in access to oral health care reflect racial and ethnic disparities.
    - Black and hispanic adults are less likely to have received an oral exam within the last year and are more likely to suffer from oral diseases.
- The current Medicaid delivery systems in place for dental services for adults on Medicaid include;
    - Fee-for-services (FFS)
    - Carve-ins to Medicaid managed care organizations (MCOs)
    - Carve-outs from the MCO; in this case states rely on other dental contractors administrators
- In some cases, states use waiver authorities such as 1115 waivers or 1915(c) to provide dental benefits for high need populations.

Panelists:

Dr. Marko Vujicic, Chief Economist and Vice President from the Health Policy Institute at the American Dental Association:

- When talking about dental benefits for Medicaid beneficiaries, it is important to note the economic costs to the United States of not adequately covering oral health. Lack of dental care results in more hospitalizations costing billions per year, with Medicaid picking up roughly 40% of those costs. Also, people with inadequate dental coverage

often have difficulty getting hired for certain jobs, contributing to underemployment and unemployment. Lack of affordable coverage and a shortage of dental providers are creating wider disparities in our adult population. We've made great strides in coverage for children in Medicaid and CHIP and now must shift our focus to adults.

Brandon Bueche (LA):

- Louisiana first addressed dental access for Medicaid beneficiaries by covering denture services when they still had a FFS delivery system. They quickly found that by only covering denture services, they were unable to fully meet the oral health needs of beneficiaries who required extractions or other services. That gap quickly made the state realize that they needed to expand coverage for dental services, but the costs were prohibitive. Adopting a managed care delivery model has enabled them to work with the six MCOs within the state to expand access to adult dental services. While coverage is still limited, the state recently launched a program expanding dental services for their I/DD population, set to go live in May, which would serve around 11,000 people. With the rollout date quickly approaching, they are still worried about the overall cost of implementation and the state is working with providers and beneficiaries to help notify those who will qualify.

Justin Gist (VA):

- Oral health contributes to an individual's overall health, which is how dental benefits are viewed in Virginia. It is important to address the elephant in the room, the elephant being the large stigma around Medicaid as a whole. Providers don't have an issue providing dental benefits for children enrolled in CHIP; however they are less willing to serve the larger Medicaid population. Even so, the commonwealth has been able provide comprehensive coverage to its beneficiaries but still faces challenges as it pertains to funding. Their comprehensive coverage is a tiered model that focuses on: preventive (teeth cleaning), periodontal health, and restorations to promote longevity. The success of dental access in Virginia would not have been successful if they had not engaged early on with benefit administrators. The state currently receives weekly updates on the number of beneficiaries receiving care and type of services.

Questions from Commissioners:

Question: What are the federal policy barriers you face when trying to address coverage of dental benefits for Medicaid adults?

Justin Gist (VA): Until dental coverage is federally mandated, we will struggle to provide comprehensive coverage.

Dr. Marko Vujicic: Echoing the point made by Virginia, the big issue here is that dental coverage requires legislative action. Although there are success stories in some states, many states are still lagging. One large barrier is people disconnecting the mouth from the body and not understanding that oral health contributes to one's overall health. Until this is more widely understood, and the funding is made available, there will still be barriers to access.

Brandon Bueche (LA): Echoes all of the points made by the other panelists, but also made the point that once his state secured more funding, they had no problem seeking approval from CMS.

Question: If MACPAC had a magic wand, what would you need from us in order to be successful?

Dr. Marko Vujicic: We need help in incentivizing all stakeholders, and need to put quality measures in place that are less focused on building the network and more on addressing the health concerns that are tied to oral health. There will not be any significant process without some sort of federal mandate.

Justin Gist (VA): Require all states to provide comprehensive coverage for five years, and after four years conduct a study that looks at the overall health of Medicaid beneficiaries.

Brandon Bueche (LA): Same request as Virginia, mandate the coverage and find the funding for it. As a state agency, we know how to do it and have the network and relationships, we just need the funding to be able to make it happen.

