Report to Congress on Medicaid and CHIP

MARCH 2023

MACPAC | Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, Section 1900 of the Social Security Act, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

Report to Congress on Medicaid and CHIP

MARCH 2023

MACPAC | Medicaid and CHIP Payment and Access Commission

March 15, 2023

The Honorable Kamala Harris
President of the Senate
The Capitol
Washington, DC 20510

The Honorable Kevin McCarthy
Speaker of the House
The Capitol
Washington, DC 20515

Dear Madam Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the March 2023 *Report to Congress on Medicaid and CHIP*. This report includes four chapters that address: improving the collection of race and ethnicity data in Medicaid; increasing the transparency and improving the collection of nursing facility payment data; giving state Medicaid programs greater flexibility in following Medicare drug coverage decisions; and examining payment policy for the nation's safety net hospitals.

Chapter 1 continues the Commission's work on health equity and includes recommendations on ways to improve Medicaid race and ethnicity data collection and reporting. Racial and ethnic health disparities persist throughout the U.S. health care system. These issues are exacerbated by the high rates of missing data on race and ethnicity, which may lead to inaccurate and incomplete understanding of health disparities. High-quality data are needed to understand and address health disparities, but collecting and reporting these data is a challenge. The Commission makes two recommendations to update the way data are collected to improve the accuracy of these data and increase Medicaid applicant response rates.

Chapter 2 focuses on the transparency of Medicaid payments to nursing facilities. Medicaid is the primary payer for most nursing facility residents. Since Congress repealed the Boren amendment, states have had considerable flexibility to set nursing facility payment rates. The Commission has undertaken long-term work to examine the extent to which Medicaid nursing facility payment policies are consistent with the statutory goals of efficiency, economy, quality, and access. Chapter 2 includes recommendations that would provide comprehensive data on payments to nursing facilities as well as regular state rate studies to assess whether payment policies are consistent with the statutory goals.

In Chapter 3, the Commission makes recommendations that would allow states the option to align drug coverage with Medicare coverage with evidence requirements under a Medicare National Coverage Determination. While Medicaid drug spending is growing overall, it is increasingly being driven by high-cost specialty drugs. From 2010 to 2015, net spending on specialty drugs in Medicaid almost doubled, growing from $4.8 billion to $9.9 billion. Under Medicare Part B, the Centers for Medicare & Medicaid Services (CMS) has the authority to evaluate whether a service or prescription drug is reasonable and necessary. Under certain circumstances, CMS can link coverage of an item or service to participation in an approved clinical study or to the collection

of additional clinical data. The Commission's recommendations would establish Medicare as a standard for acceptable coverage and could also encourage drug manufacturers to develop evidence of a drug's effectiveness in a timely manner for Medicaid beneficiaries.

The final chapter of the March report continues the Commission's work on our annual, statutorily mandated obligation to report on Medicaid disproportionate share hospital (DSH) allotments to states. As in prior years, the Commission continues to find little meaningful relationship between state DSH allotments and the number of uninsured individuals; the amounts and sources of hospitals' uncompensated care costs; and the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income and uninsured populations.

The policy response through the COVID-19 public health emergency helped lower the uninsured rate, improve hospital finances, and increase DSH allotments. MACPAC estimates that fiscal year 2024 DSH allotments will be reduced by 54 percent ($8 billion) on October 1, 2023, due to scheduled reductions that were implemented as part of the Consolidated Appropriations Act, 2021.

MACPAC is committed to providing in-depth, non-partisan analyses of Medicaid and CHIP policy, and we hope this report will prove useful to Congress as it considers future policy development affecting these programs. This document fulfills our statutory mandate to report each year by March 15.

Sincerely,

Melanie Bella, MBA
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MACPAC's March 2023 *Report to Congress on Medicaid and CHIP* contains four chapters of interest to Congress: (1) improving the collection and reporting of race and ethnicity data in Medicaid, (2) increasing the transparency and improving the collection of nursing facility payment data, (3) giving state Medicaid programs greater flexibility in following Medicare drug coverage decisions, and (4) our statutorily required review of hospital payment policy for the nation's safety-net hospitals.

CHAPTER 1: Medicaid Race and Ethnicity Data Collection and Reporting: Recommendations for Improvement

Chapter 1 continues the Commission's work on health equity and includes recommendations on ways to improve Medicaid race and ethnicity data collection and reporting. Racial and ethnic health disparities persist throughout the U.S. health care system. These issues are exacerbated by the high rates of missing data on race and ethnicity, which may lead to an inaccurate and incomplete understanding of health disparities. High-quality data are needed to understand and address health disparities, but collecting and reporting these data can be a challenge. MACPAC research found that states have difficulty collecting this information because individuals may hesitate to self-report due to concerns about how the information may be used. Additionally, individuals may not provide accurate responses if they do not understand the race and ethnicity questions or feel their identities are not reflected in the available categories for responses.

In this chapter, we make the following recommendations:

1.1 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.

1.2 The Secretary of the U.S. Department of Health and Human Services 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 materials 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.

MACPAC's recommendations to improve Medicaid application questions and application assister training aim to address the primary challenges with collecting race and ethnicity data. In conjunction with ongoing work at the federal and state levels to address other challenges, these recommendations may also lead to improvements in the completeness and accuracy of race and ethnicity data collected from Medicaid applicants.

CHAPTER 2: Principles for Assessing Medicaid Nursing Facility Payment Policies

In Chapter 2, we focus on the transparency of Medicaid payments to nursing facilities. Medicaid is the primary payer for most nursing facility residents and has an important role to play in improving the care that nursing facility residents receive. However, facilities that serve a high share of Medicaid-covered residents have worse quality outcomes on average than other facilities. The COVID-19 pandemic exposed and exacerbated many of these disparities. In response, policymakers are considering a variety of reforms to how they regulate and pay for nursing facility care.

The Commission has undertaken long-term work to examine the extent to which Medicaid nursing facility payment policies are consistent with the statutory goals of efficiency, economy, quality, and access. Transparency of Medicaid payments has been a long-standing goal of the Commission since complete data on Medicaid payments to providers are needed to inform assessment of payment policies.

In this chapter, we make the following recommendations:

2.1 To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to collect and report the following data in a standard format that enables analysis:

- facility-level data on all types of Medicaid payments to nursing facilities, including resident contributions to their cost of care;
- data on the sources of non-federal share of spending necessary to determine net Medicaid payment at the facility level; and
- comprehensive data on nursing facility finances and ownership necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and to examine the effects of real estate ownership models and related-party transactions.

2.2 To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS 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 CMS should make facility-level findings publicly available in a format that enables analysis.

As more information on Medicaid nursing facility payments becomes available, the Commission will continue to monitor state payment policies. In particular, the Commission will closely follow how any future changes in federal regulatory requirements (e.g., minimum staffing standards) affect states, providers, and beneficiaries.

CHAPTER 3: Strengthening Evidence under Medicaid Drug Coverage

Chapter 3 addresses states' concerns about covering drugs that have limited evidence of a clinical benefit and makes recommendations that would give states the flexibility to align with a Medicare decision to link coverage with participation in clinical trials or comparative studies. The recommendations would help strengthen evidence of a drug's effectiveness in the Medicaid population.

While Medicaid drug spending is growing overall, it is increasingly being driven by high-cost specialty drugs. From 2010 to 2015, net spending on specialty drugs in Medicaid almost doubled, growing from $4.8 billion to $9.9 billion. States have expressed concern about paying high prices for drugs approved through the accelerated approval pathway, which have been approved by the U.S. Food and Drug Administration on the basis of surrogate endpoints and have yet to verify a clinical benefit.

Under Medicare Part A and Part B, CMS has the authority to make a Medicare National Determination (NCD) to evaluate whether a service or prescription drug is reasonable and necessary. Under certain circumstances, CMS can link coverage of an item or service to participation in an approved clinical study or to the collection of additional clinical data. This policy is referred to as coverage with evidence development (CED).

In this chapter, we make the following recommendations:

3.1 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 coverage with evidence

development requirements implemented under a Medicare national coverage determination.

3.2 Congress should amend Section 1903(m)(2)(A)(xiii) to require the managed care contract conform to the state's policy with respect to any exclusion or restriction of coverage of a covered outpatient drug based on coverage with evidence development requirements implemented under a Medicare national coverage determination.

The Commission will continue to focus attention on prescription drugs, including policy options that could be used to address the challenges of high-cost drugs.

CHAPTER 4: Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

Chapter 4 of the March report fulfills MACPAC's annual, statutorily mandated obligation to report on Medicaid disproportionate share hospital (DSH) allotments to states for payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients. As in prior years, the Commission continues to find little meaningful relationship between state DSH allotments and the number of uninsured individuals; the amounts and sources of hospitals' uncompensated care costs; and the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income and uninsured populations.

The policy response through the COVID-19 public health emergency (PHE) helped lower the uninsured rate, improve hospital finances, and increase DSH allotments. A total of 27.2 million people, or 8.3 percent of the U.S. population, were uninsured in 2021, a 0.3 percentage point decline from 2020. Some of the decline in the uninsured rate may be attributed to the continuous coverage requirements implemented during the PHE.

Overall, we observed that the COVID-19 pandemic had a considerable effect on hospital finances. Hospitals reported $41.9 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2020, or about 4.1 percent of hospital operating expenses. Uncompensated care as a share of hospital operating expense has largely remained unchanged since 2015. In FY 2020, the aggregate operating margin for all hospitals was much lower than it has been in previous years because of the financial disruptions from the COVID-19 pandemic, and deemed DSH hospitals continued to report a lower aggregate operating margin than other hospitals. However, after accounting for DSH payments and federal provider relief funding authorized during the PHE, the aggregate total margin was similar for both deemed DSH hospitals and other hospitals. We also found that the American Rescue Plan Act (ARPA, P.L. 117-2) increased DSH allotments by $1.5 billion in FY 2023. We expect that the ARPA-increased DSH allotments will phase out by FY 2024 as the PHE comes to an end.

MACPAC estimates that fiscal year 2024 DSH allotments will be reduced by 54 percent ($8 billion) on October 1, 2023, due to scheduled reductions that were implemented as part of the Consolidated Appropriations Act, 2021. The Commission will consider recommendations on a countercyclical adjustment to DSH allotments for inclusion in the June 2023 report to Congress.

Chapter 1:

Medicaid Race and Ethnicity Data Collection and Reporting: Recommendations for Improvement

Medicaid Race and Ethnicity Data Collection and Reporting: Recommendations for Improvement

Recommendations

1.1 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.

1.2 The Secretary of the U.S. Department of Health and Human Services 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 materials 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.

Key Points

- Racial and ethnic health disparities persist throughout the U.S. health care system, and improving the quality of race and ethnicity data is needed to measure disparities and develop and implement policies to promote health equity.
- All state Medicaid programs collect race and ethnicity information on their applications and, as required by the Centers for Medicare & Medicaid Services, report these data to the Transformed Medicaid Statistical Information System. The completeness and accuracy of these reported data vary by state.
- Many states have challenges gathering these data from applicants, which can affect data quality. Applicants may have concerns with responding to these questions because of lack of understanding about how the information may be used, fears of being denied coverage, and categories not aligning with how they self-identify.
- Updating the race and ethnicity questions on the HHS model single, streamlined application with evidence-based approaches for asking these questions and explaining their purpose may ease applicant concerns and lead to increased response rates and reporting of more complete and accurate data.
- Developing model training materials that include information about the purpose of the race and ethnicity questions provides application assisters with better tools for educating applicants and may lead to improved applicant understanding and trust in providing sensitive information.

CHAPTER 1: Medicaid Race and Ethnicity Data Collection and Reporting: Recommendations for Improvement

There is a need to set priorities for advancing health equity in Medicaid to ensure beneficiaries receive equitable access to services and improve health outcomes. Improving the quality of race and ethnicity data is one step in enabling the federal and state governments, researchers, and other stakeholders to identify and measure health disparities driven by race and ethnicity and develop and implement policies to promote health equity. The Commission's recent work has focused on the collection and reporting of data to the Transformed Medicaid Statistical Information System (T-MSIS), the only federal Medicaid data source for all beneficiaries that includes eligibility, demographics, service use, and spending information (MACPAC 2022a, 2021b).[1] In addition to race and ethnicity data, the Commission acknowledges a need for collecting other demographic data to understand and address health inequities experienced by beneficiaries marginalized based on age, sex, disability status, sexual orientation, gender identity, primary language, and geography and the intersection of these identities (MACPAC 2022a). The U.S. Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), and some states have long made commitments to address health disparities and advance health equity; however, disparities in health care access and outcomes persist, and advancing health equity should be an ongoing focus (CMS 2022a, HHS 2022a).

There are known racial and ethnic health disparities in Medicaid, but the data needed to assess them are limited by quality concerns, which can lead to an inaccurate and incomplete understanding of the health disparities driven by these factors (James et al. 2021a). Improving these data will support policymakers as they develop and evaluate policies to address health disparities and equity. For example, all states collect race and ethnicity data on Medicaid applications for their own analytical purposes and to meet reporting requirements for T-MSIS; however, states have challenges with and vary in their success with collecting and reporting complete and accurate data. Multiple approaches are necessary for addressing these challenges and improving the quality of these data.

To examine the challenges in collecting and reporting race and ethnicity data and opportunities to address them, we analyzed the availability of T-MSIS race and ethnicity data and conducted a literature review and stakeholder interviews.[2] The literature review focused on the federal data collection requirements, their applicability to state Medicaid programs, and the usability of Medicaid race and ethnicity data. Similarly, the interviews addressed these topics and how state Medicaid programs collect race and ethnicity data and report them to T-MSIS. Further, the interviews focused on identifying challenges with collecting these data and how to improve their usability. We interviewed HHS, CMS, the Congressional Research Service, and state Medicaid officials; research experts; beneficiary advocates; and representatives of Medicaid managed care plans and application assister organizations.[3]

The findings from the literature review and stakeholder interviews identified several challenges with collecting and reporting complete and accurate race and ethnicity data and several potential approaches to improving these data. State Medicaid agencies can only require applicant information that is necessary for making an eligibility determination, so the race and ethnicity questions must be marked as optional (42 CFR 435.907). As a result, states sometimes have difficulty collecting this information. For example, individuals may hesitate to self-report due to concerns about how the information may be used. Additionally, individuals may not provide accurate responses if they do not understand the race and ethnicity questions or do not feel their identities are reflected by the available response options. Explaining the purpose of the questions and providing categories that are reflective of the population may help address some of the collection challenges. States also have difficulty reporting these data to CMS in part because of state eligibility system and Medicaid Management Information System (MMIS) design. For example, some eligibility systems and MMIS store these data

in different formats, leading to potential losses in completeness and accuracy during data transfers. CMS has provided states with technical instructions and ongoing technical assistance to identify state reporting issues, and these challenges are becoming less common.

Efforts to address disparities should not be delayed until all of the current data quality concerns are resolved. Although there will be some continuing challenges with the completeness and accuracy of the data, some states already have race and ethnicity data of sufficient quality, and there are multiple approaches that can support state efforts to improve the quality of these data. The Commission makes two recommendations to improve the collection of Medicaid race and ethnicity data:

1.1 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.

1.2 The Secretary of the U.S. Department of Health and Human Services 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 materials 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.

This chapter begins by describing the need for high-quality data to understand and address health disparities. It then outlines the federal and state priorities for improving race and ethnicity data. The chapter goes on to describe the federal standards for collecting race and ethnicity data, the state data collection and reporting processes, and the current quality of Medicaid race and ethnicity data. It also describes the challenges with collecting and reporting high-quality race and ethnicity data and approaches to improving their usability. The chapter concludes with the Commission's recommendations and its rationale.

Importance of High-Quality Data to Address Health Disparities

Racial and ethnic health disparities persist throughout the U.S. health care system, including in Medicaid and the State Children's Health Insurance Program (CHIP). More than 60 percent of Medicaid and CHIP beneficiaries identify as American Indian and Alaska Native, Asian American and Pacific Islander, Black, Hispanic, or multiracial, making measuring and addressing disparities in these programs particularly important (MACPAC 2022c, 2022d, and 2021a). Gaps in Medicaid race and ethnicity data quality should not necessarily prevent their use or efforts to address disparities; however, without high-quality, self-reported data across all states, CMS, states, researchers, and other stakeholders are limited in their ability to measure and monitor disparities. Similarly, these data are needed to examine efforts to address disparities in access to care, use of services, and health outcomes to evaluate their effectiveness in advancing health equity.

Historically, many types of demographic data, including race and ethnicity, have not been collected consistently or uniformly across federal and state programs. Although established federal standards for collecting race and ethnicity data exist, having multiple standards may make it challenging for those collecting these data to know which is most appropriate. Further, these data are difficult to collect and often incomplete, hindering the ability to monitor and address disparities (James et al. 2021a, 2021b; HHS 2011a; OMB 1997). Other demographic information, such as sexual orientation and gender identity and disability, do not have data collection and reporting standards that are used consistently across federal data collection efforts, which also limits the availability of high-quality data for these populations

(Equitable Data Working Group 2022, Ortman and Parker 2021). Collecting comparable data on multiple dimensions of identity is important for ensuring that these populations are accounted for when measuring inequities in access to care. More complete data also allow for the assessment of disparities at the intersection of multiple demographic groups, such as measuring access to care and health outcomes for people with disabilities by race and ethnicity (Rubin et al. 2018). As part of the Commission's ongoing health equity work, we will prioritize examining opportunities to improve the collection of other demographic data in our future work.

Federal and state-level data often have high rates of missing race and ethnicity data, which may lead to an inaccurate and incomplete understanding of health disparities (James et al. 2021b). Recent research demonstrates that individuals most likely to face health disparities because of their race and ethnicity are least likely to provide this information (Labgold et al. 2021; Sholle et al. 2019).[4] For example, one study found that those who identify as Black, Hispanic, and Asian American and Pacific Islander were more likely than white-identifying individuals to skip these questions (Dembosky et al. 2019). Furthermore, incomplete data for small populations, such as American Indian and Alaska Native populations, may produce insufficient samples for statistical analyses, so these populations are often not reported in health disparities research. Current federal reporting standards do not include detailed categories for race and ethnicity, which are needed to improve the identification of disparities among smaller subpopulations that may otherwise be masked when they are aggregated to a larger group (Chau and Chan 2021). For example, under Office of Management and Budget (OMB) standards, a person could self-identify as Hispanic but not a more specific Hispanic subgroup, such as Puerto Rican.

Federal priorities for improving race and ethnicity data quality

The collection and reporting of high-quality demographic data are priorities of the Biden Administration's Equity Executive Order (EOP 2021). The Equitable Data Working Group, established by the Equity Executive Order, recommended federal strategies to improve the collection and disaggregation of demographic data and leverage underused data sources to conduct meaningful analyses to better understand racial and ethnic disparities. The report identified many challenges with using race and ethnicity data. For example, the ability to conduct analyses on smaller subpopulations is limited due to inconsistent collection of more granular race and ethnicity categories across federal data collection efforts. This is particularly true when assessing the intersection of race and ethnicity with other identities and demographic groups, such as disability status and primary language (Equitable Data Working Group 2022, EOP 2021).

In response to the Equity Executive Order, CMS developed a framework, modeled after the Healthy People 2000 Framework, to achieve health equity and eliminate disparities. The framework outlines five priority areas: (1) expand the collection, reporting, and analysis of standardized data; (2) assess causes of disparities within CMS programs and address inequities in policies and operations to close gaps; (3) build capacity of health care organizations and the workforce to reduce health and health care disparities; (4) advance language access, health literacy, and the provision of culturally tailored services; and (5) increase all forms of accessibility to health care services and coverage (CMS 2022a).

CMS is considering many approaches to improve the quality and usability of Medicaid race and ethnicity data. These data are collected as part of the Medicaid application process, and CMS is working with states to address barriers to reporting these data to T-MSIS. However, states also have challenges with collecting complete and accurate information from all individuals who apply for Medicaid and CHIP, which limits the quality of the data reported to T-MSIS. Therefore, CMS is also exploring other approaches to augment these data by leveraging other federal and state-level data sources for internal analyses (Box 1-1). These additional approaches will supplement efforts to measure and address health disparities in Medicaid, but they will not be used to modify the race and ethnicity data available in T-MSIS (CMS 2021b).

State priorities

State Medicaid programs are prioritizing health equity, including improving the collection and reporting of race and ethnicity data. However, most states are still early in the development process, and these efforts have initially focused on establishing infrastructure to support the work. In some states, this includes designating a dedicated Medicaid health equity official or requiring managed care plans to identify a health equity officer or design health equity requirements (Akard 2022, MACPAC 2022a). For example, North Carolina recently released its State Health Improvement Plan, which sets priorities for reducing disparities in health outcomes that disproportionately affect historically marginalized populations (NCDHHS 2022).

In interviews, states shared that they use race and ethnicity data for program administration (e.g., targeted outreach to beneficiaries) and to measure health disparities. Some states have methods to disaggregate Medicaid eligibility race and ethnicity data, and others are supplementing these data with additional sources for analyses (Box 1-1). Some states use race and

BOX 1-1. Other Data Sources and Methodology to Increase Data Usability

Self-reported data are considered the best method for collecting information that reflects an individual's identity. However, given the difficulty in collecting these data, self-reported data may often be missing. To increase the usability of race and ethnicity administrative data for research purposes, federal and state agencies are exploring ways to supplement Transformed Medicaid Statistical Information System (T-MSIS) race and ethnicity data with external data sources and imputation methods. These additional data sources do not replace the Medicaid eligibility data or change the data that states submit to T-MSIS.

Most of these efforts are in the early stages of development and are primarily used for internal validation and analyses. As these techniques are developed, guidelines should be established around the appropriate use of alternative data sources and imputation for internal analyses.

Alternative data sources. States may incorporate alternative data sources to validate administrative data and conduct additional internal analyses. For example, one state reported stratifying state Consumer Assessment of Healthcare Providers and Systems data by race and ethnicity to study health disparities at the plan level. The state also uses provider-collected race and ethnicity data as a tool to better understand the accuracy of administrative data.

