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State Resource Center

MACPAC Meeting Insights: ATI's Take

December 14-15, 2023

ABOUT THIS WORK

ATI provides insights into the topics addressed in MACPAC's December 2023 meeting.
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KEY THEMES

Dual Eligible Care Delivery

- Policy and care delivery model innovations for dual eligible individuals continue to evolve at a rapid pace.
- State Medicaid agencies are increasingly focusing on their dual eligible integration strategies given the sunsetting of Medicare-Medicaid Plans (MMP), changing dual eligible special needs plans (D-SNPs) standards, and recently proposed federal rules focused on simplifying plan choice and driving enrollment into integrated products.

Data Sharing and Transparency

- An enabling component to continued policy assessment and implementation is improving data collection, sharing, and analysis processes and increasing public transparency.
- CMS has taken steps to increase transparency—particularly into managed care systems and provider payment and financing mechanisms—to more clearly understand the impact of current Medicaid policies.
- This month, MACPAC shared new data on provider payments, COVID-19 unwinding, and its annual MACStats publication.

Elevating Beneficiary Voices and Protections

- Centering needs and voices of beneficiaries has emerged as a salient theme in recent months, as states continue to grapple with the COVID-19 unwinding process and CMS introduces new rules aimed at beneficiary representation and protections.
- Of particular focus, both CMS and MACPAC have focused efforts on addressing challenges related to beneficiary engagement in state Medical Care Advisory Committees (MCACs). This year, CMS proposed a rule that would change MCAC structure and operational requirements to support beneficiary engagement.

MEDICARE-MEDICAID PLAN (MMP) TRANSITIONS *(SLIDE 1 OF 2)*

Issue

MACPAC has closely monitored the 8 **MMP states transitioning to integrated D-SNPs** by the end of 2025. MACPAC discussed findings from recent interviews with MMP states and moderated a panel discussion on MMP transitions, considerations for states developing D-SNPs, and outlooks on integrated care models.

MACPAC plans to report on the status of MMP transitions and additional interview findings in future MACPAC public meetings.

- All states with capitated Financial Alignment Demonstration MMPs must sunset the programs by December 31, 2025. Eight states with MMPs (IL, MA, MI, NY, OH, RI, SC, and TX) are **transitioning MMPs into integrated D-SNPs**.
- **Key aspects of D-SNP design**, such as the State Medicaid Agency Contract (SMAC), **afford states significant authority to retain important features of their MMP model**, including integrated member materials, unified appeals and grievances, integrated medical loss ratio reporting, and more. To successfully leverage these tools, states will need to implement new processes to monitor and oversee SMAC requirements and ensure that D-SNPs are operationalizing policies as envisioned by the state.
- For states undergoing the transition from MMPs and developing or enhancing their D-SNP program, **Medicaid procurements may create additional timing implications as they prepare for the next phase of integration post-MMP**. States need to be thinking about their integration strategy now, including how it may be impacted by procurement, to prevent potential disruption and delays as they plan for the implementation of new program and policy changes.

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Additional Resources

Visit ATI's website for more on MMP transitions:

- What's Next? Retaining the Successes of the Medicare-Medicaid Plan (MMP) Model
- MMP Transition Tip Sheets
  - Organizational Structures
  - Enrollment Policy
  - Bid & Benefit Design
  - Network Adequacy

- There are concerns that the targeted focus on dual eligible individuals that existed under the MMP may be lost in the shift to D-SNPs, resulting in a loss of formal channels to provide feedback on care delivery models and incorporation of beneficiary voices that inform continuous program improvements. As such, CMS, states, and plans should consider approaches to **keep stakeholder engagement at the forefront of MMP transitions**.
- **States will need to build internal capacity and expertise** as the landscape of integrated care continues to evolve. Support from the Medicare-Medicaid Coordination Office (MMCO) and the Integrated Care Resource Center (ICRC) can help states build this capacity by highlighting best practices and encouraging shared learnings across states.
- Even with successful MMP to D-SNP transitions, states and plans are losing critical elements in the transition out of MMPs, including passive enrollment, Medicare shared savings, and integrated financing. In addition to being features that maximize their ability to serve dual eligible individuals, it also creates incentives for states and plans to provide high-quality, integrated care. **CMS should consider opportunities for retaining these elements in the D-SNP model**, both in the short- and long-term.