Session 5: Unwinding update: State implementation and coordination with providers and community organizations

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), MACPAC staff 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. 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, make at least more than one attempt to ensure current beneficiary contact, and conduct outreach following returned mail renewals.
- MACPAC has been monitoring the unwinding and conducting continuous outreach to stakeholders including community groups, states and beneficiary advocates to report back on the unwinding process.

Current Update

- Twenty-three states started the unwinding process in February or March, while the remaining states began in April
- Five states (Arizona, Arkansas, Idaho, New Hampshire, and South Dakota) began disenrolling individuals for procedural reasons starting April 1st.
- CMS has worked with states to ensure they comply with the CAA requirements. A majority of states plan to take the full 12-14 months to complete the process.
- Much of the earlier communication efforts focused on updating beneficiary contact information. Now, CMS, states, and stakeholders are shifting to telling beneficiaries to

check their mail and respond to requests. This is often done in a coordinated effort across a number of organizations that have emerged to develop and share messages. CMS and states have also developed communication toolkits and enlisted community groups to serve as "coverage champions," with some community groups even directly contracted by states to do outreach.
- While efforts are improving, many stakeholders have expressed concerns about beneficiary awareness and ability to respond to requests. Most states interviewed report working with managed care plans to update addresses, conduct outreach, and assist beneficiaries with renewals.
- Of particular concern are beneficiaries with disabilities, who may struggle to recognize and complete re-enrollment forms. States report addressing these concerns through enhanced outreach, call-center training, and more accessible forms.
- Advocates report concern that the current attention to Medicaid redeterminations will dissipate across the 12-14 months allowed, and that beneficiaries contacted in a few months will not see the same level of outreach and attention as those currently at risk do.
- States reported difficulties using electronic-asset verification systems (E-AVS) to do redeterminations, including with incomplete data and inadequate staff expertise.

Commissioners' Comments

Commissioners praised CMS's efforts to prepare for the unwinding, the CAA's beneficiary protections, and said that state Medicaid directors were working hard to care for beneficiaries, despite sometimes having poor quality "underlying systems." Commissioners expressed concern for beneficiaries with disabilities, and suggested that more data on disenrollments by race should be collected. MACPAC staff will update Commissioners on the progress of the unwinding at every meeting for the foreseeable future.

Session 6: Proposed rule on Medicaid disproportionate share hospital third-party payer policy

Presenter:

- *Aaron Pervin, Principal Analyst and Contracting Officer*

Background & Changes

- CMS released a proposed rule implementing DSH payment changes in the Consolidated Appropriations Act, 2021 (CAA) on February 24, 2023
- DSH payments to hospitals are limited by the sum of the Medicaid shortfall and the unpaid costs of care for the uninsured. Medicaid shortfall is defined as the difference of costs of care for Medicaid eligible beneficiaries and payments received for the services. Medicaid rates are often lower than the hospital's cost of providing the care.
- The calculation of Medicaid shortfall for beneficiaries with third-party coverage is controversial. In 2017, 18.4 million Medicaid beneficiaries had third-party coverage, including 11.5 million on Medicare and 8.8 million also enrolled in private insurance.
- In 2010, CMS decided to calculate shortfall to include payments by both Medicaid and all-third party payments (e.g. Medicare and private coverage). In 2018, a court decision forced CMS to only count Medicaid payments when calculating this shortfall. This decision was overturned on appeal, and CMS eventually reinstated the 2010 methodology in 2021. In 2019, MACPAC recommended to only include Medicaid

payments for beneficiaries for whom Medicaid is the primary payer in calculations of shortfall.