A number of states we interviewed have ongoing efforts to leverage existing relationships with other public agencies, health providers, and Medicaid managed care plans to collect additional beneficiary race and ethnicity data. For example, one state Medicaid agency receives additional individual-level race and ethnicity data from other state agencies, which are saved separately from the state eligibility system and Medicaid Management Information System. The state Medicaid program is also working to collect data from managed care organizations, accountable care organizations, and hospitals. With more complete data, the state aims to monitor and address statewide inequities.

Data imputation. To address missing race and ethnicity T-MSIS data, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services (CMS), and several state Medicaid programs are developing methods to impute missing administrative data with assigned values for analytical purposes.

In June 2022, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) published a technical report on imputing race and ethnicity data for people on exchange plans (HHS 2022b). The imputation method is based on an individual's first name, surname, and geographic location. ASPE and CMS report efforts to develop a similar methodology for use with Medicaid administrative data.[5]

ethnicity data to develop targeted policies to reduce disparities in health outcomes related to chronic health conditions and to improve service delivery for Medicaid beneficiaries. For example, one interviewed state is analyzing the burden of various chronic illnesses across the Medicaid population, and the data are informing a new policy to ensure that individuals with sickle cell anemia, a disease that disproportionally affects Black individuals, have access to adequate services, medications, and treatments (Ojodu et al. 2014).

Race and Ethnicity Data Collection Standards and Guidance

Existing minimum federal standards for collecting race and ethnicity data are intended to ensure the collection and reporting of uniform and comparable data. OMB established federal minimum standards for collecting race and ethnicity data in federally sponsored data collection efforts, and HHS established more granular guidelines for collecting and reporting these data in HHS-sponsored national population health surveys (HHS 2011a, OMB 1997). However, because these standards do not directly apply to state Medicaid programs, state data collection and reporting processes may not always be consistent with those used in federal data collection efforts or in other states (Gilfoil 2022, James et al. 2021b).

Federal OMB minimum standards

First established in 1977, the OMB federal minimum standards for race and ethnicity were intended to promote the comparability of data across all federal data collection and reporting efforts, including, for example, census and population surveys.

1977 standards. OMB's 1977 Statistical Policy Directive (SPD) 15 established the first federal race and ethnicity minimum standards to be used when these data are collected but did not require their collection. The directive provided four minimum standards for the racial categories (white, Black, Asian or Pacific Islander, and American Indian or Alaskan Native) and two ethnicity categories (Hispanic origin and not of Hispanic origin). More granular categories were permitted as long as they could be aggregated into the minimum standards (OMB 1977). The inclusion of these questions in federally sponsored surveys and administrative data collection efforts is necessary for measuring racial and ethnic disparities, monitoring equal access to services, and enforcing Title VI of the Civil Rights Act (Youdelman and Hitov 2001).

1997 standards. In response to criticism that the original standards did not reflect the racial and ethnic diversity in the United States, OMB completed a comprehensive review of the standards and published updated standards informed by public comment and research. The updated SPD 15 revised the minimum federal standards to include five racial groups (white, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander) and two ethnicity categories (Hispanic or Latino and not Hispanic or Latino) (Appendix 1A). As with the 1977 directive, these minimum standards apply only if race and ethnicity information are collected, do not require the collection of race and ethnicity data, and do not directly apply to state-level data collection and reporting, including by state Medicaid programs (OMB 1997). However, to enable its own reporting as a federal agency, CMS requires states to report race and ethnicity data to T-MSIS that at minimum meet OMB standards.[6, 7]

Considered revisions. OMB has considered revisions to the 1997 OMB standards, but no changes have yet been finalized. In 2014, OMB formed the Interagency Working Group for Research on Race and Ethnicity to improve federal race and ethnicity data. In 2016, OMB published a notice of possible revisions to the 1997 minimum standards based on the work group's recommendations. Specifically, the recommendations included asking separate questions about race and ethnicity, adding a Middle Eastern and North African (MENA) racial category, and clarifying that the proposed minimum standards do not prevent the collection of more granular race and ethnicity data (OMB 2016). However, OMB did not publish an updated rule.

In 2021, the Biden Administration established the Equitable Data Working Group to assess existing federal data collection systems and programs and to propose policy recommendations to improve race and ethnicity data availability. Its report emphasized

the importance of having federal data collection standards that reflect the diverse populations in the United States. The group recommended revising the 1997 OMB standards to include groups that are not currently represented in the minimum standards, such as MENA, and to include subgroups within the Asian and Native Hawaiian and Pacific Islander categories (Equitable Data Working Group 2022, EOP 2021).

In June 2022, the chief statistician of the United States announced that the Office of Information and Regulatory Affairs, Statistical and Science Policy Office would begin a formal review of the 1997 OMB minimum standards, with the goal of publishing revised standards by summer 2024 (Orvis 2022). On January 27, 2023, OMB proposed revisions to the 1997 OMB SPD 15 minimum standards and reiterated its plans to complete the revisions by summer 2024 (OMB 2023).[8]

HHS policies on race and ethnicity data collection

HHS developed race and ethnicity data collection standards and requirements for HHS-sponsored national population health surveys that go beyond those established by the 1997 OMB rule. Although the HHS standards apply only to population health surveys, some federal and state-level data collection efforts have implemented them.

1997 HHS data inclusion policy. HHS issued a policy statement reiterating OMB standards and outlined which HHS-sponsored data collection efforts are required to collect and report race and ethnicity information in accordance with OMB standards.[9] Before this HHS policy, HHS found inconsistencies in the collection and reporting of race and ethnicity data. The policy statement cited the lack of a requirement to include questions on race and ethnicity as one of the primary reasons for the incomparable and poor-quality data across HHS data systems (Youdelman and Hitov 2001, HHS 1997).

The applicability of the 1997 data inclusion policy to state data collection activities is unclear. While the 1997 HHS policy specifically notes the applicability of the standards to administrative records, it did not directly mention state Medicaid agencies, and CMS did not enforce the collection or reporting of these data. Despite the lack of an explicit requirement, most states were collecting these data at the time the guidance was issued or began to in response to it (Youdelman and Hitov 2001). In 2004, about 70 percent of state Medicaid programs reported collecting race and ethnicity data. However, there was little consistency across state approaches, and few states asked questions that included all seven of the OMB minimum standards (LLanos and Palmer 2006).

2011 HHS implementation guidance on data collection standards. As required by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), HHS issued guidance on race and ethnicity data collection. Section 4302 of the ACA charged the Secretary of HHS to establish uniform data collection standards for race and ethnicity that, at a minimum, meet the 1997 OMB standards and develop data collection standards for sex, primary language, and disability status that would be consistently collected and reported across all federally conducted or supported health care data collection efforts (HHS 2011b). The ACA also required the Secretary to ensure that within two years of enactment, all federally sponsored and supported data collection should, to the extent practicable, collect data on race, ethnicity, sex, primary language, and disability status that meet the HHS standards. Additionally, Section 4302 of the ACA extended these data collection standards to state Medicaid programs and CHIP.

The 2011 HHS guidance established standards for collecting data on race, ethnicity, sex, primary language, and disability status. These updated race and ethnicity standards included more granular race and ethnicity categories that can be aggregated to meet OMB minimum standards (Appendix 1A). However, the 2011 HHS implementation guidance requires only HHS-conducted or -sponsored national population health surveys to use these minimum standards. The guidance does not specify standards that apply to other forms of federally sponsored and supported data collection, including those collected under Medicaid and CHIP state plans (HHS 2011a). HHS officials reported these guidelines were designed to apply only to survey data collection to allow for state and program flexibility given that some of these standards may not be applicable across the wide range of programs within HHS (HHS 2022c).

Although these standards do not explicitly apply to state Medicaid programs and CHIP, all states collect race and ethnicity information on their applications. Further, more than half of the states include race and ethnicity categories that align with the 2011 HHS guidance and report these data to CMS (SHADAC 2022).

State Data Collection and Reporting Processes

Medicaid race and ethnicity data collection methods and reporting processes are complex and often developed to meet state-specific needs. Multiple steps are necessary to collect, store, process, and transform the data into the final format required for submitting to T-MSIS. The varying methods states use for these processes can affect the completeness, accuracy, and overall quality of the data.

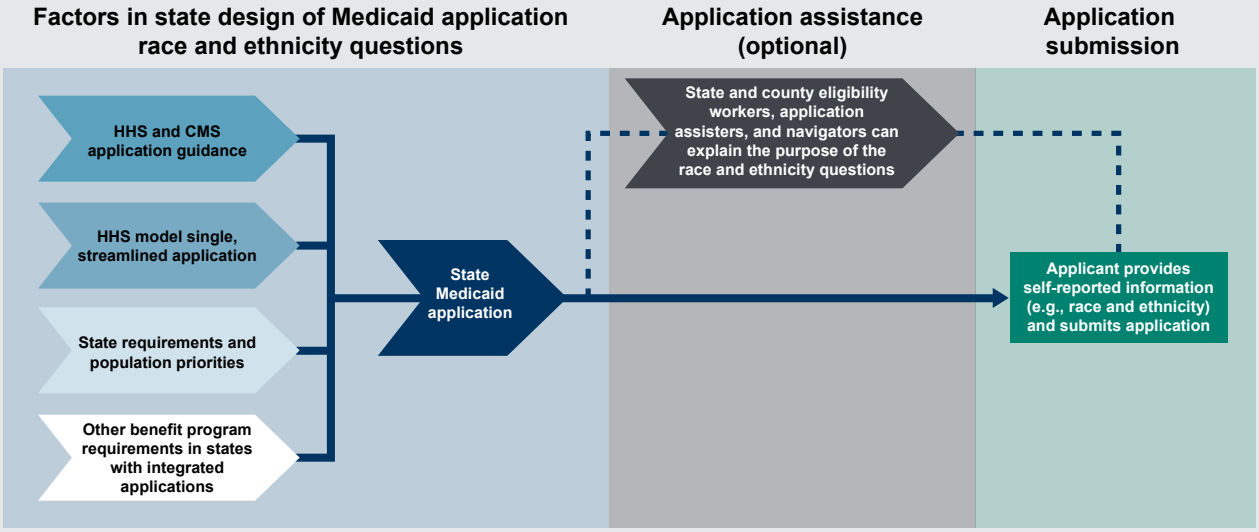
Data collection

State Medicaid programs develop their own applications. States are permitted to include only optional race and ethnicity questions on the application, as they are not a requirement of Medicaid eligibility. Race and ethnicity are typically self-reported by applicants, which is considered the preferred method for collecting data to best reflect the individual's identity (OMB 1997). Individuals can complete the application online, in person, over the phone, and, if needed, with the assistance of state- and county-level Medicaid application assisters, caseworkers, and other organizations with trained application assisters and navigators (Figure 1-1).

Application development. States have the flexibility to determine which race and ethnicity categories to include on their applications as long as the collected information allows the state to meet CMS-established reporting requirements (CMS 2022b).

In 2013, CMS provided states with a model single, streamlined application to be used to determine enrollment for Medicaid, CHIP, and qualified health plans on exchanges.[10] The model application includes optional race and ethnicity questions that align with the 2011 HHS data collection standards, which aggregate to OMB standards, and allow individuals to select multiple races and ethnicities in their responses. They do not include an option for individuals to indicate that they prefer not to provide their race and ethnicity

FIGURE 1-1. State Application Development and Race and Ethnicity Data Collection Processes



Notes: HHS is U.S. Department of Health and Human Services. CMS is Centers for Medicare & Medicaid Services.

Source: MACPAC analysis of race and ethnicity data collection process.

information, so those who choose not to respond leave these questions blank (CMS 2013a).

CMS also provided states with guidance on how to modify the model application or develop a state alternative application for CMS approval.[11] States are permitted to submit an alternative application to allow for state-specific needs and policies, as long as the application still complies with the general principles of the model application. For example, states can only require questions that are necessary for determining eligibility, and other included questions, such as those on race and ethnicity, are permitted only as optional questions. However, the guidance did not include specific information related to the inclusion or modification of the model application race and ethnicity questions (CMS 2013b).

Many states have modified or developed their own CMS-approved applications. A review of all state paper and online applications found states collect race and ethnicity information in 64 different ways, including variations in the questions and categories provided on online and paper applications. The majority of states include categories that are consistent with OMB standards or 2011 HHS standards, but many states include additional categories that expand on the 2011 HHS standards. Additionally, some states allow applicants to select multiple races and ethnicities, while other states allow only one selection, and a few have a combined race and ethnicity question. Further, some state race and ethnicity questions vary between paper and online applications. For example, some states, due to space limitations, include fewer categories to choose from on paper applications than on online applications (SHADAC 2022).[12]

Some states modified the race and ethnicity questions based on state requirements or population priorities. For example, one state's data collection standards were determined by state statute, which required 33 race and ethnicity options and additional options for individuals to choose unknown race or ethnicity or to decline to answer. The categories were developed based on research-supported practices and were informed by a community stakeholder process. Another state is developing a new application that will include race and ethnicity questions with categories that align with OMB standards and an additional question with a more extensive list of ethnicities that was determined based on the state's population diversity. The data from this additional question will be used for state-level reporting and analyses to measure health disparities for populations of interest for the state. These changes were informed by an advisory group and a request for information on the data standards.

States also have the option to integrate their Medicaid eligibility systems with other benefit programs, so some state applications are developed to meet the requirements for multiple programs. For example, 29 state Medicaid programs have multi-benefit applications that are also used to determine eligibility for the Supplemental Nutrition Assistance Program (SNAP) (Brooks et al. 2022). In our interviews, state officials noted their multi-benefit applications must meet both federal Medicaid and SNAP requirements. Federal SNAP data collection requirements are more specific compared with Medicaid. SNAP applications are required to include race and ethnicity questions with categories that meet OMB minimum standards, although states are permitted to include additional race categories.[13] Applicants must also be given the option to select multiple races, and SNAP provides states with suggestions for how to collect multiple selection responses.[14]

Role of application assisters. A variety of application assisters help individuals enroll in Medicaid and many other benefit programs. Examples of assisters include federal- and state-funded workers, such as navigators, state and county eligibility workers, community health center outreach workers, and other organizations that provide application assistance services. Almost one in five of those who applied for or renewed coverage in 2020 reported receiving assistance when applying for coverage (Pollitz et al. 2020). Additionally, application assistance is in high demand, especially by certain populations, such as mixed-coverage families, populations in highly transient or largely immigrant communities, and individuals with lower computer literacy (MACPAC 2018).

Trainings for application assisters, navigators, and state and county eligibility workers are developed at the federal, state, and organization level. CMS provides Federally Facilitated Marketplace assister training, which navigators are required to complete before helping individuals enrolling through the federal exchange. Federally funded navigators assist all individuals who apply through the health insurance exchange, including individuals who are ultimately determined eligible for Medicaid, CHIP, or other

insurance affordability programs. The training includes multiple modules about serving vulnerable and underserved populations. However, it does not include any information related to asking the optional race and ethnicity questions (CMS 2022c, Sheedy 2014).

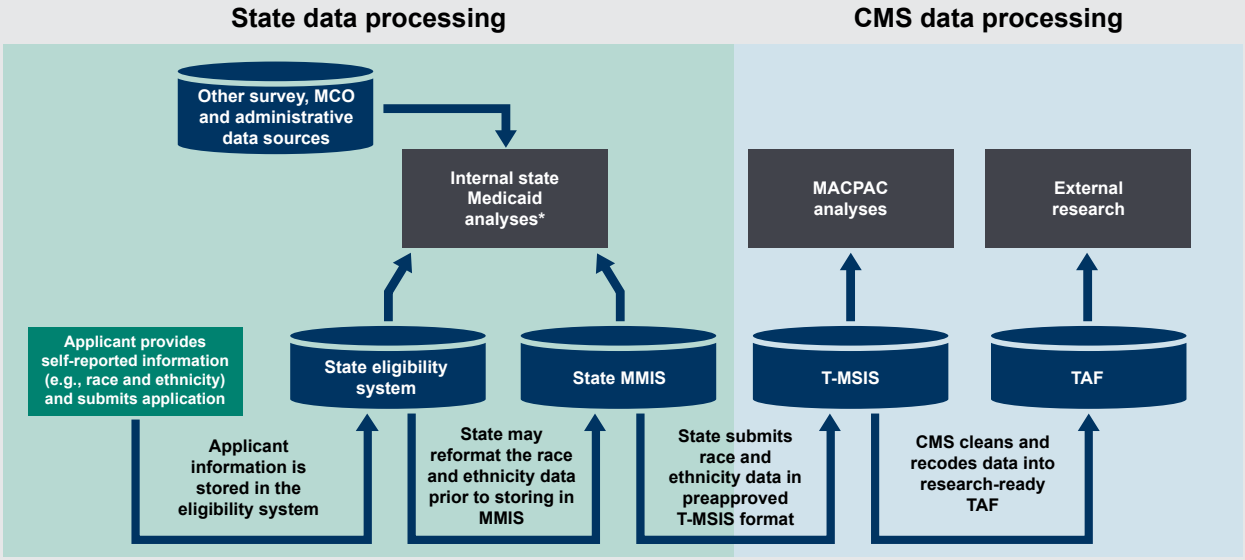
States often develop their own trainings, which may include specific information on asking about race and ethnicity. For example, one state, where more than 75 percent of applicants apply in person with a state eligibility worker, provides eligibility workers with training on how to ask race and ethnicity questions and reported that most applicants are willing to provide this information. However, few states we interviewed could confirm how often the trainings are offered and whether they discuss how to ask and explain the purpose of the race and ethnicity questions.

Application assister organizations also reported that state Medicaid programs provided them with Medicaid eligibility and enrollment training, although training specific to race and ethnicity questions was not consistently available. Application assisters often receive training related to race and ethnicity from external organizations or develop their own tools to help assisters explain how race and ethnicity data are used. For example, one application assister organization that serves primarily MENA populations shared that they developed their own training on how to ask race and ethnicity questions to better prepare their staff to assist applicants.

Data reporting

State Medicaid programs store and transfer the collected application information between multiple data systems that are used for CMS reporting processes and for internal state analyses (Figure 1-2). First, the eligibility data are stored in the state eligibility and enrollment (E&E) system, which is the state system used to store Medicaid application data and determine

FIGURE 1-2. State Data Reporting Process to the Transformed Medicaid Statistical Information System (T-MSIS)



Notes: CMS is Centers for Medicare & Medicaid Services. MCO is managed care organization. MMIS is Medicaid Management Information System. TAF is T-MSIS Analytic Files.

* In addition to states using eligibility and MMIS data for internal race and ethnicity analyses, some states supplement these data with other state data sources (e.g., other survey data, managed care organization data, and other administrative data sources). However, these data sources are never used to update the state eligibility system or MMIS or change the data submitted to T-MSIS.

Source: MACPAC analysis of race and ethnicity data collection process.

Medicaid eligibility.[15] The data from the state E&E system are then transferred to the state MMIS. The MMIS stores and maintains Medicaid enrollee data and is used to manage the state Medicaid program (GAO 2020).[16] Some states collect information in a format that is not supported by the state MMIS, so the data require reformatting before the transfer from the eligibility system to the MMIS.

The data stored in the state MMIS are used to create the T-MSIS data file. The file is formatted to meet the CMS reporting requirements, including aligning the MMIS race and ethnicity categories with OMB and 2011 HHS reporting standards. States must submit all collected race and ethnicity data, so in cases in which individuals selected multiple races or ethnicities on the application, states can submit multiple values for the individual to T-MSIS (CMS 2022b).

After T-MSIS data are submitted, they are processed by CMS and released as the research-ready T-MSIS Analytic Files (TAF). The TAF data are designed to be a research-ready version of the T-MSIS data that include data on Medicaid and CHIP enrollment, demographics, service utilization, and payments. Race and ethnicity data are included in three variables in the TAF: (1) ethnicity only, aligned with the 2011 HHS categories; (2) combined race and ethnicity, aligned with OMB minimum standards; and (3) combined race and ethnicity, aligned with 2011 HHS standards (ResDAC 2022).[17]

Medicaid Race and Ethnicity Data Quality

Some state Medicaid programs have difficulty collecting and reporting complete and accurate race and ethnicity data to T-MSIS, and the quality of the data varies by state (SHADAC 2022, CMS 2021b). CMS uses several tools to assess state-level data quality and usability and provides technical assistance to improve state-submitted T-MSIS data.

Technical assistance

CMS provides state Medicaid programs with technical instructions, technical assistance, and tools to report, assess, and identify approaches to improve the quality of the data submitted to T-MSIS. The technical instructions describe how to format and report race and ethnicity data to T-MSIS and provide a codebook for mapping race and ethnicity codes, instructions for how to code and report multiple race and ethnicity values, and examples of how to calculate some of the data quality measures used for the quality assessment (CMS 2022b). The technical assistance includes monthly meetings with states to discuss data quality improvement priorities and quarterly webinars on using the data quality assessment tools. CMS assesses the quality of the race and ethnicity data using several measures, such as data missingness. These assessments provide CMS and states with information about what is needed to improve the data submitted to T-MSIS and identify state technical assistance needs.[18]

In February 2022, CMS transitioned data quality tracking to the new Outcomes Based Assessment (OBA) to identify data concerns and assess how to address them.[19] In response to the CMS health equity focus to expand the reporting of standardized data, CMS added race and ethnicity as an OBA focus area, providing states with a more targeted assessment of their data quality and specific data measures for tracking data improvement (CMS 2022b, CMS 2022d).

The technical assistance provided to states focuses on assessing state data quality concerns and targeting critical and high-priority issues. Once CMS and the states determine which areas need improvement, the state and the state's information technology vendor develop plans to improve the data quality.[20] Some of these changes are straightforward, but some data quality issues may require large system enhancements that can take years to address.