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POTENTIAL AREAS FOR COMMENT ON CMS PROPOSED RULE ON MEDICARE ADVANTAGE (MA) FOR CY2025

Issue

CMS published a **Medicare Advantage (MA) and Medicare Part D (MAPD)** proposed rule that would make changes related to integrated programs, including dual eligible special needs plans (D-SNPs), serving dual eligible individuals for the contract year 2025. The proposed rule would promote widespread availability of integrated programs with the goal of **simplifying the enrollment process** for dual eligible individuals and **reducing the "choice overload" and aggressive marketing tactics** they currently experience.

- While the proposed rule makes significant strides towards improving integration, gaps—including **unaligned enrollment, particularly in states where behavioral health or long-term care is carved out** of Medicaid contracts—still exist that will need to be addressed as these rules take effect.
- CMS and states will likely need to collect data and **closely track enrollment changes as a result of the newly proposed monthly special enrollment period (SEP)** for integrated programs to ensure that quality goals are still being met without churn negatively impacting the experiences of dual eligible individuals.
- States may need technical assistance and policy guidance to understand how regulatory changes to integrated plans will impact their states' managed care landscapes and **long-term goals related to integration, beneficiary access, and program capacity**.

Visit ATI's website for a full summary of the proposed rule.

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MEDICAID SEXUAL ORIENTATION AND GENDER IDENTITY DATA COLLECTION

Issue

There is a **gap in collecting sexual orientation and gender identities (SOGI) data** from Medicaid beneficiaries. Sexual and gender minorities (SGM) are more likely to experience health disparities and discrimination than straight and cisgender individuals. MACPAC is evaluating what factors, barriers, and burdens exist to collect these important demographic variables. Robust and accurate data collection supports population-specific needs assessments and the development of targeted interventions to address inequities experienced by SGM individuals.

- As of November, **states have the option to incorporate CMS-developed SOGI questions into Medicaid and Children's Health Insurance Program (CHIP) applications without CMS approval**. States implementing these questions should consider how to communicate policies regarding data use and privacy to applicants.
- **CMS expects states to share SOGI data elements to Transformed Medicaid Statistical Information System (T-MSIS) starting in 2025**, though states are awaiting further instructions on how T-MSIS will collect this data. With future consistent SOGI data reporting through T-MSIS, new opportunities exist for federal and state policymakers to assess and tailor policy toward SGM individuals moving forward.
- Stakeholders have shared concerns about the **impacts of data collection methods and language inclusivity** used in SOGI questions; states implementing SOGI questions may consider what training and education may be required to both applicants and state staff handling or analyzing this information.

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ANNUAL ANALYSIS OF MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS TO STATES

Issue

States receive federal allotments to make **Disproportionate Share Hospital (DSH) payments** to certain hospitals to **offset uncompensated care for Medicaid-enrolled and uninsured individuals**. Due to scheduled reductions from Congress implemented under the Further Continuing Appropriations and Other Extensions Act, 2024, DSH allotments are set to decrease by approximately $8 billion—or 51%—starting in FY 2024.

- With the expiration of pandemic-era Medicaid continuous coverage requirements, there is **continued risk of increasing levels of uninsured individuals**, which may lead to increased levels of hospital uncompensated care costs.
- Due to the significant upcoming DSH reductions in 2024 coupled with decreasing coverage levels, states will need to **monitor hospital payment levels and consider alternative payment and financing strategies** to ensure adequate net reimbursement levels—particularly for safety net hospitals.
- States and health plans will likely require **policy direction and support as they navigate alternative methods of financing and reimbursement**—including new supplemental and directed payments, health care taxes, and other policy levers—amid **renewed federal scrutiny** of such arrangements.

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BARRIERS TO IMPROVING TRANSPARENCY OF MEDICAID FINANCING

Issue

Medicaid payment and financing mechanisms are characterized by immense complexity and a lack of transparency. Since the early 2000s, an increasing proportion of non-federal share financing is being satisfied through healthcare taxes and IGTs couples with increased utilization of supplemental and directed payments. Together, these arrangements effectively increase the share of federal financial participation above CMS-set FMAP levels.

- States' use of provider taxes and supplemental/directed payments has long been under **federal scrutiny, with repeated calls for additional guardrails and to limit their uses**. These payment and financing mechanisms have been the focus of several Government Accountability Office (GAO) reports, including its most recent December 2023 report.
- Provider taxes provide critical funds to the Medicaid system and **stripping this financing level could negatively impact Medicaid programs and beneficiaries**. The Congressional Budget Office (CBO) estimates that states would respond to reduced provider tax authorities with cuts to Medicaid payments and benefits.
- **Additional research on Medicaid payment and financing mechanisms is required** to understand the relationship between financing policies, net payment levels, provider participation rates, and beneficiary access to care. These analyses should consider the impact on each provider/service type and identify what disparities in federal financing may exist between states.