Method of calculating Medicaid shortfall	Medicaid-eligible patients with third-party coverage			Medicaid-only patients	
	Medicaid payments	Third-party payments	Costs	Medicaid payments	Costs
CMS 2010 policy	X	X	X	X	X
2018 district court ruling	X		X	X	X
MACPAC 2019 recommendation				X	X

- The CAA made changes to the shortfall definition, consistent with MACPAC's recommendations. However, the CAA included an exception for hospitals that serve a large number of duals. For the top 3% of hospitals in terms of number or share of inpatient days for duals, the DSH limit becomes the higher of the CMS 2010 policy or the MACPAC 2019 recommendation.
- The proposed rule codifies the CAA change to the DSH definition, and has CMS use the most recent available cost report data to determine which hospitals are eligible for the top 3% exception. States and hospitals will be notified which hospitals are eligible before October of each year.
- In 2018, MACPAC estimated that 422 DSH hospitals received a total of $1 billion in excess of their DSH limit, representing 6.1 percent of DSH payments. CMS proposes to require auditors to estimate overpayments on DSH audits to facilitate recoupment. After audits are filed, overpayments are usually redistributed to other hospitals within a state.
- CMS is also proposing changes to the DSH reduction methodology. This lowers the level of any DSH funding reductions to states that target DSH payments to hospitals with high levels of uncompensated care. CMS also proposes that DSH allotments be posted on CMS's website instead of in the *Federal Register*, to reduce administrative burden.

<u>Commissioners' Comments</u>

Commissioners expressed support for a MACPAC comment on the rule. Comments are due April 25th, and will be circulated internally amongst Commissioners beforehand. The comments are likely to reiterate prior MACPAC comments and recommendations in support of requiring transparency around which hospitals received redistributed payments (from those originally overpaid) and timely announcement of DSH allotments to states. MACPAC may also comment in support of requiring the 3% of hospitals ("excepted" hospitals) to report shortfall separately for third-party coverage patients.

Session 7: Access to home- and community-based services

Presenters:

- *Tamara Huson, Analyst*
- *Asmaa Albaroudi, Senior Analyst*

Overview & HCBS Coverage:

- To see previous background and work the Commission has done on access to home-and community-based services (HCBS), please go to our website.
- Analysts presented an overview of their draft chapter on improving access to HCBS that included interviews with stakeholders, roundtables, environmental scans, and panel discussions.
- In order to be determined eligible for long-term services and supports (LTSS), an individual must meet certain standards and functional criteria that is based on the individual's physical or cognitive status. There are multiple different pathways states can take in providing LTSS support. Once determined eligible, the individual is entitled to a full range of services provided within their state.
    - Some states provide HCBS services through an amendment in their state plan, but the majority of HCBS are issued through Section 1915(c) and Section 1115 waivers.
- During an environment scan conducted in 2022, MACPAC reviewed Section 1915(C) and Section 1115 waiver documents, and Section 1915(i) and Section 1915(k) state plan authorities for all 50 states and the District of Columbia. Using HCBS taxonomy— which included seven categories—analysts mapped the services offered under each waiver to the applicable category and population. Through their scan, they found the most commonly provided services to be: caregiver support, home-based services, equipment, technology and modifications, and day services. The least common provided services were: rent and food expenses for live-in caregivers, as well as participant training. Please see their chart below:

Environmental Scan Results

HCBS taxonomy categories	Count of Medicaid HCBS Authority and States Offering HCBS, by Target Population						
	Intellectual and developmental disabilities or autism	Physical and other disabilities	Aged	Brain injury	Mental illness and serious emotional disturbance	Medically fragile and technology dependent	HIV/ AIDS
Total number of waivers and authorities	129	86	76	33	28	27	10
Total number of states	51	49	50	26	23	23	10

Notes: The number of states includes all 50 states and the District of Columbia for a total of 51.
Source: MACPAC analysis of approved Section 1915(c) and Section 1115 waivers and Section 1915(i) state plan authority, July 2022. Does not include Section 1915(k) state plan authority.