The focus of CMS-provided technical assistance and use of data quality tools differs among states. The majority of states interviewed received technical assistance from or reported regular communications with CMS or its data contractor, Mathematica, regarding T-MSIS data quality. A couple of states with low-quality race and ethnicity data shared that efforts to improve these data were at the state level, and they had not received specific technical assistance from CMS directing them to improve these data. Additionally, some states shared issues with mapping state collected data to the T-MSIS format, but in conversations with CMS and other experts, some of these issues are due to the

design of state-level systems, and overall, these issues are becoming less common.

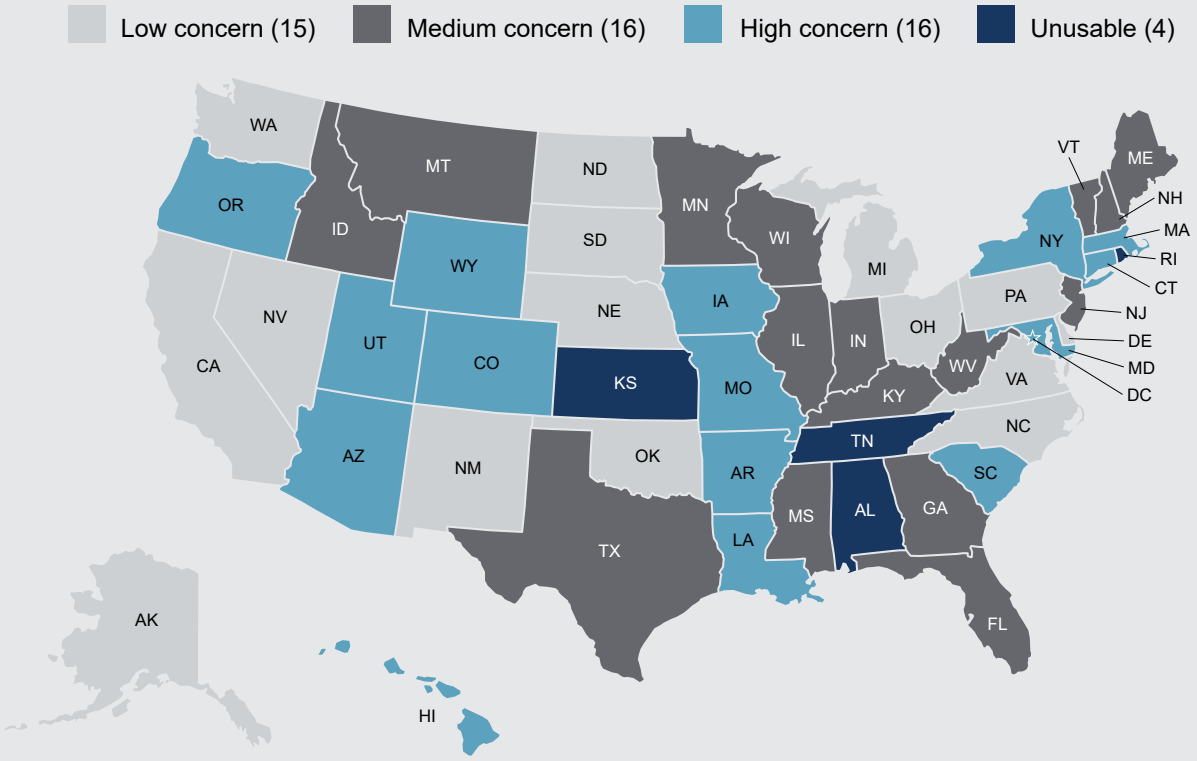
Data quality assessment tool

After the initial state-level data assessment, CMS uses the Data Quality (DQ) Atlas tool to assess state race and ethnicity data quality and its usability for analytical work. In the most recent assessment of TAF race and ethnicity data, CMS determined that 31 states have usable data for analyses, and 19 states and the District of Columbia have unusable data (Figure 1-3).

The CMS DQ Atlas assessment uses two criteria to measure race and ethnicity data quality. The first is data completeness, which is defined as the percentage of records with non-missing values. In the 2020 data quality assessment, 18 states were missing more than 20 percent of race and ethnicity data.[21] The percentage of missing data varies by state, with some states reporting this information from nearly all applicants and others reporting these data from fewer than half of applicants (CMS 2021a).

The second criteria is data accuracy, which uses the American Community Survey (ACS) as a benchmark for the TAF race and ethnicity data. Accuracy is assessed by the number of combined race and ethnicity categories for which the TAF and the ACS Medicaid population estimates differ by less than 10 percent.[22] In the 2020 quality assessment, 28 states reported at least one race or ethnicity category for which the TAF percentage differed from the ACS Medicaid population benchmark by more than 10 percent (CMS 2021a).[23]

FIGURE 1-3. Centers for Medicare & Medicaid Services Data Quality Assessment of Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files Race and Ethnicity Data, FY 2020



Note: FY is fiscal year.

Source: CMS 2021a.

TABLE 1-1. Race and Ethnicity Code Data Quality Assessment Criteria

Percentage of records with missing values	Number of race and ethnicity categories for which TAF differs from ACS by more than 10 percent	Data quality assessment
x ≤ 10 percent	0	Low concern
x ≤ 10 percent	1 or 2	Medium concern
x ≤ 10 percent	3 or more	High concern
10 percent < x ≤ 20 percent	0 or 1	Medium concern
10 percent < x ≤ 20 percent	2 or more	High concern
20 percent < x ≤ 50 percent	Any value	High concern
x > 50 percent	Any value	Unusable

Notes: TAF is Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files. ACS is American Community Survey.

Source: CMS 2021a.

CMS combines these two criteria to assign states a data quality assessment of low, medium, or high concern or unusable. States with low- and medium-concern data are considered states with usable data for analyses. These states typically have either complete and accurate data or have only minimal concerns with one of these two criteria. States with high-concern or unusable data are not considered usable for analyses. These states have high rates of missing data, misalignment between the TAF and ACS benchmark, or issues with both criteria (Table 1-1).

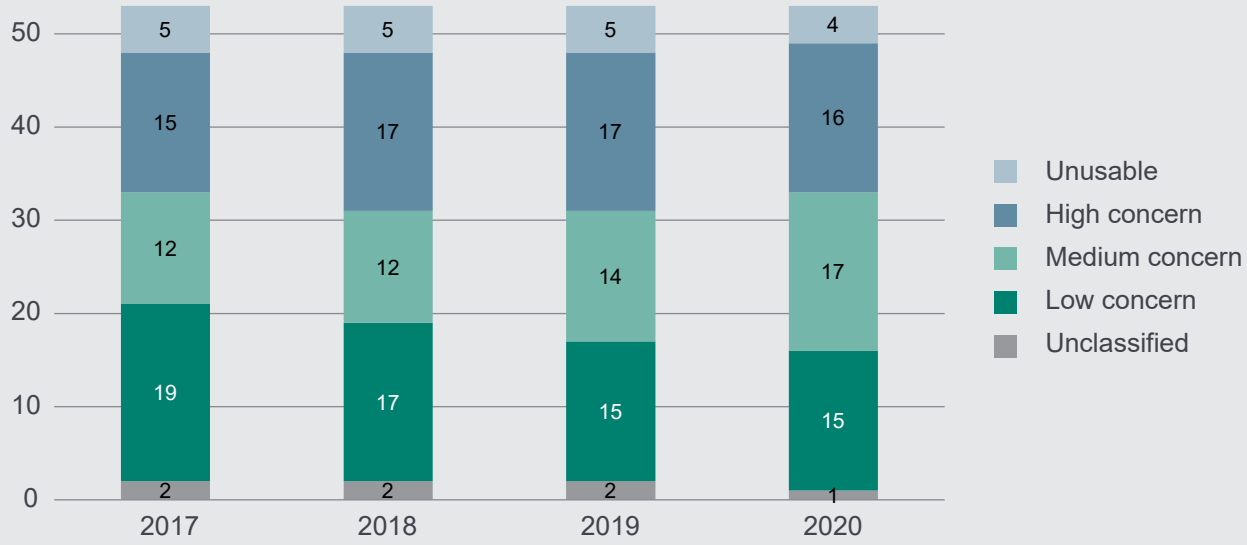
The overall quality of TAF race and ethnicity data has been consistent over the past four years, with only one or two states improving or declining in quality year to year (Figure 1-4). Since 2017, 39 states have been assigned the same data quality assessment in all four years; 10 states' data quality improved, with three improving from the high concern or unusable categories to medium or low concern; and three states' data quality worsened and no longer report usable data for analyses.

Challenges with Improving Data Quality

High-quality T-MSIS race and ethnicity data need to be comparable to allow for national and state-level analyses, and the meaningfulness of the comparisons rely on the data being complete and accurate. There are many challenges with collecting and reporting these data that may limit the ability to measure health disparities. Although it may not be feasible to collect race and ethnicity data from all applicants, research has shown that data are often not missing at random. Therefore, when a large proportion of data are missing, the data do not represent the whole population and can mask health disparities of underrepresented populations (James et al. 2021a, Labgold et al. 2021, Sholle et al. 2019).

Although all state Medicaid programs collect race and ethnicity information, many states have challenges with gathering these data from applicants due to applicant willingness to respond or understanding of the questions. Applicants may skip these questions because they are concerned about how the information may be used, including fear of being denied coverage. For example, one assister organization shared that some applicants who had previously been denied coverage were worried that providing additional, optional information could lead to another denial. Applicants may also not understand how to respond to the questions, especially when categories do not align with how they self-identify. For example, one organization that serves primarily MENA populations shared that many individuals will check "other" and write in their country of origin rather than select one of the provided categories.

FIGURE 1-4. Centers for Medicare & Medicaid Services Data Quality Assessment of State Medicaid Race and Ethnicity Data, FYs 2017–2020



Notes: FY is fiscal year. Results are from the Centers for Medicare & Medicaid Services Data Quality (DQ) Atlas, assessing the quality and usability of 2017–2020 Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) race and ethnicity data for 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. The counts represent the number of states, territories, and the District of Columbia with race and ethnicity data that are considered usable (low or medium concern), unusable (high concern and unusable) for statistical analyses, or unclassified by the DQ assessment because the territory was missing American Community Survey benchmark data (CMS 2021a).

Source: TAF 2017–2020 (CMS 2022d).

Many states have difficulty reporting data because of misalignment among how state eligibility systems, MMIS, and T-MSIS store and format race and ethnicity data. While many states have eligibility systems and MMIS that collect and store race and ethnicity in categories that facilitate simple one-to-one mapping with the T-MSIS formatted categories, some states do not. Before submitting the data to T-MSIS, these states must reformat and aggregate the data, which can sometimes affect the quality of the submitted data (Saunders and Chidambaram 2022, SHADAC 2022). For example, three states collect MENA categories; however, when these states aggregate the data to align with T-MSIS categories, that granularity is not reported (SHADAC 2022). Additionally, some states' eligibility systems and MMIS are misaligned, which can lead to diminished data quality during the transfer process. For example, two states that collect multiple race and ethnicity selections shared that the state MMIS was not designed to store multiple selections. Therefore, in these states, the individual's more detailed information is not included in the data that are submitted to T-MSIS.

Approaches to addressing challenges

During our research, several potential approaches to improving the collection and reporting of complete and accurate Medicaid race and ethnicity data emerged. One approach focused on providing states with an updated model application using evidence-based approaches to race and ethnicity questions that have been shown to improve applicant response rates and data accuracy. For example, the U.S. Census Bureau found that response rates increased when using a combined race and ethnicity question and with the wording "Select all boxes that apply" rather than "Select one or more boxes" for multiple selections.[24] Including the MENA category improved data accuracy because these individuals reported that without this option,

they were unsure of how to self-identify (Matthews et al. 2017). Further, a recent state-based study found that requiring applicants to respond to the race and ethnicity question, which included an opt-out response of "Don't know" or "Choose not to answer," led to a substantial increase in response rates for both the race and ethnicity questions (NYSOH 2021, Planalp 2021). Additionally, some states have begun to include language on the application to describe how these data will be used or clarify that providing the information will not affect their eligibility (SHADAC 2022).

Another approach involved providing all types of assisters (e.g., state and county eligibility workers, application assisters, navigators, and anyone else who may assist individuals with the application process) with model training materials that include information to share with applicants that could improve their trust in providing their race and ethnicity. For example, some application assister organizations have developed trainings for explaining the purpose of these questions and uses of the data to help assisters answer applicant questions. Providing all types of assisters with training materials about these questions and providing them with template language to use with applicants has improved their comfort and trust in sharing sensitive information (James et al. 2021a, Baker et al. 2005).

There are also promising federal and state efforts to improve data reporting. CMS provides targeted technical assistance to all states to help them identify and address data reporting issues, as described previously. Some states are also working to resolve system issues. For example, two states are in the process of redesigning their eligibility system and MMIS to store race and ethnicity data in a format that supports both state needs and federal reporting requirements. CMS should continue to prioritize improving race and ethnicity data reporting and provide states technical assistance until all states are able to submit usable data for analyses.

MACPAC's recommendations to improve Medicaid application questions and application assister training aim to address the primary challenges with collecting race and ethnicity data. In conjunction with ongoing work at the federal and state levels to address other challenges, these recommendations may also lead to improvements in the completeness and accuracy of race and ethnicity data collected from Medicaid applicants.

Commission Recommendations

Recommendation 1.1

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 race and ethnicity questions and the guidance for implementing these changes on state-designed applications would help to address some of the challenges with collecting complete and accurate race and ethnicity information. The model application has not been updated since it was first released in 2013, and there are more recent evidence-based approaches that can improve response rates. Further, updated guidance is needed to explain how these changes can be implemented on state-designed applications given that the majority of states have made modifications to the model application or developed an alternative application. This approach maintains state flexibility to customize their applications based on their own programmatic needs and priorities, while also enabling them to collect data in a format that can be aggregated to support federal reporting standards and cross-state analyses.

As with the 2013 model single, streamlined application, the development process for updating the application and race and ethnicity questions should include public comment, stakeholder consultation (including states, beneficiaries, and assister organizations), and consumer testing before implementation (CMS 2013a). Furthermore, the application questions should implement user-tested and research-based approaches that have been shown to help improve the collection of complete and accurate data. For example,

these approaches could include using a combined race and ethnicity question, requiring a response to the questions on online applications with a selection to opt out of a response, and adding options to select "Don't know" or "Choose not to answer" on both online and paper applications. In addition, the application should include language explaining the purpose of the race and ethnicity questions. This additional information should be included on all translated versions of the applications (Planalp 2021, Matthews et al. 2017). Ensuring applicants understand the reasons for collecting race and ethnicity data, how these data may be used by federal and state governments, and that their response does not affect their eligibility has been shown to make them feel more comfortable providing sensitive information.

HHS should consider the implications of any changes to the model application for purposes of Medicaid data collection on other programs serving Medicaid beneficiaries and should coordinate any updates with other Administration-wide efforts. For example, changes to the race and ethnicity questions could affect states with multi-benefit applications as well as those that use the federal exchange, which also relies on the HHS model application. Additionally, HHS should coordinate any updates with the revisions to the OMB minimum standards, which are anticipated by summer 2024 (Orvis 2022).

The Commission also underscores the importance of coordinating efforts to update the model application with the possible collection of additional demographic information. Questions about other demographic characteristics, such as sexual orientation, gender identity, and disability status, are often excluded or not asked using comparable methods. Collecting data on these populations is needed to understand their experiences accessing and using Medicaid services, but additional work is required to determine the most appropriate methods to collect these data.

Implications

Federal spending. The Congressional Budget Office assumes that this policy would not affect federal spending. Updating the model, single streamlined application could lead to increases in administrative costs in the short term as the new application is developed and implemented, including in matching costs to the states for any associated systems changes. Furthermore, coordinating any updates to the applications with anticipated revisions to race and ethnicity standards and other demographic data may minimize costs.

States. In the process of updating the model application, states may participate in developing the application or in the review process, which may lead to short-term costs to states. Additionally, there may be operational costs with implementing changes to data collection on the application and the reporting of these data to CMS. For example, it is anticipated that system upgrades may be necessary, which may lead to additional state costs. However, these costs would likely be eligible for a higher federal matching rate.

Enrollees. To the degree that improved data collection increases the ability for CMS and state Medicaid programs to assess and address disparities, there might be improved enrollee experience.

Plans and providers. State updates to race and ethnicity data collection could lead to increased costs to plans and providers. For example, to align with updated state Medicaid data collection standards, plans may need to make system changes to adopt these standards or to meet new state contracting requirements. Plans and provider ability to meet health equity accreditation and outreach to beneficiaries may also benefit with improved data completeness and accuracy.

Recommendation 1.2

The Secretary of the U.S. Department of Health and Human Services 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 materials 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 state and county eligibility workers, navigators, and application assisters funded by the state and other community-based assisters with training materials on how to ask applicants for race

and ethnicity information is an important component in improving applicant trust when providing sensitive information. Individuals often seek assistance during the application process, affording assisters with the opportunity to explain the purpose and value of responding to the race and ethnicity questions (CMS 2022c, MACPAC 2018). Research has shown that providing application assisters and navigators with a script to educate individuals about why the application asks these questions and how the information will be used can improve the applicant's comfort with responding (James et al. 2021, NYSOH 2021, Planalp 2021, Baker et al. 2005).

State eligibility workers and assisters receive training to assist applicants, but they do not consistently receive specific training on asking the race and ethnicity questions. CMS provides the Federally Facilitated Marketplace assister training, but it does not include information on asking optional race and ethnicity questions (CMS 2022c). Some states also develop trainings, but they are inconsistently provided to assisters.

CMS should develop training materials that specifically address how to ask the race and ethnicity questions and continue to update these materials to reflect the most recent evidence on how to increase applicant understanding and willingness to respond. These materials should inform the Federally Facilitated Marketplace assister training materials as well as materials provided to state Medicaid programs, assister organizations, community organizations, providers, plans, and any other organizations that may assist with the application process. The training materials should be developed with input from stakeholders, including states, beneficiaries, and assisters, and draw on research. The training materials should be designed to both educate assisters and provide them with sample language to use when speaking to applicants. CMS should also provide states with technical assistance to modify the training to reflect state-specific populations and application details, and the training should be customizable for assister organizations that are serving specific populations.

Implications

Federal spending. The Congressional Budget Office assumes that this policy would not affect federal spending. Developing new training materials could lead to increases in federal costs in the short term as the new materials are developed and implemented. Anticipated revisions to race and ethnicity standards and other demographic data may lead to additional costs if updates to the training materials are needed to reflect future changes on the model application.

States. States are working to improve the completeness and accuracy of their race and ethnicity data. States not currently providing training materials, but that adapt the CMS-provided training materials for state-specific needs, may have an increase in short-term costs. For states that have developed and invested in training materials, the additional effort to update the materials could be minimal. Additionally, there may be costs for states if they provide trainings to assister organizations and other types of organizations that may interact with applicants.

Enrollees. To the degree that revised training materials lead to improved application assistance provided to enrollees and increased enrollee understanding of the purpose of these data, enrollees may experience an improved application process.

Plans and providers. Plans and providers that serve in an assister or navigator role may need to adapt their training materials to implement these updates, which may lead to some short-term costs. These new trainings may also improve their ability to assist individuals applying for Medicaid.

Endnotes

[1] Other potential federal- and state-level data sources include the Health Resources and Services Administration and state-level managed care data. Other data sources, such as Centers for Medicare & Medicaid Services claims forms (e.g., CMS-1450 and CMS-1500), could be useful for collecting race and ethnicity information. However, T-MSIS is the only data source that includes information about all Medicaid beneficiaries, making it the primary data source for Medicaid-specific analyses.

[2] Using methods developed by CMS, MACPAC analyzed the raw T-MSIS race and ethnicity data to assess their completeness and accuracy (MACPAC 2022b, CMS 2021a).

[3] Interviewees included state officials from Hawaii, Kentucky, Maryland, Massachusetts, Nevada, North Carolina, and Oregon; research and policy experts from the National Health Law Program, State Health Access Data Assistance Center at the University of Minnesota, and Mathematica; application assisters from ACCESS Community Health and Research Center, Georgians for a Healthy Future, Public Health Solutions, and WithinReach; and managed care organizations and health plan associations, including Priority Partners and the Blue Cross Blue Shield Association.

[4] Recent research indicates that the demographic and health characteristics of individuals not reporting race and ethnicity information differ from those who do, suggesting race and ethnicity data are missing not at random. Therefore, standard analytical methods that assume the race and ethnicity information are representative of the full population will most likely produce results that are biased and underestimate racial and ethnic disparities.

[5] The report found that the imputation algorithm performed best with regard to enrollees who identified as Asian American, Native Hawaiian, and Pacific Islander; Black; Hispanic; or white and was not as reliable for enrollees who identified as American Indian and Alaska Native or multiracial.

[6] In addition to the OMB minimum standards, states do have the option to report more granular categories to CMS. T-MSIS includes the option for states to report race and ethnicity information that align both with the OMB categories and the more granular 2011 HHS categories (HHS 2011a, OMB 1997).

[7] Although this work does not specifically focus on the collection and reporting of race and ethnicity data for CHIP, the T-MSIS data reporting requirements are the same for Medicaid and separate CHIP.

[8] The purpose of the revisions is to ensure the race and ethnicity questions and categories reflect the populations in the United States. The proposed revisions include collecting race and ethnicity in a singular question, adding Middle Eastern and North African as a new minimum category, requiring the collection of more granular categories, and updating the terminology and definitions in SPD 15 (OMB 2023).

[9] The 1997 HHS inclusion policy applies to the following HHS-sponsored data collection and reporting activities: statistical data collection; administrative records; research, evaluation, and other study projects; applications, grants, and contract proposals submitted to HHS and its agencies or major operating components that collect data from the public; and reporting systems for civil rights compliance (HHS 1997).

[10] The ACA included provisions to streamline eligibility, enrollment, and renewal processes, including requiring a single application for Medicaid, CHIP, and subsidized exchange coverage. In 2013, CMS released federal guidance for developing applications, including a model single, streamlined application (CMS 2013a, 2013b).

[11] The review and approval of the application occurs through the State Plan Amendment process.