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ENGAGING BENEFICIARIES THROUGH MEDICAL CARE ADVISORY COMMITTEES (MCACs) TO INFORM MEDICAID POLICYMAKING

Issue

States are federally required to have an MCAC to inform Medicaid policymaking. However, **MCACs vary widely across states, are used inconsistently, and rarely include diverse Medicaid beneficiary representation**. MACPAC made several policy recommendations to address the administrative, financial, and social barriers that Medicaid beneficiaries face in meaningfully participating in MCACs.

- MACPAC **recommendations focus on sub-regulatory guidance and state adoption of best practices**, rather than regulatory changes.
  - **CMS should issue sub-regulatory guidance and provide technical assistance** to states to address challenges in beneficiary recruitment/participation and meeting facilitation tactics.
  - States should include policies in MCAC bylaws to **promote diverse beneficiary recruitment.**
  - States should **streamline application requirements and processes** and address logistical, financial, and meeting content barriers faced by participating beneficiaries.
- Some experts have expressed concerns with setting minimum diversity requirements, noting that many **states struggle with meeting existing beneficiary engagement requirements**.
- Separately, in April 2023 CMS **proposed a rule that would change MCAC structure** and operational requirements to support more meaningful beneficiary engagement (CMS 2442-P).

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DATA UPDATE ON UNWINDING THE CONTINUOUS COVERAGE PROVISIONS

Issue

As the unwinding of the pandemic-era continuous coverage requirement unfolds, **states are reporting data on redeterminations to CMS**. With all states having now completed at least one cohort of redeterminations, **CMS has released new data** assessing states' redetermination rates, procedural termination rates, call center volume, and other variables. These data identify possible barriers in beneficiary renewal efforts; however, additional data on other aspects of redeterminations will help paint a fuller picture.

- Nationally, **nearly three in four Medicaid terminations occurred for procedural reasons**. The majority of states (38 states) have procedural termination rates of 50% or greater.
- Automatic **transitions to the exchange** may help mitigate mass losses of coverage, but it is unclear to what extent individuals experience gaps in coverage during this transition.
- These **data may support policymakers as they consider how to more permanently modify eligibility and enrollment processes**, such as ex parte renewal policies.
- In December 2023, CMS released an **interim final rule that creates new enforcement authorities**—including financial penalties—for states failing to meet reporting or redetermination requirements. ATI expects that CMS is unlikely to levy financial penalties, but instead more heavily leverage corrective action plans.

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HIGHLIGHTS FROM MACSTATS 2023

Issue

MACStats shared **highlights from their annual data book** and commissioners discussed where further research is needed, with a particular focus on Medicaid managed care.

- MACStats includes data and statistics on enrollment, spending, and key aspects of the programs, including federal match rates, access to care, and eligibility levels nationwide. **Key highlights include:**
  - **38%** of the population enrolled in Medicaid or CHIP
  - Medicaid and CHIP enrollment grew **56%** in the past 8 years
  - **70%** of beneficiaries are enrolled in comprehensive Medicaid managed care
  - **4.9%** of beneficiaries that use LTSS account for **28.5%** of Medicaid spending
- There is a growing **focus on managed care quality, utilization, and spending**. States and managed care plans (both Medicaid and MA) should anticipate calls for research and insight in this area, which **may translate to additional reporting requirements**.
- Click here to access MACStats.

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ATI knows Medicaid.

Our team can guide you through the complex regulatory landscape and bring to bear actionable and innovative policy insights.

ATI has experience working directly with state Medicaid agencies, managed care plans, providers, and advocates to advance Medicaid delivery system and payment reforms.

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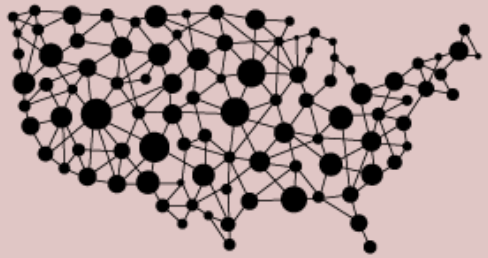

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