- Based on analysts' review of state's waivers, they found certain commonalities among states in terms of certain target groups–all states and DC provide HCBS for Intellectual/Developmental Disability (I/DD), autism, and aged populations.

- Since 2013, national spending on HCBS, as a proportion of total LTSS expenditures, has exceeded spending on institutional care. However, it was noted that for some populations and states, spending on institutional care still exceeds spending on HCBS.

Access to HCBS: MACPAC's findings from their research focused on the current barriers to beneficiaries accessing services and challenges faced by states.

- Limited provider capacity and workforce shortages are barriers that impede access to services.The COVID-19 pandemic only exacerbated this issue, and the American Rescue Plan Act (ARPA) provided a temporary increase in the federal medical assistance percentage (FMAP) for state Medicaid programs to help address this issue and enhance HCBS infrastructure. This enhanced FMAP is set to expire 6 months after the end of the PHE. Currently 33 states and DC are using these funds to make changes to payment policies.
- States are allowed to set caps on Section 1915(c) waivers to help states control costs, but have used ARPA funding to reduce waiting lists. However waitlists to enroll continue to differ by population and state. There are currently six states using ARPA funding to try and eliminate/reduce waiting lists. During stakeholder interviews, it was found that challenges exist in identifying the extent to which barriers occur because of lack of data.
- Stakeholders noted that beneficiaries sometimes lack information on available HCBS supports and find the process confusing. The information and referral/assistance (I&R/A) entity is used to provide assistance to beneficiaries, occasionally through a no wrong door (NWD) system. However, lack of training and high turnover rates for information counselors remains a burden.
- Ongoing staffing shortages and limited state resources hinder efforts to expand HCBS system capacity. Stakeholders suggested ways to streamline HCBS, including aligning requirements under different HCBS authorities and rethinking HCBS program design. An example of this is the state of Minnesota, where they established a Waiver Reimagine Advisory Committee aimed at consolidating the state's four disability waiver programs into only two.
    - Creating a core benefit for HCBS was an option discussed by stakeholders. However, concerns were expressed around workforce availability to do so, as well as the need for more financial support, and limited state capacity.

Next Steps:

- The barriers faced by beneficiaries when trying to access HCBS are due to workforce shortages, lack of information on HCBS supports, complex and prolonged eligibility determinations, and caps on enrollment and waiting lists. States run into challenges when trying to administer HCBS programs because of limited capacity and trouble navigating the copious amount of federal requirements.
- MACPAC analysts will continue to explore ways to expand access through viewing policy levers intended to support improving access for beneficiaries and reducing administrative burdens.

<u>Commissioners' Comments</u>

Commissioners' expressed overall support for the findings presented. Commissioners discussed the importance, when talking about direct care workers, of looking more broadly at what is

required to provide those services. Because a challenge with direct care workers is the way in which they are paid (through FFS), which creates a gap once the needs of a beneficiary are identified and how long it takes for a direct care worker to be located, trained and briefed on the needs of the beneficiary. The large number of waivers and state authorities that constitute HCBS was worrisome to a few Commissioners because they interpret the immense amount of waivers as creating administrative burden and higher costs. Commissioners also voiced the concern that so many waivers creates more issues from both a management and compliance perspective. Commissioners encouraged MACPAC's analysts to consider ideas for streamlining the process and establishing a more clear pathway for access.

Session 8: Denials and appeals in managed care: Interview findings

Presenters:

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

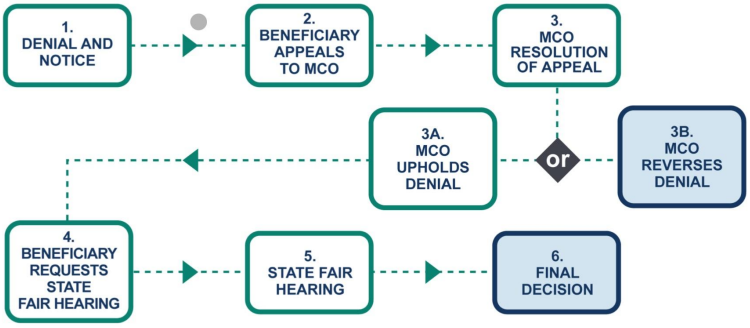
Background

- MACPAC has identified denials and appeals of care in managed care as an area for exploration. At this meeting, staff presented state and stakeholder interview results. In September, staff will present the results of a beneficiary focus group. Mathematica has been contracted to conduct this. 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. This work will inform potential recommendations, to be issued later in the year.