[12] The majority of states include race and ethnicity categories that align with OMB or HHS standards, but the number of categories included on Medicaid applications vary by state and sometimes between paper and online applications within a state. For example, 7 state paper application and 7 state online application race categories align with OMB standards, and 12 state online application and 13 state paper application ethnicity categories align with OMB standards. Some states include additional categories that align with HHS guidance. For example, 27 state online application and 6 state paper application race categories align with HHS guidance, and 6 state online application and 28 state paper application ethnicity categories also align with HHS guidance (SHADAC 2022).

[13] The Food and Nutrition Service (FNS) established application requirements for all FNS programs. For example, all state FNS agencies are required to obtain race and ethnicity information for all applicants according to prescribed specifications. Race and ethnicity must be collected using a two-question format and the minimum categories must align with OMB standards. States are permitted to include additional categories for race only. Ethnicity must be collected before race, and applicants have the option to choose multiple race categories (FNS 2005).

[14] One state with an integrated application developed an alternative approach to multiple selection. The state application includes predetermined multiracial category combinations, and individuals who do not identify with the options provided can select an “other” multiracial category.

[15] The E&E system is used for many state functions, including storing state Medicaid application information; determining eligibility for enrollment, renewals, and change in circumstances; and supporting enrollment into the appropriate program. Some states have integrated the E&E system with other public programs, and in these states the E&E system will store and determine eligibility for these additional programs (GAO 2020).

[16] State Medicaid programs are required to have an MMIS to be eligible for federal funding. The MMIS supports the management of the state Medicaid program and is the source for state-submitted eligibility and claims data (CMS 2021c).

[17] The TAF research-ready file is created using T-MSIS data. The TAF includes two combined race and ethnicity variables, one aligning with OMB categories and one aligning with 2011 HHS guidance variables. The OMB category variable includes seven race and ethnicity categories and a multiracial category, created from the multiple race and ethnicity values available in T-MSIS. This race and ethnicity variable is used in the Data Quality (DQ) Atlas to assess the quality of the race and ethnicity (CMS 2021a).

[18] States submit monthly reports to T-MSIS. CMS evaluates these state-submitted race and ethnicity data using four primary criteria: (1) the percentage of MSIS IDs with unspecified, unknown, missing, or invalid race and ethnicity codes; (2) the rate of missing segment effective dates on the segment that includes the race and ethnicity data; (3) the percentage of MSIS IDs with the American Indian and Alaska Native indicator turned on that do not have American Indian and Alaska Native reported as the race value; and (4) the index of dissimilarity for either the race or the ethnicity data element that indicates changes in the response distribution month over month (Mathematica 2023).

[19] Before the development of the Outcomes Based Assessment, CMS used the T-MSIS Priority Items (TPIs) Data Quality Tool. CMS identified 32 TPIs to help states identify, track, and set priorities for their data quality issues and focus areas. The TPIs were based on state reporting requirements, and if states were unable to comply with the requirements for a TPI, it was flagged as a data quality issue for the state (CMS 2021d).

[20] In addition to CMS data quality assessments, some states also conduct internal validation and analyses to improve data quality. For example, one state regularly monitors changes in data quality within its eligibility system and works with state agency partners and MMIS vendors to improve its data. Some states conduct internal processes that mimic the CMS DQ Atlas and Outcomes Based Assessment criteria, and others validate their administrative data against other state eligibility reports to review the distribution of race and ethnicity data.

[21] The DQ Atlas assesses missing data based on the combined TAF race and ethnicity variable. If neither the race nor ethnicity codes are provided in the source T-MSIS data, the race and ethnicity flag in TAF will be set to null, indicating the data are missing. Additionally, if the ethnicity code is equal to zero (a valid value indicating non-Hispanic ethnicity) and the race code is missing in the source T-MSIS data, the race and ethnicity flag in TAF will be set to null. However, if the ethnicity code is missing and the race code is non-missing in T-MSIS, then the race and ethnicity code in TAF is set equal to the reported race code in T-MSIS (CMS 2021a).

[22] The Medicaid population within the ACS includes all individuals who reported having "Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability."

[23] The TAF distribution includes missing race and ethnicity information in the denominator. Although there are some benefits to excluding non-missing data from the denominator, including missing information in the denominator can help DQ Atlas users and researchers evaluate whether a state has a high rate of missing data for only one or two of the race and ethnicity categories. This can be important for evaluating whether the data are accurately representing the state population (Mathematica 2022).

[24] In 2015, the Census Bureau examined multiple dimensions of these questions, including the question format, the response categories, and instructions, and tested multiple approaches to asking these questions to improve the quality and usability of the collected data for the 2020 Census (Matthews et al. 2017).

References

Akard, J. 2022. Improving health equity in Medicaid: State policy innovation and research. *Academy Health Blog Post*, March 2. https://academyhealth.org/blog/2022-03/improving-health-equity-medicaid-state-policy-innovation-and-research.

Baker, D.W., K.A. Cameron, J. Feinglass, et al. 2005. Patients' attitudes toward health care providers collecting information about their race and ethnicity. *Journal General*

Internal Medicine 20, no.10: 895–900. https://pubmed.ncbi.nlm.nih.gov/16191134/.

Brooks, T., A. Gardner, A. Osorio, et al. 2022. Integration of Medicaid and non-health program eligibility systems. Washington, DC: KFF. https://www.kff.org/health-reform/state-indicator/integration-of-medicaid-and-non-health-program-eligibility-systems/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. *CMS framework for health equity 2022–2032*. Baltimore, MD: CMS. https://www.cms.gov/files/document/cms-framework-health-equity.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. *CMS technical instructions: Reporting race and ethnicity in the T-MSIS eligible file*. https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/109701.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Training for navigators, agents, brokers, and other assisters. Baltimore, MD: CMS. https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022d. *DQ Atlas: DQ assessment of race and ethnicity*. Baltimore, MD: CMS. https://www.medicaid.gov/dq-atlas/landing/topics/single/map?topic=g3m16&tafVersionId=25.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. *DQ Atlas background and methods resource: Race and ethnicity*. Baltimore, MD: CMS. https://www.medicaid.gov/dq-atlas/downloads/background_and_methods/TAF_DQ_Race_Ethnicity.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. *A new method to improve measurement of race-and-ethnicity in CMS data and applications to inequities in quality of care*. Baltimore, MD: CMS. https://www.cms.gov/files/document/new-method-improve-measurement-race-and-ethnicity-cms-data-and-applications-inequalities-quality.pptx.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021c. Medicaid data sources—general information. Baltimore, MD: CMS. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021d. CMS technical instruction: Overview of data quality T-MSIS priority items. https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/54044.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. CMCS informational bulletin regarding "Model eligibility application and guidance on state alternative applications." April 30. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/CIB-04-30-2013_78.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. CMCS informational bulletin regarding "Guidance on state alternative applications for health coverage." June 18. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/state-alt-app-guidance-6-18-2013.pdf.

Chau, V., and P. Chan. 2021. One size does not fit all: Appreciating the diversity of Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) and the implications for mental health. *SAMHSA Blog*, May 25. https://www.samhsa.gov/blog/one-size-does-not-fit-all-appreciating-diversity-asian-americans-native-hawaiians-pacific.

Dembosky, J.W., A.M. Haviland, A. Haas, et al. 2019. Indirect estimation of race/ethnicity for survey respondents who do not report race/ethnicity. *Medical Care* 57, no.5: e28–e33. https://www.ingentaconnect.com/content/wk/mcar/2019/00000057/00000005/art00001.

Equitable Data Working Group. 2022. *A vision for equitable data: Recommendations from the equitable data working group*. Washington, DC: Equitable Data Working Group. https://www.whitehouse.gov/wp-content/uploads/2022/04/eo13985-vision-for-equitable-data.pdf.

Executive Office of the President (EOP). 2021. Advancing racial equity and support for underserved communities through the federal government. Executive Order 13985. *Federal Register* 86, no. 14 (January 25): 7009–7013. https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government.

Executive Office of the President, Office of Management and Budget (OMB). 2023. Initial proposals for updating OMB's race and ethnicity statistical standards. Notice

and request for comments. *Federal Register* 88, no. 18 (January 27): 5375–5384. https://www.federalregister.gov/documents/2023/01/27/2023-01635/initial-proposals-for-updating-ombs-race-and-ethnicity-statistical-standards.

Executive Office of the President, Office of Management and Budget (OMB). 2016. Standards for maintaining, collecting, and presenting federal data on race and ethnicity. Notice of proposed rulemaking. *Federal Register* 81, no. 190 (September 30): 67398–67401. https://www.federalregister.gov/documents/2016/09/30/2016-23672/standards-for-maintaining-collecting-and-presenting-federal-data-on-race-and-ethnicity.

Executive Office of the President, Office of Management and Budget (OMB). 1997. Revisions to the standards for the classification of federal data on race and ethnicity. Notice of decision. *Federal Register* 62, no. 210 (October 30): 58782–58790. https://www.federalregister.gov/documents/1997/10/30/97-28653/revisions-to-the-standards-for-the-classification-of-federal-data-on-race-and-ethnicity.

Executive Office of the President, Office of Management and Budget (OMB). 1977. *Race and ethnic standards for federal statistics and administrative reporting*. Directive No. 15. (May 12). https://transition.fcc.gov/Bureaus/OSEC/library/legislative_histories/1195.pdf.

Food and Nutrition Service (FNS), U.S. Department of Agriculture. 2005. *Civil rights compliance and enforcement—nutrition programs and activities*. Report no. 113-1. Alexandria, VA: U.S. Department of Agriculture. https://www.fns.usda.gov/fns-instruction-113-1.

Gilfoil, C.S. 2022. *Demographic data collection in Medicaid & CHIP: CMS authority to collect race & ethnicity data*. Washington, DC: National Health Law Program. https://healthlaw.org/wp-content/uploads/2022/09/Issue-Brief-Demo-Data-Medicaid-final.pdf.

James, C., S. Pamar, S. Hudson Scholle, et al. 2021a. *Improving data on race and ethnicity: A roadmap to measure and advance health equity*. Washington, DC: Grantmakers in Health. https://www.gih.org/wp-content/uploads/2021/12/GIH-Commonwealth-Fund-federal-data-report-part-2.pdf.

James, C., S. Pamar, S. Hudson Scholle, et al. 2021b. *Federal action is needed to improve race and ethnicity data in health programs*. Washington, DC: Grantmakers in Health. https://www.gih.org/wp-content/uploads/2021/10/GIH-Commonwealth-Fund-federal-data-report-part-1.pdf.

Labgold, K., S. Hamid, S. Shah, et al. 2021. Estimating the unknown: Greater racial and ethnic disparities in COVID-19 burden after accounting for missing race and ethnicity data. *Epidemiology* 32, no. 2: 157–161. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8641438/pdf/nihms-1754433.pdf.

LLanos, K., and L. Palmer. 2006. *Using data on race and ethnicity to improve health care quality for Medicaid beneficiaries*. Hamilton, New Jersey: Center for Health Care Strategies. http://www.chcs.org/media/Using_Date_to_Reduce_Health_Disparities.pdf.

Mathematica. 2023. E-mail with MACPAC, January 27.

Mathematica. 2022. E-mail with MACPAC, December 19.

Matthews, K., J. Phelan, N.A. Jones, et al. 2017. *2015 national content test race and ethnicity analysis report: A new design for the 21st century*. Washington, DC: U.S. Census Bureau. https://assets.documentcloud.org/documents/4316468/2015nct-Race-Ethnicity-Analysis.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. Chapter 6: Medicaid's role in advancing health equity. In *Report to Congress on Medicaid and CHIP*. June 2022. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-6-Medicaids-Role-in-Advancing-Health-Equity.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022b. *Availability of race and ethnicity data for Medicaid beneficiaries*. Washington, DC: MACPAC. https://www.macpac.gov/publication/availability-of-race-and-ethnicity-data-for-medicaid-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022c. Exhibit 1: Medicaid and CHIP enrollment as a percentage of the U.S. population, 2021 (millions). In *MACStats: Medicaid and CHIP Data Book*. December 2022. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-and-chip-enrollment-as-a-percentage-of-the-u-s-population/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022d. Exhibit 2: Characteristics of noninstitutionalized individuals by age and source of health coverage, 2021. In *MACStats: Medicaid and CHIP Data Book*. December 2022. Washington, DC: MACPAC. https://www.macpac.gov/publication/characteristics-of-non-institutionalized-individuals-by-source-of-health-insurance/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. *Racial and ethnic disparities in Medicaid: An annotated bibliography*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *Update on Transformed Medicaid Statistical Information System (T-MSIS)*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/04/Update-on-Transformed-Medicaid-Statistical-Information-System-T-MSIS.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. *Eligibility, enrollment, and renewal: Case study findings*. Washington, DC: MACPAC. https://www.macpac.gov/publication/eligibility-enrollment-and-renewal-case-study-findings/.

New York State of Health (NYSOH). 2021. *Cultural humility: NY State of Health race & ethnicity questions*. Albany, NY: NYSOH. https://info.nystateofhealth.ny.gov/sites/default/files/Cultural%20Humility%20and%20NYSOH%20Race%20and%20Ethnicity%20Questions.pdf.

North Carolina Department of Health and Human Services, Division of Public Health (NCDHHS). 2022. *North Carolina state health improvement plan*. Raleigh, NC: NCDHHS. https://schs.dph.ncdhhs.gov/units/ldas/docs/NCSHIP-2022-Full.pdf.

Ojodu, J., M.M. Hulihan, S.N. Pope, and A.M. Grant. 2014. Incidence of sickle cell trait—United States, 2010. *Morbidity and Mortality Weekly Report* 63, no. 49: 1155–1158. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4584538/.

Ortman, J.M., and K.L. Parker. 2021. *Why do federal agencies ask about sexual orientation and gender identity (SOGI) on surveys?* Report no. FCSM-21-01. Washington, DC: Federal Committee on Statistical Methodology. https://nces.ed.gov/FCSM/pdf/FCSM_21_01_062221.pdf.

Orvis, K. 2022. *Reviewing and revising standards for maintaining, collecting, and presenting federal data on race and ethnicity*. White House Briefing Room, June 15. https://www.whitehouse.gov/omb/briefing-room/2022/06/15/reviewing-and-revising-standards-for-maintaining-collecting-and-presenting-federal-data-on-race-and-ethnicity/.

Planalp, C. 2021. *New York State of Health pilot yields increased race and ethnicity question response rates.* Minneapolis, MN: State Health Access Data Assistance Center. https://www.shvs.org/new-york-state-of-health-pilot-yields-increased-race-and-ethnicity-question-response-rates/.

Pollitz, K., J. Tolbert, L. Hamel, and A. Kearney. 2020. *Consumer assistance in health insurance: Evidence of impact and unmet need*. Washington, DC: KFF. https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/.

Research Data Assistance Center (ResDAC). 2022. Data documentation: TAF demographic and eligibility file. Minneapolis, MN: ResDAC. https://resdac.org/cms-data/files/taf-de/data-documentation.

Rubin, V., D. Ngo, Á. Ross, et al. 2018. *Counting a diverse nation: Disaggregating data on race and ethnicity to advance a culture of health*. Oakland, CA: PolicyLink. https://www.policylink.org/sites/default/files/Counting_a_Diverse_Nation_08_15_18.pdf.

Saunders, H., and P. Chidambaram. 2022. *Medicaid administrative data: Challenges with race, ethnicity, and other demographic variables*. Washington, DC: KFF. https://www.kff.org/medicaid/issue-brief/medicaid-administrative-data-challenges-with-race-ethnicity-and-other-demographic-variables/.

Sheedy, K. 2014. *Medicaid agency training for consumer assisters in Federally Facilitated Marketplace states.* Portland, ME: National Academy for State Health Policy. https://nationaldisabilitynavigator.org/wp-content/uploads/resources-links/Medicaid_Training_for_Assisters_in_FFM_States.pdf.

Sholle, E.T., L.C. Pinheiro, P. Adekkanattu, et al. 2019. Underserved populations with missing race ethnicity data differ significantly from those with structured race/ethnicity documentation. *Journal of the American Medical Informatics Association* 26, no. 8–9: 722–729. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6696506/pdf/ocz040.pdf.

State Health Access Data Assistance Center (SHADAC), University of Minnesota. 2022. *Collection of race, ethnicity, language (REL) data on Medicaid applications: New and updated information on Medicaid data collection practices in the states, territories, and District of Columbia*. Minneapolis, MN: SHADAC. https://www.shvs.org/wp-content/uploads/2022/11/SHVS_Collection-of-Race-Ethnicity-Language-REL-Data-on-Medicaid-Applications.pdf.

U.S. Department of Health and Human Services (HHS). 2022a. Health equity timeline. Washington, DC: HHS. https://thinkculturalhealth.hhs.gov/clas/health-equity-timeline.

U.S. Department of Health and Human Services (HHS). 2022b. *Imputation of race and ethnicity in health insurance marketplace enrollment data, 2015–2022 Open Enrollment Periods*. Washington, DC: HHS. https://aspe.hhs.gov/reports/imputation-race-ethnicity-marketplace-enrollment-data.

U.S. Department of Health and Human Services (HHS). 2022c. Interview with MACPAC, October 20.

U.S. Department of Health and Human Services (HHS). 2011a. *Implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status*. Washington, DC: HHS. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//43681/index.pdf.

U.S. Department of Health and Human Services (HHS). 2011b. *Approaches for identifying, collecting and evaluating data on health care disparities in Medicaid and CHIP*. Washington, DC: HHS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/4302b-rtc.pdf.

U.S. Department of Health and Human Services (HHS). 1997. *Policy statement on inclusion of race and ethnicity in DHHS data collection activities*. Washington, DC: HHS. https://aspe.hhs.gov/collaborations-committees-advisory-groups/hhs-data/hhs-data-council-introduction/dc-archive/policy-statement-inclusion-race-ethnicity-dhhs-data-collection-activities.

U.S. Government Accountability Office (GAO). 2020. *Medicaid information technology: Effective CMS oversight and states' sharing of claims processing and information retrieval systems can reduce costs*. Report no. GAO-20-179. Washington, DC: GAO. https://www.gao.gov/assets/gao-20-179.pdf.

Youdelman, M., and S. Hitov. 2001. *Racial, ethnic and primary language data collection: An assessment of federal policies, practices and perceptions*. Washington, DC: National Health Law Program. https://healthlaw.org/wp-content/uploads/2018/09/shire.report.pdf.

APPENDIX 1A: Data Collection Standards

TABLE 1A-1. Race and Ethnicity Data Collection Standards

1977 OMB minimum standards	1997 OMB minimum standards	2011 HHS guidance
Race Categories		
White	White	White
Black	Black or African American	Black or African American
Asian or Pacific Islander	Asian	Asian Indian
		Chinese
		Filipino
		Japanese
		Korean
		Vietnamese
		Other Asian
American Indian or Alaskan Native	American Indian or Alaska Native	American Indian or Alaska Native
	Native Hawaiian or Other Pacific Islander	Native Hawaiian
		Guamanian or Chamorro
		Samoan
		Other Pacific Islander
Ethnicity Categories		
Hispanic origin	Hispanic or Latino	Mexican, Mexican American, Chicano/a Puerto Rican Cuban Another Hispanic, Latino/a, or Spanish origin
Not of Hispanic origin	Not Hispanic or Latino	Not of Hispanic, Latino/a, or Spanish origin

Notes: OMB is Office of Management and Budget. HHS is U.S. Department of Health and Human Services.

Sources: HHS 2011; OMB 1997, 1977.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on January 27, 2023.

Medicaid Race and Ethnicity Data Collection and Reporting

1.1 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.

1.2 The Secretary of the U.S. Department of Health and Human Services 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 materials 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.

1.1-1.2 voting results	#	Commissioner
Yes	16	Allen, Bella, Bjork, Brooks, Carter, Cerise, Davis, Duncan, Gerstorff, Giardino, Gordon, Heaphy, Johnson, Medows, Scanlon, Weno
Not present	1	Herrera Scott

Chapter 2:

Principles for Assessing Medicaid Nursing Facility Payment Policies

Principles for Assessing Medicaid Nursing Facility Payment Policies

Recommendations

2.1 To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to collect and report the following data in a standard format that enables analysis:

- facility-level data on all types of Medicaid payments to nursing facilities, including resident contributions to their cost of care;
- data on the sources of non-federal share of spending necessary to determine net Medicaid payment at the facility level; and
- comprehensive data on nursing facility finances and ownership necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and to examine the effects of real estate ownership models and related-party transactions.

2.2 To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS 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 CMS should make facility-level findings publicly available in a format that enables analysis.

Key Points

- Medicaid is the largest payer for nursing facility care and has an important role to play in reducing health disparities that have been exacerbated by the COVID-19 pandemic.
- Medicaid payment rates and methods vary widely by state, and there are limited data available about how rates compare to costs and how Medicaid payment policies affect quality outcomes.
- Most Medicaid-covered nursing facility residents are dually eligible for Medicare, but payment incentives for Medicare and Medicaid are not well aligned.
- To advance Medicaid statutory goals of efficiency, economy, quality, and access, states should do the following:
  - ensure that nursing facility payment rates are sufficient to cover the costs of efficient and economically operated facilities;
  - design payment methods to incentivize better quality outcomes and reduce health disparities; and,
  - aim to get the maximum value for the amount that they are spending.

CHAPTER 2: Principles for Assessing Medicaid Nursing Facility Payment Policies

Medicaid is the largest payer for nursing facility care and has an important role to play in improving the care that nursing facility residents receive. However, facilities that serve a high share of Medicaid-covered residents have long had worse quality outcomes on average than other facilities. The COVID-19 pandemic has exposed and exacerbated many of these disparities. In response, policymakers are considering a variety of reforms to how they regulate and pay for nursing facility care.

The Commission has identified several principles for states to consider when setting Medicaid nursing facility payment rates and payment methods. These principles are intended to advance the statutory goals of Medicaid payment policy: economy, efficiency, quality, and access (§1902(a)(30)(A) of the Social Security Act (the Act)).

First, in the Commission's view, Medicaid payments should be sufficient to cover the costs of efficient and economically operated nursing facilities. When assessing payment adequacy, states should consider all types of Medicaid payments that providers receive and review reported costs carefully. For example, states should consider the costs of staffing facilities at appropriate levels to meet residents' care needs and the potential for transactions with related parties in the same nursing facility chain to inflate costs reported on state cost reports.

Second, states should design nursing facility payment methods to incentivize better quality outcomes and reductions in health disparities. Although many of the factors that affect quality care are outside of Medicaid's authority, the persistent disparities between Medicaid-covered residents and those covered by other payers are an issue that Medicaid payment policy can help address. Doing so would also help reduce racial and ethnic disparities.

Finally, nursing facility payment policies should be evaluated based on whether they are efficient—that is, whether states are getting the maximum value for the amount they are spending. Comparing payment rates and quality outcomes across states can help identify potential opportunities to improve efficiency, particularly in states with relatively high payment rates and poor outcomes. In addition, policymakers should continue to explore opportunities to improve efficiency across payers by better aligning payment incentives for patients dually eligible for Medicare and Medicaid. More detailed state-level analyses are needed to identify the best approaches for each state, which would require increased state capacity to examine these issues.

The Commission recommends that the Secretary of the U.S. Department of Health and Human Services (HHS) direct the Centers for Medicare & Medicaid Services (CMS) to take the following actions to improve the availability of data to assess whether state payment policies are consistent with these principles:

- To improve transparency of Medicaid spending, the Secretary of HHS should direct CMS to collect and report the following data in a standard format that enables analysis:
  - facility-level data on all types of Medicaid payments to nursing facilities, including resident contributions to their cost of care;
  - data on the sources of non-federal share of spending necessary to determine net Medicaid payment at the facility level; and
  - comprehensive data on nursing facility finances and ownership necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and to examine the effects of real estate ownership models and related-party transactions.
- To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of HHS should direct CMS to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS 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 CMS should make facility-level findings publicly available in a format that enables analysis.

The Commission reviewed data on Medicaid payment methods, payment amounts, and quality outcomes to better understand the factors that affect the development of nursing facility payment policies and whether they are achieving their intended goals. This chapter summarizes the Commission's analyses, which informed the development of the Commission's payment principles and recommendations. The chapter begins with background information on nursing facility industry trends and Medicaid's role relative to other payers. Then it discusses current Medicaid payment policies, how they can be used to improve quality, and how they align with other payers. The chapter concludes by discussing the payment principles, recommendations, and supporting rationale in more detail.

As more information on Medicaid nursing facility payments becomes available, the Commission will continue to monitor state payment policies. In particular, the Commission will closely follow how any future changes in federal regulatory requirements (e.g., minimum staffing standards) affect states, providers, and beneficiaries.

Background

Nursing facilities are institutions certified by a state to offer 24-hour medical and skilled nursing care, rehabilitation, or health-related services to individuals who do not require hospital care.[1] Medicaid is the primary payer for most nursing facility residents, but it generally pays less than other payers. The nursing facility industry faces a number of challenges, which are generally worse for facilities that serve a high share of Medicaid-covered residents and have been exacerbated by the COVID-19 pandemic.

Role of nursing facilities in the continuum of care

Nursing facilities provide both short-term care for patients recovering from a hospital stay and long-term care for residents who need ongoing assistance with activities of daily living. Of the approximately 1.1 million patients and residents receiving care in nursing facilities on September 30, 2019, about half had short stays of less than 100 days, and half had long stays of more than 100 days (Abt Associates 2020).[2]

The short-term care that nursing facilities provide (referred to as "skilled nursing facility (SNF) services") is part of the continuum of post-acute care after a hospital stay. Nursing facilities generally provide more intensive care than home health providers and less intensive care than rehabilitation or long-term care hospitals. In 2019, nursing facilities accounted for about half of all Medicare hospital discharges to post-acute care providers (MedPAC 2022a).

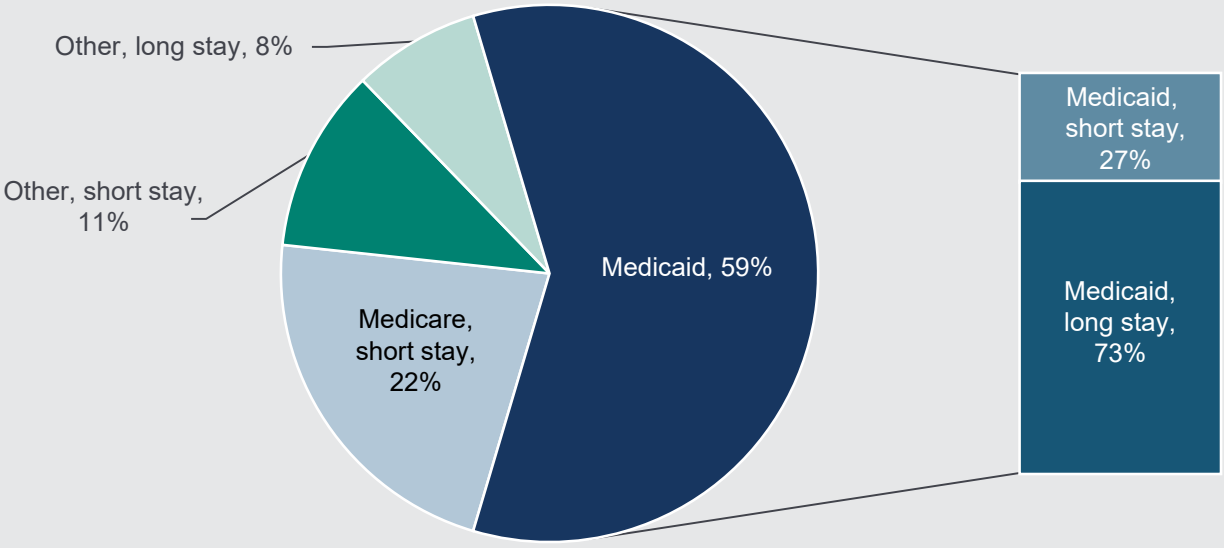
The long-term care that nursing facilities provide is also part of the continuum of long-term services and supports (LTSS). Nursing facility services remain an important site of care for beneficiaries who are not able to receive care in the community. In fiscal year 2019, nursing facility services accounted for about 80 percent of Medicaid spending on institutional LTSS, 33 percent of total Medicaid LTSS expenditures, and 11 percent of total Medicaid spending (Murray et al. 2021).[3]

Medicaid coverage of nursing facility care

In 2019, Medicaid was the primary payer for 59 percent of nursing facility residents (Figure 2-1). Most Medicaid-covered nursing facility residents had long stays, but about one-quarter of Medicaid-covered residents had short stays of less than 100 days. Medicare is the largest payer of short-stay nursing facility residents. About 19 percent of nursing facility residents were not covered by either Medicare or Medicaid. Long-stay residents not covered by Medicare or Medicaid likely paid for their care out of pocket because private insurance coverage for long-term care is rare.[4]

About 90 percent of Medicaid-covered nursing facility residents are older than age 65 (Abt Associates 2020). Non-elderly Medicaid beneficiaries with a need for institutional LTSS are often served in other settings, such as intermediate care facilities for individuals with intellectual or developmental disabilities, which are outside the scope of this chapter (ASPE 2013).

FIGURE 2-1. Characteristics of Nursing Facility Patients and Residents by Primary Payer and Length of Stay, 2019



Notes: Short-stay patients are defined as individuals residing in the facility for less than 100 days. Long-stay residents are defined as residing for more than 100 days. Analysis is based on nursing facility residents who were active on September 30, 2019. Length of stay is based on the number of days between the entry date and the target date of the latest Minimum Data Set assessment used in the analysis, not the discharge date of the stay.

Source: Abt Associates 2020.

Medicaid eligibility requirements. To qualify for Medicaid coverage, nursing facility residents must have low income and assets. Many Medicaid-covered nursing facility residents are eligible through mandatory eligibility pathways that are tied to the receipt of supplemental security income (SSI), which in 2022 had an income limit of $841 a month and an asset limit of $2,000 for individuals. As of 2018, 42 states also provided Medicaid coverage to nursing facility residents with incomes up to 300 percent of the SSI limit (an option referred to as the "special income rule"), 25 states used the medically needy option to allow higher-income individuals to qualify for Medicaid coverage by subtracting the amount that they paid for their care from their income (a process referred to as "spenddown"), and 21 states provided coverage to seniors and persons with disabilities up to 100 percent of the federal poverty level regardless of whether they had a nursing facility level of care (referred to as the "poverty-level pathway") (Musumeci et al. 2019).[5] According to an analysis by the HHS Assistant Secretary for Planning and Evaluation using 2006–2007 data, 22 percent of Medicaid-covered nursing facility residents qualified through SSI-related pathways, 50 percent qualified through the special income rule, 21 percent qualified through a medically needy pathway, and about 7 percent qualified through the poverty-level pathway (ASPE 2013).

Because the out-of-pocket costs for nursing facility care are substantial and few individuals have private long-term care insurance, many private-pay nursing facility residents with long stays eventually become eligible for Medicaid after spending most of their income and assets toward the cost of their care.[6] In 2001, more than half of Medicaid-covered nursing facility residents began their Medicaid coverage after residing in the nursing facility, and 21 percent of Medicaid-covered residents began coverage after residing in the facility for more than six months (Wenzlow et al. 2008).

Post-eligibility treatment of income. Unlike many other Medicaid beneficiaries who have little or no cost-sharing obligations, recipients of LTSS are required to contribute most of their income toward the cost of their care through a process known as "post-eligibility

treatment of income." The amount of income that a beneficiary can retain is set by the state's personal needs allowance and other exceptions.[7] In 2018, the median state personal needs allowance for institutional care was $50 per month, meaning that in most states, all but a small amount of a Medicaid-covered resident's income went toward the cost of their care (Musumeci et al. 2019).

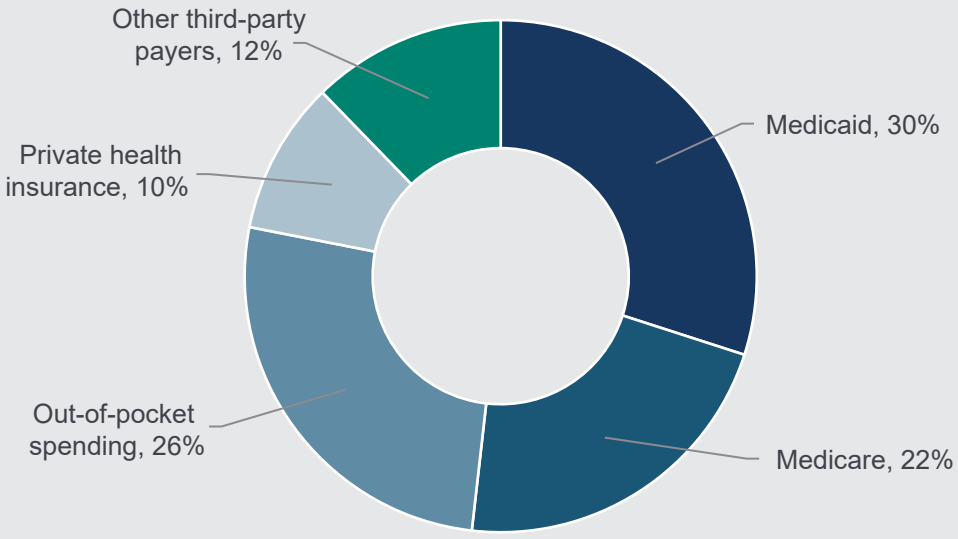
Residents' contributions to the cost of their care reduce the amount of state and federal Medicaid payments that a facility receives. In 2019, these contributions accounted for about 10 percent of Medicaid payments to nursing facilities (MACPAC 2023a).

Patients dually eligible for Medicare and Medicaid. The vast majority (84 percent) of Medicaid-covered nursing facility residents are dually eligible for Medicare and Medicaid (Abt Associates 2020). For these beneficiaries, Medicare pays for SNF care during the initial portion of their stay, and Medicaid pays for subsequent days of care. Medicare Part B also continues to cover physician and therapy services for long-stay nursing facility residents after the Medicare Part A SNF benefit is exhausted. State Medicaid programs have the option to pay for Medicare cost sharing during the initial portion of the stay, but most do not, which results in lower payments to the facility (MACPAC 2013).

Medicaid payments compared with other payers

According to the National Health Expenditure Accounts, Medicaid accounted for 30 percent of total revenue for all nursing facilities, including those that were part of continuing care retirement communities, in 2019 (Figure 2-2). Although Medicaid is the largest payer for nursing facility services, Medicaid payments as a share of total revenue are much lower than the share of nursing facility residents covered by Medicaid (59 percent) (Abt Associates 2020). Medicaid payments are generally lower than other payers because of differences in the services that Medicaid covers and because Medicare typically pays facilities much more than the costs of care for Medicare-covered patients.

FIGURE 2-2. Sources of Revenue for Nursing Facilities and Continuing Care Retirement Communities, 2019



Note: Analysis includes all certified nursing facilities, including those part of continuing care retirement communities.
Source: OACT 2022.

Differences in resident acuity and covered services. Medicaid payment rates are not comparable to those in Medicare because of differences in resident acuity and the services that Medicaid covers. First, long-stay residents, who are predominately covered by Medicaid, generally have less intensive nursing and therapy care needs than short-stay patients covered by Medicare, so the costs of their care are lower (MACPAC 2023a, Abt Associates 2020). Second, for patients dually eligible for Medicare and Medicaid, Medicare Part B continues to pay for some physician and therapy services for long-stay residents, and so these services are not included in the Medicaid rate. Third, because of Medicaid spenddown and post-eligibility treatment of income rules, many Medicaid-covered residents pay for a substantial portion of their care out of pocket, which reduces the amount that Medicaid pays the facility.

Medicare payment rates often exceed facility costs. According to the Medicare Payment Advisory Commission (MedPAC), Medicare has long paid SNF payments much more than their costs of care for Medicare-covered patients. For example, freestanding nursing facilities reported a 20 percent aggregate Medicare profit margin in fiscal year 2019, compared with an aggregate non-Medicare margin of -2 percent (MedPAC 2021). Although some stakeholders contend that high Medicare payment rates are justified because they can offset low Medicaid payment rates, MedPAC has long argued that this policy is inefficient, since the policy benefits facilities that serve more Medicare-covered residents instead of facilities that serve a high share of Medicaid-covered residents (MedPAC 2022b). In addition, because Medicare payment rates are set nationally, they do not account for differences in Medicaid payment rates across states. As discussed in the following sections, state payment rates vary widely, and in some states, facilities report positive Medicaid margins.

Industry trends

In 2019, there were 15,462 certified nursing facilities nationwide. Most nursing facilities (93 percent) are certified by both Medicare and Medicaid, and most of these facilities (97 percent) are freestanding, meaning that they are not based within a hospital. Roughly 9 percent of facilities are part of a continuing care retirement community, which includes assisted living options in addition to certified nursing facility beds (Abt Associates 2022).

Ownership. In 2022, most nursing facilities (72 percent) were for profit, and about two-thirds of facilities (66 percent) were also part of a larger chain.[8] Nursing facility chains vary widely in size: in 2022, about 15 percent of nursing facilities were part of chains with 10 facilities or fewer, and about 11 percent of nursing facilities were part of chains with more than 100 facilities (ASPE 2022a).

Between 2016 and 2021, a total of 3,254 nursing facilities were sold, and the pace of transactions has generally increased since 2016 (ASPE 2022b). About one-third of these transactions involved multiple owners (ASPE 2022b). For example, multiple related parties can own a nursing facility when a private equity firm purchases a nursing facility, sells the real estate to another entity, and then leases the building to a third entity that manages the care provided.

Declining occupancy rates. Even before the COVID-19 pandemic, nursing facility occupancy rates were declining, which creates financial challenges for facilities that must continue to pay fixed overhead and capital costs with declining revenue. Between 2010 and 2019, occupancy rates declined from 88 to 85 percent, in part because of efforts to shift care to home- and community-based services, and since the start of the COVID-19 pandemic, occupancy rates have declined even further (MedPAC 2022b). In January 2021, median occupancy rates reached a low of 69 percent, and by November 2022, median occupancy rates were 78 percent (CLA 2023).

Nursing facility closures. Between 2015 and 2019, more than 500 nursing facilities closed (Flinn 2020). Although some closures are expected as care shifts from nursing facilities to other settings, closures can be particularly problematic in rural areas where residents may not have access to other facilities nearby where their loved ones can easily visit. In 2018, 7.7 percent of U.S. counties had no nursing facility, an increase of 44 counties since 2008; these closures were more common in facilities that served a higher share of Medicaid-covered residents (Sharma et al. 2021).

New care models. Despite the challenges that the nursing facility industry faces, some providers are testing new models of care that reflect resident preferences for less institutional, more homelike settings. One example is the Green House initiative launched in 2003 with funding from the Robert Wood Johnson Foundation. In contrast to the average

nursing facility, which has about 100 beds with many shared rooms, facilities participating in the Green House initiative have about 10 to 12 beds and single-occupancy rooms. The model has shown promising quality outcomes, but these facilities represent less than 2 percent of nursing facilities and serve less than 1 percent of all nursing facility residents. Moreover, these facilities report that it has been challenging to expand access to more Medicaid-covered nursing facility residents because of Medicaid payment rates and state limitations on Medicaid covering private rooms if they are not medically necessary (Waters 2021).

Facilities that serve a high share of Medicaid-covered residents

The payer mix of Medicaid, Medicare, and private-pay residents varies widely and is associated with a number of facility characteristics (Table 2-1). Although some of these differences may reflect facility decisions on whether to accept more short-stay patients versus long-stay residents, they also reflect facility decisions about whether to accept Medicaid-covered residents. Federal law prohibits facilities from discharging a resident once they become Medicaid eligible, but in many states, facilities can choose to not admit residents who are likely to become Medicaid eligible.[9] As a result, there is evidence that Medicaid-covered residents may have more difficulty accessing high-quality facilities (Sharma et al. 2020).

Quality ratings. On average, facilities that serve a high share of Medicaid-covered residents have lower quality ratings than other facilities on all of the domains measured by the Medicare.gov Care Compare five-star rating system (Box 2-1). However, there is wide variation in the quality of care provided to Medicaid-covered residents, and in 2019, 12 percent of facilities that served the highest quartile of Medicaid-covered residents had five-star ratings overall (the highest on Care Compare) compared with 21 percent of all facilities in our analysis.

TABLE 2-1. Facility Characteristics by Payer Mix, 2019

Characteristics	All facilities	Share of residents whose primary support was Medicaid			
		Lowest quartile (< 48%)	Second quartile (48–61%)	Third quartile (61–71%)	Highest quartile (> 71%)
Average Medicare.gov Care Compare five-star quality ratings					
Overall rating	3.1	3.7	3.1	2.8	2.7
Inspection component	2.7	3.2	2.8	2.6	2.4
Staffing component	2.9	3.4	2.9	2.7	2.6
Quality measure component	3.6	3.9	3.6	3.5	3.4
Race and ethnicity of nursing facility residents					
White, non-Hispanic	77%	86%	81%	74%	65%
Black, non-Hispanic	13	7	10	15	21
Hispanic	5	3	4	6	7
Other	5	5	5	6	6
Ownership					
Private, for profit	74%	56%	73%	82%	84%
Private, non-profit	21	38	22	13	11
Public	5	6	5	5	5

Note: Analysis excludes hospital-based nursing facilities and those that are not dually certified by Medicaid and Medicare.

Sources: MACPAC, 2022, analysis of Medicare.gov Care Compare, Medicare cost reports, and the Minimum Data Set.

Racial and ethnic disparities. Facilities serving a high share of Medicaid-covered residents also serve more racial and ethnic minorities, so poor quality ratings in these facilities contribute to health disparities. In general, Black Medicaid beneficiaries are more likely than white Medicaid beneficiaries to receive care in nursing facilities, and when they do, they are less likely to be admitted to high-quality facilities (Zuckerman et al. 2018). The racial and ethnic disparities in nursing facility care are long standing and have persisted even as other health care settings, such as hospitals, have been desegregated (Nolen et al. 2020).

Facility ownership. For-profit facilities are more likely to serve a high share of Medicaid patients than non-profit facilities. For-profit facilities generally have lower staffing levels than other facilities and have lower average quality ratings than other types of facilities (Paul et al. 2016). As a result, some of the differences in quality by payer mix that we observe may be a result of differences in facility ownership. Recent research has highlighted additional quality challenges in for-profit facilities owned by private equity investors, but we do not have data to distinguish these facilities from other for-profit facilities (Braun et al. 2021, Gupta et al. 2021).

BOX 2-1. Medicare.gov Care Compare Five-Star Ratings for Nursing Facilities

Since 2008, the Centers for Medicare & Medicaid Services (CMS) has been reporting five-star quality ratings for nursing facilities on its Medicare.gov Care Compare website. The composite five-star rating is based on three components that have continued to be refined over time:

- **Inspection star ratings** based on the findings from on-site inspections conducted by state survey agencies to assess practices to ensure the safety of residents.[10] Facilities receive a lower star rating if they have more identified deficiencies and if these problems persist upon follow-up visits. Star ratings are assigned on a curve, and so the 20 percent of facilities in each state with the worst inspection ratings are assigned one star, and the 10 percent of facilities with the best inspection ratings in each state are assigned five stars.
- **Staffing star ratings** based on nursing facilities' reported hours of registered nurse and total nurse staffing, which includes registered nurses, licensed practical nurses, and certified nurse assistants. After adjusting for differences in resident acuity, facilities with higher staffing hours per resident day relative to other facilities receive higher star ratings. Historically, nursing facilities self-reported staffing data to CMS, but since 2016, CMS has required nursing facilities to submit staffing data through an auditable payroll-based journal (PBJ) system that is more accurate. CMS began using PBJ data for star ratings in 2018. In 2022, CMS began using the PBJ data to include additional measures of staff turnover and weekend staffing in Care Compare (CMS 2022a). These additional measures are not included in our analyses of 2019 staffing ratings.
- **Quality star ratings** based on performance on a range of measures used to assess quality of care for short-stay and long-stay nursing facility residents. Many of the measures are calculated using data from the Minimum Data Set, which collects information on all nursing facility residents. In 2019, CMS added several additional measures based on Medicare fee-for-service claims data, which are included in our analysis (CMS 2019). Some of these claims-based measures, such as hospitalization and emergency department visit rates, include patients dually eligible for Medicare and Medicaid because Medicare is the primary payer for hospital care. However, these measures do not include patients who are enrolled in Medicare Advantage plans, including plans intended to integrate care for dually eligible patients.