Current Requirements

- Denials (known formally as adverse benefit determinations) occur when an MCO denies authorization of a requested service, reduces/suspends/terminates the authorized service, or denies payment for services already received. An appeal is a review of an adverse benefit determination.
- There is little data on the extent to which Medicaid MCOs deny care. However, research suggests MCOs deny care at higher rates than Medicare Advantage (MA) plans. Appeals are exceedingly rare across MA, Medicaid and exchange plans.
- Under the 2016 managed care rules, a beneficiary must exhaust appeals with the plan before receiving a hearing from the state. As a result, the beneficiary's first step is to appeal the denial with the plan itself. MCOs must resolve appeals within 30 days, and states can require even quicker turnaround.

Federal Medicaid Requirements: Appeals Process



- The federal government does not require monitoring of denial rates, appeal outcomes, or denial audits. However, federal rules allow states to impose additional rules on MCOs such as requiring an external medical review. External Quality Review Organizations (EQROs) contract with states to conduct oversight of MCOs. Additionally, the federal government now collects general appeals data annually.

Stakeholder Interview Findings

- After interviewing state and federal officials, providers, MCOs, beneficiary advocates and EQROs, MACPAC sought to find out whether the denial and appeal processes ensure beneficiary access and to examine how state and federal officials monitor MCO denial and appeal processes.
- Stakeholders suggested that denial notices can be lengthy and lack critical information. They pointed to the medical and legal jargon (often required by federal rules) and a lack of a detailed denial reason. “Missing documentation” is also a common reason for denials, and providers and beneficiary advocates said that slow denial notifications from MCOs limit the ability to appeal.
- Stakeholders suggested that MCOs have a conflict of interest in handling their own appeals, and said that external support (such as a provider, family member or legal advocate) is an important factor in deciding whether to appeal.
- States reported monitoring trends in denials and appeals to identify access issues. States expressed an interest in exploring clinical appropriateness denials more. States noted that they find plenty of appropriate denials, and are thankful that these improper claims are caught by MCOs. Over half of states report monitoring denial outcomes.
- MCOs reported conducting extensive staff training to ensure that appeals were handled in a consistent way.

Commissioners’ Comments

Commissioners said that appeals and denials are a big reason for provider abrasion in the Medicaid program. While someone on commercial insurance may bear the cost of improper care, in Medicaid the provider does, which is an additional risk to them. Also, Medicaid providers must do uncompensated administrative work to prepare lengthy letters of medical necessity to MCOs. One commissioner suggested that from their experience as a provider, provider-led MCOs saw far fewer denials than those owned by investors. Provider led MCOs are therefore more “beneficiary centric.” Another Commissioner cited a recent ProPublica article on Cigna using automatic denials, and suggested that investor owned MCOs do not operate in a vacuum and may be using automatic denials for Medicaid beneficiaries. One Commissioner suggested that given MCOs seek NCQA certification, that could be an area to examine in the future for

understanding what is required for certification with respect to the handling of appeals and denials. Other topics mentioned included the burden of retroactive denials, the need for more transparency and data, and the difficult balance of writing denial letters in “layperson” speak (as required by NCQA) and the need to convey complex medical information. Commissioners recognized the role of utilization management in controlling costs, and expressed a desire for a greater understanding of the process. Staff will present results from the beneficiary focus group in September, and then MACPAC will begin exploring recommendations.