Effects of COVID-19 pandemic

The COVID-19 pandemic has had a disproportionate effect on nursing facilities and their residents. Although nursing facility residents account for less than 1 percent of the U.S. population, they have accounted for about 15 percent of COVID-19 deaths as of December 2022 (CMS 2022b).

While the level of community spread is the primary contributor to the rate of COVID-19 infections in nursing facilities, the pandemic has also exposed and exacerbated long-standing nursing facility quality issues (GAO 2022). A low number of direct care staff per resident and the use of shared rooms have been associated with rates of COVID-19 transmission and death (Harrington et al. 2020a, Li et al. 2020). Because Medicaid-covered residents are more likely to reside in facilities with these characteristics, studies have found that these residents have been disproportionately affected by the pandemic (Weech-Maldonado et al. 2021).

As discussed previously, the COVID-19 pandemic has also led to declines in nursing facility occupancy rates, which have created financial challenges for facilities because of their fixed overhead and capital costs. Although some of the declining occupancy is due to an acceleration of the shifting patterns for post-acute care and LTSS that began before the pandemic, some changes in the occupancy have been driven by pandemic-specific factors, such as the high death rate of nursing facility residents.

In response to lower occupancy rates, nursing facilities have also decreased staffing levels. For example, between January and September 2020, the number of direct care hours declined 9.8 percent, which was commensurate with the decline in nursing facility residents (Werner and Coe 2021). However, as use of nursing facility care begins to recover from pandemic lows, some facilities have reported challenges rehiring staff because of increased labor costs, and without sufficient staff, facilities cannot use all available beds (CLA 2023).

A variety of state and federal policy changes have supported nursing facilities during the COVID-19 public health emergency. For example, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) created a time-limited provider relief fund to offset immediate losses and also provided grants to states that some have used to increase Medicaid payment rates (MACPAC 2021a). In addition, CMS has authorized a number of temporary waivers of regulatory requirements for nursing facilities, including allowing nursing facilities to be paid Medicare's higher SNF rate for long-stay residents with acute care needs without requiring a prior hospital stay. These temporary changes have helped most nursing facilities manage the disruption in their finances so far, but many providers are concerned about their financial viability after these policies expire (CLA 2023, 2022a).

Policymakers are also using early lessons from the pandemic to consider a variety of permanent nursing facility regulatory and payment reforms. In 2022, the National Academies of Sciences, Engineering, and Medicine released a report recommending a variety of reforms to CMS's oversight of nursing facilities and changes to Medicare and Medicaid policies. Notably, the report calls for greater transparency and stronger evaluations of Medicaid nursing facility rates, which align with the Commission's recommendations discussed later in this chapter (National Academies 2022).

Medicaid Payment Policies

States have considerable flexibility to set Medicaid nursing facility payment rates and methods. MACPAC's analyses of these policies have found wide variation in the types of payments that states make, how these payments are financed, and how Medicaid payments compare to nursing facility costs.

Federal Medicaid payment requirements

Nursing facility services have been a required Medicaid benefit since the program's enactment in 1965, but Congress has made several changes over time to the rules governing how states pay providers. The original statute had few limitations, but in 1972, Congress required that states pay on a reasonable cost-related basis, similar to Medicare, because of concerns that states were overpaying providers (Committee on Finance 1972).[11] In 1980, the Boren amendment to the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) removed this requirement and instead required Medicaid nursing facility payments to be "reasonable

and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards." To help states meet this requirement, the Boren amendment also required nursing facilities to submit uniform Medicaid cost reports.

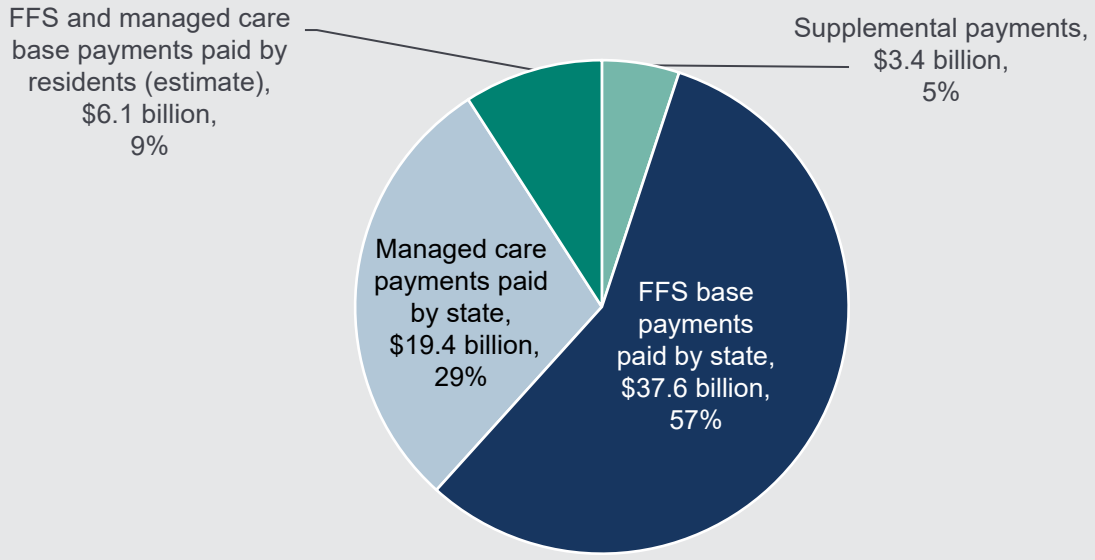
The Boren amendment was difficult to implement and led to a number of provider lawsuits. CMS never formally defined an "efficient and economically operated" facility, so each state developed its own method to comply with this requirement. In 1990, the U.S. Supreme Court ruled in *Wilder v. Virginia Hospital Association* that the Boren amendment created a privately enforceable right for providers, which led to a growth of lawsuits challenging provider payment rates and the methods that states had used to develop them (Wiener and Stevenson 1998).[12] In 1996, Congress repealed the Boren amendment and gave states additional flexibility to set their own payment rates as long as they developed them using a public process (§1902(a)(13)(A) of the Act).

A separate Medicaid statutory provision, Section 1902(a)(30)(A) of the Act, still requires Medicaid payment policies to be consistent with the principles of efficiency, economy, quality, and access to care.[13] In 2015, the U.S. Supreme Court ruled in *Armstrong v. Exceptional Child Center, Inc.* that providers no longer have a right to sue in federal court to enforce these Medicaid payment requirements, so now they can only be enforced by CMS.[14]

Types of Medicaid payments to nursing facilities

In 2019, nursing facilities were paid approximately $66.5 billion for care to Medicaid-covered residents (Figure 2-3). The two main categories of payment are base payments, which are typically paid on a per diem basis for a specific resident, and supplemental payments, which are generally paid in a lump sum for a fixed period of time. Most payments are base payments made through the fee-for-service (FFS) delivery system, but a growing share of Medicaid payments to nursing facilities are made through managed care and supplemental payments. In the following sections, we discuss each of these types of payments in more detail as well as the limitations of available data for measuring these payments.

FIGURE 2-3. Base and Supplemental Payments to Nursing Facilities, 2019



Notes: FFS is fee for service. Resident contributions to their share of cost are estimated based on the difference between allowed payment rates and actual Medicaid payment amounts in states with available data.

Sources: MACPAC, 2022, analysis of CMS-64 net expenditure data and the Transformed Medicaid Statistical Information System (T-MSIS).

FFS base payments. Medicaid programs typically pay nursing facilities a daily rate for Medicaid-covered residents according to a state fee schedule. Currently, most states set Medicaid nursing facility payments based on the costs for various cost centers, such as direct care (i.e., medical supplies and wages of staff providing direct care), indirect care (e.g., the costs of social services and patient activities), administration, and capital. However, Medicaid payments are not intended to cover all costs for all facilities because states set limits on which costs are allowable and set ceilings on the amount of costs that can be reimbursed for particular cost centers (e.g., a fixed percentage of the median or average costs for a particular cost center among similar facilities in the state). Less than a third of states use a price-based method to set payments prospectively based on historic costs adjusted for inflation and other factors (MACPAC 2019a, 2019b).

The base payments that states pay are reduced by resident contributions to their cost of care, which are paid to the facility directly. Based on our analysis of claims data in the Transformed Medicaid Statistical Information System (T-MSIS), resident contributions to their cost of care accounted for about 10 percent of base payments to nursing facilities in 2019 (MACPAC 2023a).

Managed care base payments. In 2019, 24 states paid for some or all nursing facility care through managed care organizations, up from just 8 states in 2004. Most states with managed LTSS (MLTSS) include full coverage for nursing facility services, although some states carve out long-stay nursing facility residents from some programs (Dobson et al. 2021, Lewis et al. 2018).

In April 2016, CMS established a new option for states to direct managed care plans to pay particular types of providers according to specified rates or methods, which is referred to as "directed payments." Based on MACPAC's review of directed payment arrangements approved as of December 31, 2020, 14 states established minimum fee schedules for nursing facility services provided in managed care (typically no less than the Medicaid FFS rate), and 6 states required managed care plans to increase payments to nursing facilities by a fixed amount above base payment rates, similar to supplemental payments in FFS (MACPAC 2022a).

Managed care payments to nursing facilities are also subject to post-eligibility treatment of income rules, but information on resident contributions to their cost of care is not available for all states. For example, in our analyses of 2019 T-MSIS data, five states with MLTSS reported managed care base payments paid by the state but did not report the total allowed amount, after accounting for resident contributions to their share of cost, and so we could not include managed care payments in these states in our analyses (MACPAC 2023a).

The limited data available on managed care payments to nursing facilities suggest that they are similar to FFS in many states. In the four states with MLTSS that we interviewed in 2020 (Kansas, New York, Rhode Island, and Wisconsin), managed care plans all paid nursing facilities according to FFS rates and methods. Many states had directed payment arrangements that required plans to pay facilities' FFS rates, but plans also noted that it was administratively easier to do so. Because many managed care plans relied on state rate setting methods to set their own rates, the stakeholders we interviewed noted the need for states to maintain their FFS rate setting capacity even after moving to MLTSS (MACPAC 2020a).

Supplemental payments. In 2019, 23 states made a total of $3.4 billion in supplemental payments to nursing facilities, which accounted for approximately 5 percent of total nursing facility payments. The use of supplemental payments varies widely by state: 27 states and the District of Columbia did not make any supplemental payments, and 6 states made payments that were more than 30 percent of total FFS Medicaid payments to nursing facilities (MACPAC 2020b).

Medicaid FFS base payment rates and supplemental payments cannot exceed the upper payment limit (UPL), which is an estimate of what Medicare would have paid for the same service in the aggregate.[15] States are required to submit provider-level information on base and supplemental payments to CMS annually to demonstrate compliance with these UPL requirements (CMS 2022c). When calculating the UPL, states are supposed to account for differences in resident acuity and differences in services that Medicaid and Medicare cover; nevertheless, states and CMS still face challenges accurately calculating the UPL because Medicaid and Medicare payment rates are not directly comparable (CMS 2022c).

MACPAC's review of these UPL demonstration data found several discrepancies between the amount of payments reported on UPL demonstrations and the amount of payments claimed by states on CMS-64 reports in the Medicaid Budget and Expenditure System (MBES), which is the official record of actual Medicaid spending.[16] CMS is currently implementing a new process for states to report provider-level supplemental payment data through MBES, which will hopefully help improve the reliability of these data in future years (CMS 2021).

Financing of Medicaid payments

Similar to other Medicaid payments, states and the federal government jointly finance Medicaid nursing facility payments according to the state's federal matching assistance percentage (FMAP). The non-federal share of Medicaid payments can be financed by state general funds, provider taxes, and intergovernmental transfers (IGTs) or certified public expenditures (CPEs) from local governments, including publicly owned nursing facilities.

State use of nursing facility provider taxes has grown in recent years, from 22 states in 2004 to 45 states in 2019 (Gifford et al. 2019). States are allowed to use provider taxes to finance their Medicaid programs as long as the taxes are imposed on a broad base of providers (i.e., not just providers who serve a high share of Medicaid patients), are uniformly applied based on a common tax basis (e.g., provider revenue or the number of certified nursing facility beds), and do not guarantee that providers are paid back the amount that they contribute in taxes. In practice, many states use the increased federal funding generated by provider taxes to increase Medicaid payments, which is permissible as long as the tax does not exceed 6 percent of net patient revenue for the class of providers. Many states impose taxes up to this maximum allowable amount, and in 2019, 22 states had nursing facility provider taxes between 5.5 and 6 percent of provider revenue (KFF 2020).[17]

IGTs and CPEs are commonly used to finance nursing facilities that are publicly owned, which accounted for about 5 percent of all nursing facilities, according to Medicare cost reports in 2019. However, in some states, the number of facilities that are classified as publicly owned for Medicaid purposes is much higher than the number on Medicare cost reports because of complex ownership arrangements between public hospitals and privately operated nursing facilities. Specifically, in some states, it is common for public hospitals to buy or lease privately operated nursing facilities so that these facilities can receive IGT-financed supplemental payments targeted to government-owned facilities. For example, in Indiana, 90 percent of nursing facilities in the state received supplemental payments targeted to government-owned facilities in 2019, including 181 facilities that were classified as privately owned on Medicare cost reports (MACPAC 2023b). Indiana reported more than $1 billion in nursing facility supplemental payments in 2019, more than any other state, but it is unclear how much of these payments were retained by nursing facilities and how much of these payments were returned to the public hospitals that financed these payments (Galewitz 2017).

During interviews with stakeholders about the factors that affect their nursing facility payment methods, we learned that state decisions to use supplemental payments are often affected by the methods that states use to finance the non-federal share of Medicaid payments. Although states and nursing facilities generally preferred that rate increases be implemented through increases to base payments rather than supplemental payments, these stakeholders generally viewed supplemental payments as a better way to target funding to providers to ensure that they were paid back the amount that they contributed through provider taxes or IGTs (MACPAC 2020a).

Base payment rates vary widely

According to our analyses of base payment rates reported in T-MSIS in 2019, Medicaid nursing facility payment rates varied widely by state and facility. Even after adjusting for differences in the area wage index and differences in resident case mix, average state payment rates ranged from 62 to 182 percent of the national average. Across facilities within states, we also observed considerable variation (MACPAC 2023a).

Although Medicaid rates are often lower than costs, we found that Medicaid payments appeared to exceed the costs of care in some facilities in 2019 (Figure 2-4). The median facility had payment rates that were 86 percent of costs. However, about one-fifth of facilities

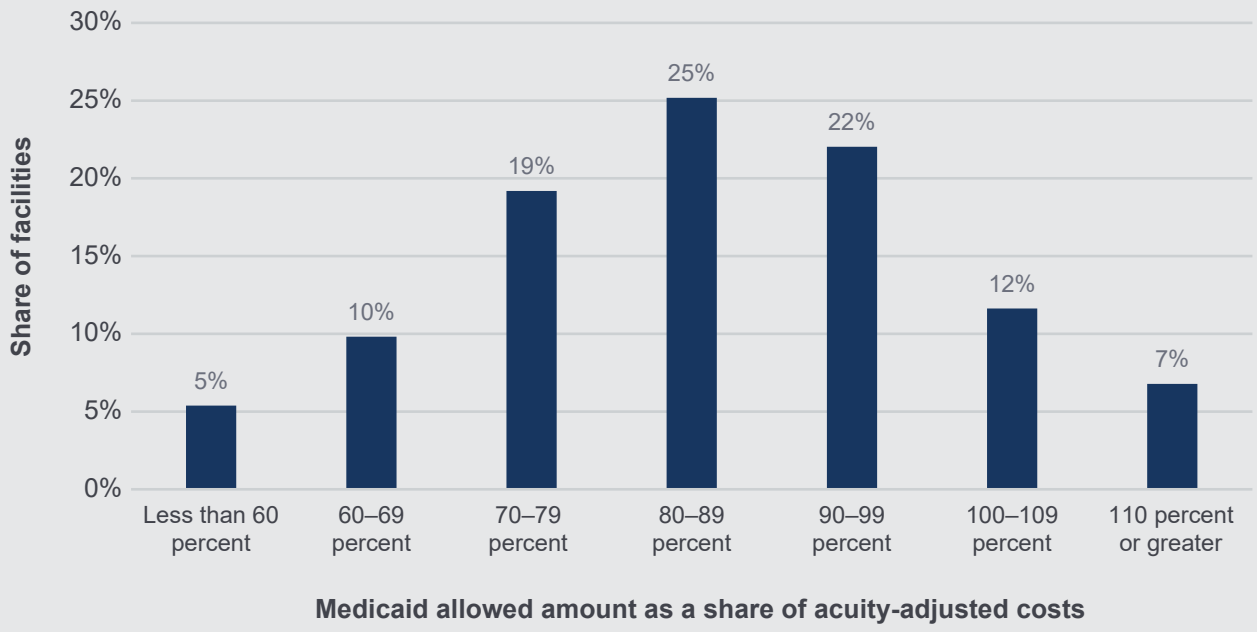
had base payment rates greater than 100 percent of costs, and 15 percent of facilities had base payment rates less than 70 percent of costs.

Our estimates of Medicaid payments relative to costs have several limitations. First, we were not able to find reliable data on supplemental payments to providers in all states. In states in which data were available, they suggested that these payments can substantially affect the distribution of Medicaid payments relative to costs (MACPAC 2023a). Second, we were not able to collect information on provider contributions to the non-federal share, which can reduce the net payments that providers receive. Third, the Medicare cost report data we used for this analysis does not account for state-specific differences in allowable costs or the potential effects of related-party transactions, which may inflate costs reported on facility-specific cost reports (Adelberg et al. 2022). Finally, because of the limits of available data, we were not able to examine payments relative to costs after the start of the COVID-19 pandemic, which has resulted in increased nursing facility costs and also increased Medicaid payment rates in many states.

Using Medicaid Payments to Improve Quality

Medicaid payment policy has the potential to help improve quality outcomes and reduce disparities. To better understand Medicaid's role, the Commission has examined how nursing facility staffing levels vary by state, how they relate to Medicaid payment policies, and which barriers states face in changing payment policies to promote better outcomes.

FIGURE 2-4. Distribution of Medicaid Base Payment Rates as a Share of Acuity-Adjusted Costs, 2019



Notes: Base payment rates include resident contributions to their share of costs. Analysis excludes Alaska, Idaho, and New Hampshire because of unreliable or missing data. Data on resident contributions to their share of costs were not available for managed care payments in California, Massachusetts, New Jersey, Rhode Island, and Virginia, and so only fee-for-service spending is included for these states.

Source: Abt Associates, 2022, analysis for MACPAC of the Transformed Medicaid Statistical Information System (T-MSIS), Medicare cost reports, and the Minimum Data Set.

Background on staffing standards

Although staffing levels are just one of many measures of quality, higher staffing levels are associated with a variety of positive health outcomes and have been a key area of focus for states during the pandemic.[18] Moreover, because staffing levels are primarily affected by how much facilities pay nurses and nurse aides (often referred to as "direct care staff"), payment policy can play an important role in helping to address this issue.

Nursing facilities are staffed by a variety of nurses and nurse aides with different levels of training that provide direct care, including the following:

- registered nurses (RNs), who have at least a two-year degree and are responsible for overseeing residents' care;
- licensed practical nurses (LPNs), who have a one-year degree and typically provide routine bedside care (such as taking vital signs); and
- certified nurse aides (CNAs), who have at least 75 hours of training and generally assist residents with activities of daily living.[19]

Currently, CMS requires facilities have licensed nurse staff (RNs or LPNs) available 24 hours a day, an RN available eight hours a day, and a full-time director of nursing. For a 100-bed facility, this standard equates to 0.3 hours per resident day (HPRD) of licensed nurse staff.

In 2001, a CMS staffing study found that staffing levels of at least 0.75 HPRD of RN staffing and 4.1 HPRD of total staffing of nurses and nurse aides (RNs, LPNs, and CNAs) were associated with optimal quality. The study did not find improvement in quality for facilities that staffed above this level (CMS 2001). Although some stakeholders have argued that 4.1 HPRD is too high a standard for most nursing facilities, this standard continues to be endorsed by a variety of nursing groups (Schnelle et al. 2016, CGNO 2014). Yet, according to CMS's Care Compare website, approximately 72 percent of nursing facilities had total staffing levels below 4.1 HPRD in 2019. CMS is currently conducting an updated staffing study using more recent data to inform the development of new staffing standards (CMS 2022d).

CMS assigns star ratings to facilities based on how their staffing levels compare to other facilities. In our analysis, we examined the share of facilities with one- or two-star staffing ratings, which included facilities with less than 0.5 HPRD of RN care and 3.6 HPRD of total staffing of nurses and nurse aides in 2019.

State variation in staffing levels

Overall, nursing facility staffing levels vary widely across states. For example, in three states (Alaska, Hawaii, and North Dakota) and the District of Columbia, fewer than 10 percent of freestanding nursing facilities had one- or two-star staffing ratings on Medicare.gov Care Compare in 2019, while in three other states (Georgia, Louisiana, and Texas), more than 70 percent of facilities had these low ratings (MACPAC 2022b).

We also found wide state variation in the disparities between facilities that serve a high share of Medicaid-covered residents and those that do not. For example, in 2019, the difference between the average staffing star rating in the quartile of facilities that served the highest share of Medicaid-covered residents was more than one star lower than the quartile of facilities that served the lowest share of Medicaid-covered residents in seven states (Kansas, Illinois, North Carolina, Ohio, Pennsylvania, Utah, and Virginia). In comparison, the difference between the quartile of facilities that served the highest and lowest share of Medicaid-covered residents was less than 0.1 stars in eight states (Arkansas, Delaware, Mississippi, North Dakota, New Mexico, Oklahoma, Oregon, and Wyoming) (MACPAC 2023c).

The wide state variation that we observe suggests a role for state policy. Although some state variation may be due to factors other than Medicaid, disparities by payer mix are likely affected by Medicaid payment policies. Moreover, the fact that some states have relatively high staffing levels and few disparities by payer mix shows that ensuring adequate staffing to meet the needs of Medicaid-covered residents is an achievable goal.

Relationship between payment rates and staffing

Prior research has suggested that increasing Medicaid payment rates has the potential to improve staffing. For example, studies of rate increases in California, Ohio, and Pennsylvania found that they were associated with improved staffing, particularly for RNs and LPNs (Hackman 2019, Bowblis and Applebaum 2017, Bishop 2014).

However, in our analysis of 2019 data, we did not find a clear relationship between Medicaid payments and staffing levels (Table 2-2). Average base payment rates were higher for facilities with a five-star staffing rating (the highest) compared with facilities with a one-star rating (the lowest). However, after accounting for differences in facility costs, the Medicaid payment-to-cost ratio in facilities with five-star staffing ratings was 7 percentage points lower on average than facilities with a one-star rating.

Average costs are lower in facilities with lower staffing levels in part because these facilities spend less on staff, which is a substantial component of nursing facility costs.[20] After estimating what costs would be if facilities had similar staffing levels, the difference in Medicaid margins between facilities with low staffing levels and high staffing levels narrows, but Medicaid margins are still higher for facilities with lower staffing ratings.[21]

Role of Medicaid payment methods and state staffing requirements

In addition to increasing payment rates, states can also change other policies to encourage facilities to spend more of the revenue that they receive on staff. Two approaches that we studied are (1) changing Medicaid payment methods to incentivize spending on direct care staff and (2) requiring that facilities meet minimum staffing standards that exceed federal requirements. To better understand the potential effects of these policies, we conducted a literature review of relevant studies published since 2008.

Medicaid payment methods. Examples of Medicaid payment methods that may promote higher staffing levels include wage pass-through payments that require facilities to spend a specified portion of the

TABLE 2-2. Average Medicaid Base Payments per Day and Acuity-Adjusted Costs by Five-Star Staffing Rating, 2019

Five-star staffing rating in the CMS Nursing Home Quality Rating System	Number of facilities in analysis	Average Medicaid base payment rate per day	Average cost of care for Medicaid-covered residents	Average Medicaid base payment as a share of costs	Average Medicaid base payment as a share of costs if facilities were staffed with at least 3.6 HPRD
All facilities	**12,377**	**$199.74**	**$237.85**	**84%**	**82%**
1 star (lowest)	1,701	183.26	209.36	88	83
2 star	3,451	195.71	227.54	86	83
3 star	3,739	201.93	243.94	83	82
4 star	2,572	209.66	257.41	81	81
5 star (highest)	831	230.54	286.93	80	80

Notes: CMS is Centers for Medicare & Medicaid Services. HPRD is hours per resident day. The threshold for a three-star staffing rating in 2019 was 3.6 HPRD. Base payments include resident contributions to their share of costs. Average costs and payments are weighted by the number of Medicaid days in each facility. Alaska, Idaho, and New Hampshire were excluded from analysis due to data quality issues. The analysis also excluded facilities with missing payment data and outlier staffing costs.

Source: Abt Associates, 2023, analysis for MACPAC of the Transformed Medicaid Statistical Information System (T-MSIS), Medicare cost reports, the Minimum Data Set, and Medicare.gov Care Compare.

Medicaid rate on staff wages, cost-based payment methods that tie payment rates to spending on direct care staff, and pay for performance (P4P) incentive payments that tie payments to meeting staffing goals.

Overall, there is limited research available about the effectiveness of these methods. One multivariate study using 2002 data found that cost-based payment methods were associated with both higher RN staffing and higher total staffing (Harrington et al. 2007). A review of wage pass-through policies implemented between 1996 and 2004 found CNA staffing levels increased in the initial years after implementation but found no statistically significant effect on RN or LPN staffing (Feng et al. 2010). Finally, one review of eight Medicaid P4P programs compared with a nationwide control group found that only one state had a statistically significant effect on staffing measures and that the effects on resident-level outcomes were also limited (Werner et al. 2013).

In response to the COVID-19 pandemic, a number of states made changes to their Medicaid payment policies related to staffing. As of fall 2021, 12 states increased payments to direct care workers, 1 state added a new wage pass-through policy, and 4 states implemented new payment incentives related to staffing since 2020 (MACPAC 2022a).[22] In 2022, Illinois implemented a new rate increase for CNAs that was different from other policies that we studied because it targeted higher wages to more experienced staff to help improve staff retention (IL HFS 2021).

During our interviews, we heard mixed perspectives about whether states would be able to continue rate increases in the long term. Some states financed temporary rate increases using grants from the $150 billion Coronavirus Relief Fund authorized by the CARES Act, which can be used only for expenses incurred during the public health emergency. As a result, to continue these rate increases after the public health emergency using Medicaid authorities, these states would need to provide additional state matching funds.

Minimum staffing standards. States can set their own minimum staffing standards that exceed federal requirements. According to MACPAC's review of state staffing policies in 2021, 38 states and the District of Columbia have state minimum staffing standards that exceed the federal requirements of 0.3 HPRD of licensed nurse staff for a 100-bed facility. However, state standards vary widely. For example, 9 states have standards that are less than 2.0 HPRD, and 11 states and the District of Columbia have standards that are greater than 3.0 HPRD. In addition, states vary in whether they have specific requirements for licensed nurse staff or whether the HPRD requirements apply to all nurses and nurse aides (including CNAs) (MACPAC 2022b).

Prior research has found that increases in minimum staffing standards are associated with improvements in staffing, particularly for CNAs. For example, an analysis of new minimum staffing requirements in California and Ohio found a 5 percent increase in HPRD overall but a reduction in skill mix (i.e., the ratio of RNs to all direct care staff) (Chen and Grabowski 2014).[23] In another study that examined the effects by payer mix, facilities that served a higher share of Medicaid patients reported larger increases in staffing, including RN staffing, in response to increases in minimum staffing requirements, resulting in larger gains in other measures of quality of care (Bowblis 2011).

Several states recently changed their staffing requirements in response to the COVID-19 pandemic. In our review of policies enacted as of October 2021, we identified 10 states that increased minimum staffing standards since 2020. Two states (Maine and New Jersey) added new minimum wage requirements specifically for direct care staff, a new type of policy that we did not find in states before the pandemic (MACPAC 2022a).

Minimum loss ratio requirements that cap nursing facility profits and require facilities to spend a minimum amount on staffing are a new policy approach to promote staffing that is being developed in Massachusetts, New Jersey, and New York. In 2019, median staffing costs as share of nursing facility revenue were 34 percent but varied widely by state. Facilities in the 90th percentile of Medicaid-covered days have higher median staffing costs as a share of revenue (36 percent), which suggests that policies to increase the share of revenue spent on staff may have less of an effect on facilities that serve a high share of Medicaid-coverage residents (Bowblis et al. 2023).

In April 2022, CMS requested information from stakeholders about raising federal minimum staffing standards, and a new staffing study intended to inform

these efforts is underway (CMS 2022d). Although the relationship between higher staffing levels and higher quality care has been well documented, questions remain about what an appropriate minimum staffing standard should be. Increasing federal standards would help improve quality, but it would also likely result in increased costs for facilities, which may require some state Medicaid programs to make higher payments (CLA 2022b).

Challenges changing state payment methods

Despite the potential for Medicaid payment policies to help improve the quality of nursing facility care, progress in developing new payment models has been relatively slow compared with other provider types. Between 2014, when MACPAC first reviewed FFS nursing facility payment policies, and 2019, when we updated our compendium, few states made any substantial changes to their nursing facility payment methods (MACPAC 2019a). During subsequent interviews with state officials, nursing facilities, and other stakeholders in 2020, we learned that limited state capacity, industry resistance, and a lack of clarity about value-based payment goals were the primary barriers to change (MACPAC 2020a).

Limited state capacity. The state officials we interviewed described several limits in their capacity to make changes to their already complicated financing systems. Some states faced reductions in staffing to analyze Medicaid nursing facility FFS rates due to budget cuts or the expansion of MLTSS. In addition, states reported losing institutional knowledge because of staff turnover, which was hard to replace because Medicaid nursing facility payment policy is so complex. Some states hire external consultants to support their capacity when making new reforms, but these states later reported a similar loss of institutional knowledge when the consultants who initially designed the payment system were no longer available to evaluate future changes to payment policies.

Industry resistance to change. The nursing facility industry associations that we interviewed were generally active in lobbying state policymakers against changes in payment methods that could create winners and losers among nursing facilities in their states. Instead, these associations primarily advocated for increased payment rates because of a view that state payment rates were too low to cover costs and concerns that states would cut rates further for budgetary reasons. In states that did get provider support for payment changes, state officials noted the need to engage stakeholders early and provide sufficient time to prepare for any change.

Lack of clarity about value-based payment goals. Twenty-five states had P4P incentive payment programs in nursing facilities in 2019, but the state officials that we interviewed in seven states noted that P4P programs in their states did not appear to be particularly effective (MACPAC 2019a). For example, one state's program was more than two decades old, and due to secular trends and federal policies implemented in recent years, most facilities had already achieved most of the program's initial goals related to reducing survey deficiencies and meeting targets for culture change to promote more person-centered care. States reported challenges selecting new measures that were tied to quality outcomes, such as reductions in rehospitalizations or improvement in long-stay quality measures, because of a lack of consensus among stakeholders about how these quality measures should be defined and how the targets should be set.

In the states we studied, interviewees did not mention any efforts to incorporate nursing facilities into alternative payment models that states were using for their acute care populations, such as accountable care organizations. Although stakeholders acknowledged the high rate of avoidable hospital use among Medicaid-covered nursing facility residents, they noted that it was difficult to develop alternate payment models for residents dually eligible for Medicare and Medicaid because savings from reducing hospital use for these residents accrue to Medicare rather than Medicaid.

We also heard a lack of consensus among stakeholders about whether a value-based measure of cost savings is appropriate in assessing value for nursing facility care because of the risk that facilities may reduce costs by cutting direct care staff needed to meet residents' care needs. One state in our study, New York, switched from a cost-based payment method to a price-based system in 2017 to provide more budget predictability for the state, uniformity across facilities, and administrative efficiency.

Although the state still sets prices based on prior year cost reports, the state has less control than it would in a cost-based system on how facilities spend the Medicaid revenue that they receive. Recently, in response to the COVID-19 pandemic, New York increased state minimum staffing standards and added a new requirement that facilities spend at least 70 percent of their total revenue on direct care, which are other tools that states can use to address staffing issues in the absence of cost-based payment systems (Reiland 2022).

Interaction between Medicare and Medicaid Payment Policy

Because Medicare is the second-largest payer for nursing facility care, many of the payment standards used by Medicare are also used by Medicaid programs. In addition, because most Medicaid-covered nursing facility residents are dually eligible for Medicare and Medicaid, Medicare payment incentives can affect the care that Medicaid-covered residents receive. To understand these interactions in more detail, the Commission has been monitoring the effects of recent changes to Medicare's acuity adjustment system and the findings of recent evaluations of efforts to reduce avoidable hospital use for dually eligible residents.

Acuity adjustment changes

In October 2019, Medicare changed the method it uses to classify SNF patient acuity from Resource Utilization Group Version IV (RUG-IV) to the Patient-Driven Payment Model (PDPM). Under the RUG-IV model, nursing facilities were incentivized to provide additional therapy services because the measure of a resident's therapy care needs was predominately determined by the number of minutes of therapy the facility provided. PDPM corrects these incentives by setting a case-mix weight based on a resident's primary diagnosis. The case-mix weights for PDPM were developed over several years but used data only for Medicare-covered nursing facility residents, not Medicaid-covered residents (Acumen 2018).

As of July 2019, 34 states used RUG-based payment methodologies for Medicaid-covered residents, and so Medicare's change has prompted many states to reassess their acuity-adjustment methods (MACPAC 2019a). As of October 1, 2023, CMS will no longer collect information needed to determine RUG case-mix groups on the Minimum Data Set, which will make it more difficult for states to continue RUG-based methods. CMS has provided states the option of requiring facilities to report additional information through a state supplement to the Minimum Data Set until September 30, 2025, if needed to help ease the transition (CMS 2022c).

Because PDPM was not developed to measure their acuity or resource use, some components of PDPM are not a good measure of the care needs for long-stay residents. The PDPM includes five components for measuring the acuity of an SNF patient: nursing, physical therapy, occupational therapy, speech-language pathology, and non-therapy ancillary. Although the nursing component is similar to the previous RUG-IV model, the therapy components are different and substantially overstate the needs of long-stay residents (Abt Associates 2020). Because of the challenges adapting the PDPM therapy components to long-stay residents and the fact that most therapy services are not included in the Medicaid nursing facility benefit, CMS issued guidance in 2022 recommending that states exclude the therapy portions of the PDPM from their Medicaid payment methods (CMS 2022c).

Another limitation of PDPM is that the underlying data used to develop the nursing component were based on a 2007 study of nursing staff time, the latest that CMS has completed. Some stakeholders have noted the need for an updated time study that reflects current staffing patterns at high-quality facilities and also considers the unique needs of long-stay Medicaid-covered residents (Harrington et al. 2020b).

Incentives to reduce avoidable hospital use

About one-quarter of nursing facility residents are transferred to hospitals each year, and many of these hospitalizations could be avoided if residents received quick diagnoses and treatments in nursing facilities. Overall, avoidable hospital use for nursing facility

residents is estimated to cost Medicare and Medicaid more than $1.9 billion a year (RTI 2019).

Unfortunately, misaligned payment incentives between Medicare and Medicaid do not reward states or providers for addressing this issue. Because Medicare is the primary payer for hospital care, the savings from delivery system reforms typically accrue to Medicare rather than Medicaid. Moreover, nursing facilities do not have strong incentives to reduce hospital use for Medicaid-covered residents because Medicare pays for a new SNF stay at a higher rate than a Medicaid-covered stay when a resident is hospitalized and later returns to a nursing facility.

Policymakers have been exploring a number of different approaches to address these misaligned incentives, but the results have been mixed so far.

CMS demonstrations. In 2009, CMS launched the Nursing Home Value-Based Purchasing Demonstration, which provided incentive payments to nursing facilities if they reduced avoidable hospitalizations.[24] However, the final evaluation found that there were not major pre- and post-intervention performance differences for participating nursing facilities, and the resulting cost savings were limited (L&M Policy Research 2013).[25]

The CMS Center for Medicare and Medicaid Innovation (CMMI) has tested two models to reduce avoidable hospitalization among nursing facility residents by helping Medicaid-covered long-stay nursing facility residents access additional skilled care at a nursing facility instead of being transferred to the hospital. Although the CMS evaluation of these initiatives found that the care coordination services helped to reduce hospital use, the payment incentives did not meaningfully affect outcomes, and the overall model did not meet CMMI's cost-effectiveness test (RTI 2019).

Managed care plans. During our interviews in 2020, we spoke to representatives from a variety of Medicaid managed care plans with different degrees of integration with Medicare Advantage plans, but we heard little about efforts to better coordinate the Medicare and Medicaid nursing facility benefits. In 2022, 49 percent of all Medicare beneficiaries were enrolled in a Medicare Advantage plan, including 4.2 million beneficiaries in dual-eligible special needs plans (D-SNPs) and 98,000 in institutional special needs plans (I-SNPs), which are limited to long-stay nursing facility residents (MedPAC 2022c).

The D-SNPs that we spoke with that were aligned with the Medicaid managed care plans in their states primarily focused their efforts on helping beneficiaries with long-term care needs access services in the community rather than the nursing facility. However, the MLTSS models in these states (Rhode Island and New York) covered only short-term nursing facility stays, and so the views of these plans may not reflect the range of strategies being used by other aligned D-SNPs in states that cover more nursing facility residents through their MLTSS programs.

Two of the states that we studied (Alabama and Wisconsin) had a growing presence of I-SNPs that were exploring new models to avoid hospitalizations by providing additional care to residents in nursing facilities. In Alabama, the I-SNP we spoke with had some facilities that participated in the CMMI model to reduce avoidable hospitalizations by embedding nurse practitioners in the facility and was planning to continue some aspects of the initiative with all participating facilities in the I-SNP after the demonstration expired. In Wisconsin, providers identified a similar opportunity to improve care and believed that they could compete favorably with other Medicare special needs plans, so they reported that they were in the early stages of developing a provider-owned I-SNP.

Payment Principles

Overall, Medicaid can play an important role in helping to address many of today's challenges with assuring access to quality nursing facility care. For Medicaid to achieve its potential, it is important for policymakers to design payment policies that advance the statutory goals of efficiency, economy, quality, and access. In 2014, MACPAC developed an overarching provider payment framework for assessing whether payments are consistent with these goals, which has guided the Commission's development of the following principles for nursing facility payment policy (MACPAC 2014).

Payment rates should cover the costs of economic and efficient providers

Although costs are an imperfect measure of payment adequacy, the Boren amendment standard that payments be sufficient to cover the costs for efficient and economically operated facilities is a useful benchmark for assessing Medicaid nursing facility payment rates. As discussed earlier in this chapter, Medicare payment rates are not an appropriate benchmark for Medicaid because of the differences in the acuity of short- and long-stay residents and the different services covered by the Medicaid and Medicare nursing facility benefits. Although the Boren amendment led to a number of provider lawsuits and was difficult for CMS to enforce, the underlying payment principle is sound and is consistent with the current requirements of Section 1902(a)(30)(A).

In the Commission's view, it is also important to consider the costs of ensuring adequate staffing and compliance with other quality and safety standards. As illustrated in our analyses of Medicaid payments relative to costs, facilities with lower staffing levels have lower costs on average, but much of these differences are explained by the fact that these facilities spend less on direct care staff overall.

The Commission is also concerned about the potential for related-party transactions to increase costs above what would be expected for an economically operated facility. As a result, states should collect more data on related parties using consolidated cost reports for the larger nursing facility chain to better understand the effects of these transactions.

Finally, when states assess Medicaid payment rates, it is important to consider all types of Medicaid payments that nursing facilities receive, including supplemental payments, which were not available for our analyses. It is also important to consider how provider contributions to the non-federal share reduce the net payments that facilities receive even though these data were also not readily available.

Payment methods should incentivize better quality and reductions in health disparities

The persistent disparities that Medicaid-covered nursing facility residents face are not consistent with the statutory requirement that Medicaid beneficiaries have access to care "at least to the extent that such care and services are available to the general population in the geographic area" (§1902(a)(30)(A) of the Act). Although the nursing facility industry overall may continue to face quality challenges because of factors outside of Medicaid's control, Medicaid payment policy can help ensure that Medicaid-covered residents have access to the same quality of care available to other nursing facility residents.

Our work so far has highlighted a number of ways that states can change payment policies to incentivize higher staffing levels and other quality measures. It is also important for states to consider other state policy levers to promote quality and health equity, such as minimum staffing standards and policies to help Medicaid-covered residents access care in high-quality facilities. Current evaluations of these policies are limited, and so more research would help policymakers identify strategies that are most effective.

States should aim to get the maximum value for the amount they are spending

Efficiency is a measure of whether states are getting the most value (in terms of quality and access) for the amount that they are spending. To identify opportunities to improve efficiency, it is helpful to compare payment rates and quality outcomes across states. States with the highest payment rates and lowest quality outcomes likely have the greatest opportunity to improve efficiency by changing payment methods to get better outcomes for the same level of spending.

Our work on payment rates and staffing has illustrated potential opportunities for states to improve the efficiency of their programs by requiring or incentivizing facilities to spend more of their Medicaid revenue on direct care staff. Although our work has identified some promising practices, more detailed state-level analyses

are needed to identify the best policy approach for each state.

Similarly, for states with large supplemental payments, there may be opportunities to improve efficiency by tying more payments to meaningful quality outcomes or incorporating supplemental payments into base payment rates that have stronger quality incentives. Although it can be politically and budgetarily difficult for states to change supplemental payments because of how they are financed, most of the funding for these payments is provided by the federal government, and so it is important that the payments are consistent with statutory payment goals.

Finally, there are several opportunities to improve the efficiency of Medicare and Medicaid payment for dually eligible patients. The Commission agrees with MedPAC's assessment that it is inefficient to use high Medicare payment rates as a tool for offsetting low Medicaid payment rates and encourages policymakers to set appropriate payment rates for each program as a first step toward aligning payment incentives (MedPAC 2022b). In addition, it will be important for policymakers to grapple with the fact that savings from reducing avoidable hospital use accrue to Medicare rather than Medicaid. Although prior CMMI demonstrations to correct these incentives have had mixed results, it is important to continue testing new models. D-SNPs, I-SNPs, and Medicaid managed care plans can also play a role in testing new approaches to better coordinate care for long-stay nursing facility residents.

Commission Recommendations

The Commission makes two recommendations on actions that HHS and CMS can take to improve the data available to help policymakers evaluate whether Medicaid nursing facility payments are consistent with MACPAC's payment principles and the statutory goals of efficiency, economy, quality, and access.

Recommendation 2.1

To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to collect and report the following data in a standard format that enables analysis:

- facility-level data on all types of Medicaid payments to nursing facilities, including resident contributions to their cost of care;
- data on the sources of non-federal share of spending necessary to determine net Medicaid payment at the facility level; and
- comprehensive data on nursing facility finances and ownership necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and to examine the effects of real estate ownership models and related-party transactions.

Rationale

Transparency of Medicaid payments has been a long-standing goal of the Commission since complete data on Medicaid payments to providers are needed to inform assessment of payment policies. This recommendation is similar to MACPAC's prior recommendation calling for greater transparency of Medicaid hospital payments (MACPAC 2016). In 2020, Congress partially implemented this recommendation by requiring reporting of provider-level supplemental payment data, but CMS has not taken any action to date on the other components of the recommendation related to the transparency of managed care payments or data on provider contributions to the non-federal share.

Our review of available federal data on Medicaid nursing facility payments found several gaps in the data on base payments, supplemental payments, and provider contributions to the non-federal share that this recommendation would help address.

First, although base payment information is available for many states in the T-MSIS, the base payment data that are available do not always include information on resident contributions to their cost of care. Because of Medicaid post-eligibility treatment of income rules for long-term care, these contributions are often large and can substantially affect measures of Medicaid payment rates. In states with available data, these contributions accounted for approximately 10 percent of total

Medicaid base payments to nursing facilities in 2019 (MACPAC 2023a).

To improve the availability of data on allowed base payment amounts (which are inclusive of resident contributions to the cost of their care), CMS could provide states with more guidance on how to report them in T-MSIS, particularly for managed care encounters. CMS could also revisit how resident contributions to their cost of care are reported on UPL demonstrations (which include provider-level data on FFS base and supplemental payments). Based on our review of 2019 UPL demonstrations, most states reported allowed payment amounts, but six states reported only amounts paid by the state.

Second, we found that the provider-level supplemental payment data reported on state UPL demonstrations were incomplete and often did not match data that were reported on CMS-64 expenditure reports. Because supplemental payments are such a large share of Medicaid spending for nursing facilities in many states, a lack of complete provider-level data severely limits our ability to assess total Medicaid payment rates.

In response to MACPAC's prior supplemental payment recommendations, Congress required CMS to develop a new system for states to submit supplemental payment data in a standard format beginning October 1, 2021, but these data are not yet available for MACPAC's analysis. CMS is implementing this new reporting requirement through the same financial management system that is used for CMS-64 expenditure reports so that supplemental payment data are reported consistently in these different sources (CMS 2021).

Third, data on provider contributions to the non-federal share of nursing facility payments are important because they reduce the net payments that providers receive. CMS does not currently have a good process in place to collect provider-level data on sources of non-federal share, so implementing this part of the recommendation would likely require more administrative effort for CMS than the effort required to improve the completeness of the payment data that they already collect.

To help stakeholders evaluate Medicaid nursing facility payments, it is also important to collect comprehensive data on nursing facility finances necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents. Although Medicare cost reports do provide some information on nursing facility finances in a standard format, our review of available cost data found several gaps that could be addressed if CMS required greater transparency. Some states may already collect these data on state-specific Medicaid cost reports, but these data are not collected in a standard format that enables cross-state analysis.

First, at the facility level, we found that the estimated costs of care for Medicaid-covered residents was generally much lower than the costs of care for other nursing facility residents because of differences in resident acuity and differences in the types of costs that are paid for by Medicaid and other payers (MACPAC 2023a).[26] To help stakeholders better assess the costs of care for Medicaid-covered residents, CMS could improve the completeness and availability of the resident acuity information by payer that it currently collects through the Minimum Data Set.[27] In addition, CMS could work with states to further clarify state definitions of allowable costs and how they relate to Medicare cost reports or other standard reports of nursing facility costs. Requiring more standardization of cost information reported to CMS would not limit a state's flexibility to define allowable costs for their Medicaid program, but it would provide a useful baseline for comparing costs and payments across states.

Second, more transparency of related-party transactions would help shed light on practices that may inflate costs above what they would be if a facility were operated more economically and efficiently (Adelberg et al. 2022). States currently have the flexibility to develop state-specific cost reports that collect these data, and some states, such as California and Virginia, have already developed consolidated cost reports to track these expenditures that could be a potential model for other states.[28]

Third, more transparency of real estate ownership models is also important for understanding related-party transactions, especially arrangements in which the facility real estate is owned by one entity and then leased to another. Section 6101 of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) included new requirements for nursing facilities to report additional ownership information

in the Provider Enrollment, Chain, and Ownership System (PECOS), which was made publicly available by CMS in 2022 (ASPE 2022a). However, these data do not include information on the ultimate owners of some chains, and they do not separately identify specific types of arrangements that stakeholders have raised concerns about, such as real-estate investment trusts and private equity ownership (Braun et al. 2023, GAO 2023, Braun et al. 2021). In addition, these data do not identify public or private ownership, which is important for analyses of Medicaid supplemental payments to publicly owned nursing facilities. To address these limitations, CMS could expand its interpretation of disclosable parties and other information required to be reported in PECOS. On February 15, 2023, CMS proposed additional reporting requirements for nursing facilities owned by private equity entities and real-estate investment trusts, but this proposed rule has not yet been finalized (CMS 2023).

Finally, making the payment and cost data that are collected publicly available in a standard format will help improve transparency and enable further analyses by other researchers. To improve the usability of these data, it would be particularly helpful for CMS to identify facilities by their CMS certification numbers (CCNs), if available. CCNs are used to identify facilities on CMS's Care Compare website, which can be used to help compare Medicaid payments and costs to quality outcomes. CCNs are also used on Medicare cost reports, which have additional information on total nursing facility revenue and margins that may be helpful for understanding Medicaid payments and costs in the context of overall nursing facility finances. States currently have the option to provide the CCN on their state UPL demonstrations, but our review of these data found that this field was often missing.

Implications

Federal spending. This recommendation would result in increased administrative effort for the federal government, but these changes are not expected to result in increased federal spending. Federal administrative burden could be reduced if efforts to collect Medicaid nursing facility payment and cost data are coordinated with existing systems and federal reporting requirements.

States. Depending on how the recommendation is implemented, it could affect state administrative effort. Improving the transparency of base and supplemental payments can be implemented by improving existing reporting structures, but collecting and reporting data on sources of non-federal share would require new reporting by states.

Enrollees. This policy would not have a direct effect on enrollees. However, over time greater transparency of Medicaid payments and costs may lead to changes in state payment rates and methods that affect the extent to which Medicaid payments to nursing facilities are spent on direct care staff and other activities related to patient care.

Plans. Health plans may need to provide additional information about managed care payments to nursing facilities. However, health plans are already required to submit payment information to states and the federal government through T-MSIS, and it is unlikely that this recommendation would substantially increase administrative burden for health plans.

Providers. This policy would not directly affect Medicaid payments to providers. However, over time greater transparency may lead to changes in state payment rates and methods by allowing more stakeholders to participate in the rate development process. This recommendation could also increase administrative burden for providers to the extent to which data on provider finances and related-party transactions are not currently collected by states and the federal government.

Recommendation 2.2

To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS 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 CMS should make facility-level findings publicly available in a format that enables analysis.

Rationale

Information on how Medicaid payment rates compare with costs and quality outcomes is important for assessing whether payment policies are consistent with the statutory goals. State-level analyses are needed for an accurate assessment of these issues due to a lack of complete data at the federal level and state-specific differences in definitions of allowable costs.

Federal regulations currently require states to make annual findings that FFS nursing facility rates are reasonable and adequate to meet the costs of efficiently and economically operated providers (42 CFR 447.253). However, CMS has not enforced this requirement since the Boren amendment was repealed, and even when the Boren amendment was in place, CMS did not provide states with guidance about how to conduct these studies.

Although the Boren amendment has been repealed, it is still important for states to conduct rate studies to inform the public process for developing nursing facility rates, which is required in Section 1902(a)(13)(A) of the Act. In addition, Section 1902(a)(30)(A) of the Act still requires payments to be consistent with efficiency, economy, quality, and access.

To strengthen this requirement, CMS should update existing regulations to clarify what states should review and the process for making the results of these reviews publicly available. Although the existing regulation describes only assessments of payment rates, it is also important for states to consider payment rates in relation to quality outcomes and health disparities to assess whether states are maximizing efficiency. The measures used in Medicare.gov Care Compare can be a starting point for assessing nursing facility quality, but states should also consider whether to examine additional measures that are specific to the needs of Medicaid-covered residents.

When updating existing regulations, CMS can provide more clarity about what information states should include in their assessments of nursing facility rates. Although current regulations require only rate studies for FFS payments, it would be helpful for states to also include information on all Medicaid payments to nursing facilities, including managed care and supplemental payments. Because most states already provide managed care payment data in T-MSIS, including this additional data may not add much more administrative burden.

CMS can also provide more guidance in regulation or subregulatory guidance about how states should compare payments to the costs of efficiently and economically operated facilities. Such guidance could also include a model approach that states could follow. Because state definitions of allowable costs differ, it would be helpful for states to document how the methods that they use are the same or different from commonly accepted standards, such as those used on Medicare cost reports. Similarly, because Medicaid-covered residents often have different care needs than other nursing facility residents, it is important that states describe their methods for adjusting costs to account for differences in resident acuity.

Ultimately, an assessment of whether Medicaid payments are sufficient requires states to make policy judgments about which facilities are operating efficiently and economically. Although CMS should continue to allow states to make these policy judgments, CMS could provide specific standards that states can use as a starting point. In addition, it would help improve transparency if states made the criteria that they use to assess payment rates available to all interested stakeholders.

Implications

Federal spending. This recommendation could result in increased administrative effort for the federal government, but these changes are not expected to result in increased federal spending.

States. This recommendation is likely to increase administrative effort for states that are not currently conducting regular assessments of nursing facility rates. However, states should be able to use the information that they already collect from state cost reports and state payment systems to conduct these

analyses. Moreover, the administrative effort could be reduced if CMS provided increased technical assistance and analytic support to states.

Enrollees. This policy would not have a direct effect on enrollees. However, over time increased transparency about how payment rates relate to quality and access goals may result in changes in state nursing facility payment policies to better achieve these goals.

Plans. Depending on how this recommendation is implemented, health plans may need to provide additional information about managed care payments to nursing facilities. However, health plans are already required to submit payment information to states and the federal government through T-MSIS, and it is unlikely that this recommendation would substantially increase administrative burden for health plans.

Providers. This policy would not directly affect Medicaid payments to providers. However, over time greater transparency may lead to changes in state payment rates and methods by allowing more stakeholders to participate in the rate development process. Because most nursing facilities already submit cost report information to states, it is unlikely that this recommendation would substantially increase administrative burden for providers.

Endnotes

[1] Although the term "nursing home" is commonly used by stakeholders, we use the term "nursing facility" in this chapter because it is the term used to define these services in the Medicaid statute. Historically, the Medicaid statute used the terms "skilled nursing facility" to refer to short-term, post-acute care and "intermediate care facility" to refer to long-term services and supports provided by nursing facilities. The Nursing Home Reform Act of 1987, which was part of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), changed the statute to refer to both types of care as "nursing facility care" and to require common standards regardless of resident length of stay.

[2] The number of individuals served by nursing facilities throughout the year is greater than the number of individuals served at a point in time. For example, in 2020, about 1.2 million Medicare fee-for-service beneficiaries had at least one nursing facility stay during the year, while only 247,500 in Medicare beneficiaries were included in our analyses of individuals receiving care in nursing facilities as of September 30, 2019 (MedPAC 2022b, Abt Associates 2020).

[3] Other institutional LTSS providers include intermediate care facilities for individuals with intellectual disabilities and institutions for mental diseases, which are outside the scope of this chapter.

[4] As of 2017, approximately 7 percent of individuals age 50 and older had long-term care insurance (LIMRA 2017).

[5] The Patient Protection and Affordable Care Act (P.L. 111-148, as amended) provided states with the option to expand Medicaid coverage to non-elderly adults with incomes below 138 percent of the federal poverty level. However, most nursing facility residents (89 percent) are older than age 65 and thus do not qualify for this eligibility group (Abt Associates 2020).

[6] In 2015, the median annual private-pay charge for a semiprivate nursing facility room was $80,300 (Genworth Financial, Inc. 2015).

[7] For example, if a Medicaid-covered resident has a spouse residing in the community, the resident can protect a greater portion of their income from post-eligibility treatment of income rules.

[8] This analysis was limited to nursing facilities that are certified by Medicare and excluded nursing facilities that are only certified by Medicaid.

[9] Some states require that nursing facilities admit residents regardless of payer. However, in practice, Medicaid residents in these states often still have difficulty finding a nursing facility bed, as evidenced by secret shopper studies showing that nursing facilities respond more favorably to hypothetical private pay applicants (Kowalczyk and Arsenault 2020).

[10] States must conduct in-person surveys of facilities at least once a year, according to standards set by CMS. These surveys are unannounced and include assessments of a variety of issues that affect patient safety and quality of life, such as infection control, medication management, and protection from physical and mental abuse. Medicaid finances state survey activities at a 75 percent federal medical assistance percentage (FMAP) (§1903(a)(2)(D) of the Act).

[11] In 1968, the Social Security Amendments of 1967 (P.L. 90-248) also added the requirement that states "assure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

[12] *Wilder v. Virginia Hospital Association*, 88-2043, (SCT June 14, 1990).

[13] The Medicaid payment principles of efficiency, economy, and quality in Section 1902(a)(30)(A) of the Act were added by the Social Security Amendments of 1967, and the standard that payments assure access to care similar to what is available to the general population was added by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).

[14] *Armstrong v. Exceptional Child Center, Inc., et al.*, 14-15, (SCT July 7, 2014).

[15] Because Medicare's SNF payment covers therapy costs and Medicaid nursing facility payments typically do not, CMS requires states to adjust Medicare payment rates used in UPL calculation to exclude non-covered services (CMS 2022c).

[16] In 14 of the 23 states reporting supplemental payments on CMS-64 expenditure reports, the reported spending on UPL demonstrations was similar, while in 2 states spending reported did not match. In several states, supplemental payments were recorded on CMS-64 expenditure reports but not on UPL demonstrations (three states) or no UPL demonstration was submitted (four states). Nine states reported supplemental payments on UPL demonstrations that are not listed as supplemental payments on CMS-64 expenditure reports.

[17] Provider taxes for which 75 percent or more of taxpayers in a class receive 75 percent or more of their total tax costs back from Medicaid are generally limited to 6 percent of providers' net patient revenue. More information about provider taxes is available in MACPAC's issue brief *Health Care-Related Taxes in Medicaid* (MACPAC 2021b).

[18] The relationship between higher staffing levels and better quality care has been well documented. For example, a recent systematic review found that higher registered nurse (RN) staffing levels were associated with fewer pressure ulcers, decreased urinary tract infections, reduced emergency department use, fewer hospitalizations, and decreased mortality (Dellefield 2015). Although RN staffing has the strongest link to quality, higher levels of total direct care staffing (i.e., RNs, licensed practical nurses, and certified nurse aides) are also associated with improved outcomes (Harrington et al. 2020b).

[19] During the COVID-19 pandemic, CMS has allowed states to waive or reduce training requirements for CNAs. Other non-nursing staff, such as therapists, social workers, and activities staff, also provide direct care, but they are not included in measures of nurse staffing levels.

[20] In 2019, wages for staff accounted for 51 percent of costs for nursing care at nursing facilities (MACPAC 2023a).

[21] In our analysis, we estimated what costs would be if facilities were staffed at 3.6 HPRD, which was the threshold for a three-star staffing rating in 2019.

[22] We also identified four states with pending legislation to increase minimum staffing requirements.

[23] Specifically, this study reviewed California's increase of minimum standards from 3.0 to 3.2 HPRD in 2000 and Ohio's increase of minimum staffing standards from 1.6 to 2.75 HPRD in 2002 (Chen and Grabowski 2014).

[24] In the Nursing Home Value-Based Payment Demonstration, nursing home performance was assessed using measures from four domains: nurse staffing (30 percent of performance weight), quality outcomes (20 percent), survey deficiencies (20 percent), and potentially avoidable hospitalization rates (30 percent).

[25] During the three years of the Nursing Home Value-Based Payment Demonstration, savings were realized in Arizona (year one) and Wisconsin (years one and two); no savings were generated in Arizona (years two and three), New York (years one through three), and Wisconsin (year three) (L&M Policy Research 2013).

[26] For example, in 2019, the average acuity-adjusted costs per day for Medicaid-covered nursing facility residents were $239.35, compared with average costs of $293.36 per day for all nursing facility residents (MACPAC 2023a).

[27] The Minimum Data Set does not currently identify payer source explicitly, but it does include information on a resident's Medicare and Medicaid enrollee identification number that can be used to infer the payer source (Abt Associates 2020).

[28] Calif. Health and Safety Code § 128734.1 (2021) and Virginia Code tit. 12, § 30-70-450 (2000).

References

Abt Associates. 2022. Analyses for MACPAC of Medicare cost report data, Medicare.gov Care Compare, the Transformed Medicaid Statistical Information System (T-MSIS), and state upper payment limit demonstrations.

Abt Associates. 2020. *Comparison of nursing facility acuity adjustment methods*. Washington, DC: MACPAC. https://www.macpac.gov/publication/comparison-of-nursing-facility-acuity-adjustment-methods/.

Acumen, LLC (Acumen). 2018. *Skilled nursing facilities patient-driven payment model technical report*. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Technical_Report_508.pdf.

Adelberg, M., A. Dobosenski, and E. Prendergast. 2022. *Report on data transparency related to skilled nursing facilities*. Minneapolis, MN: Faegre Drinker. https://www.faegredrinker.com/en/services/experience/2022/1/report-on-data-transparency-related-to-skilled-nursing-facilities.

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2022a. *Ownership of skilled nursing facilities: An analysis of newly-released federal data*. Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/documents/fd593ae970848e30aa5496c00ba43d5c/aspe-data-brief-ownership-snfs.pdf.

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2022b. *Changes of ownership of hospital and skilled nursing facilities: An analysis of newly-released CMS data*. Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/documents/be6f3366294bd30a08a8ae90c84f3894/aspe-datapoint-change-ownership-pecos.pdf.

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2013. *Medicaid-Financed Institutional Services: Characteristics of nursing home and IF/IDD residents and their patterns of care*. Washington, DC: ASPE. https://aspe.hhs.gov/reports/medicaid-financed-institutional-services-characteristics-nursing-home-icfiid-residents-their-1.

Bishop, C.E. 2014. High-performance workplace practices in nursing homes: An economic perspective. *Gerontologist* 54, supplement 1: S46–S52. https://pubmed.ncbi.nlm.nih.gov/24443605/.

Bowblis, J.R., C. Brunt, H. Xu, et al. 2023. Understanding nursing home spending and staff levels in the context of recent nursing staff recommendations. *Health Affairs* 42, no. 2: 197–206. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00692.

Bowblis, J.R., and R. Applebaum. 2017. How does Medicaid reimbursement impact nursing home quality? The effects of small anticipatory changes. *Health Services Research* 52, no. 5: 1729–1748. https://pubmed.ncbi.nlm.nih.gov/27581748/.

Bowblis, J.R. 2011. Staffing ratios and quality: An analysis of minimum direct care staffing requirements for nursing homes. *Health Services Research* 46, no. 5: 2495–1516. https://pubmed.ncbi.nlm.nih.gov/21609329/.

Braun, R.T., D. Williams, D. Stevenson, et al. 2023. The role of real estate investment trusts in staffing US nursing homes. *Health Affairs* 42, no. 2: 207–216. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2022.00278.

Braun, R.T., H. Jung, L.P. Casalino, et al. 2021. Association of private equity investment in U.S. nursing homes with the quality and cost of care for long-stay residents. *JAMA Health Forum* 2, no. 11: 1–13. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2786442.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. Medicare and Medicaid programs: Disclosures of ownership and additional disclosable parties information for skilled nursing facilities and nursing facilities. Proposed rule. *Federal Register* 88, no. 31 (February 15): 9820–9830. https://www.federalregister.gov/public-inspection/2023-02993/medicare-and-medicaid-programs-disclosures-of-ownership-and-additional-disclosable-parties.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. CMS enhances nursing home rating system with staffing and turnover data. July 27, 2022, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/press-releases/cms-enhances-nursing-home-rating-system-staffing-and-turnover-data.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. COVID-19 nursing home data. Baltimore, MD: CMS. https://data.cms.gov/covid-19/covid-19-nursing-home-data.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Letter from Daniel Tsai to state Medicaid directors regarding "Guidance on nursing facility state plan payment and upper payment limit approaches in Medicaid relying on the Medicare patient-driven payment model." September 21, 2022. https://www.medicaid.gov/federal-policy-guidance/downloads/smd22005.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022d. Medicare program; Prospective payment system and consolidated billing for skilled nursing facilities; Updates to the quality reporting program and value-based purchasing program for federal fiscal year 2023; Request for information on revising the requirements for long-term care facilities to establish mandatory minimum staffing levels. Proposed rule. *Federal Register* 87, no. 73 (April 15): 22720–22809. https://www.federalregister.gov/documents/2022/04/15/2022-07906/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Letter to state Medicaid directors regarding new supplemental payment reporting and Medicaid disproportionate share hospital requirements under the Consolidated Appropriations Act, 2021. December 10, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/smd21006.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. CMS improving nursing home compare in April 2019. March 5, 2019, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/press-releases/cms-improving-nursing-home-compare-april-2019.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2001. Appropriateness of minimum nurse staffing ratios in nursing homes: Phase II final report. Baltimore, MD: CMS. http://www.phinational.org/wp-content/uploads/legacy/clearinghouse/PhaseIIVolumeIofIII.pdf.

Chen, M., and D. Grabowski. 2014. Intended and unintended consequences of minimum staffing standards for nursing homes. *American Journal of Health Economics* 24, 7: 822–839. https://pubmed.ncbi.nlm.nih.gov/24850410/.

CliftonLarsonAllen (CLA). 2023. Factsheet: *State of the nursing home sector*. Washington, DC: American Health Care Association/National Center for Assisted Living. https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/State-of-Nursing-Homes-Infographic.pdf.

CliftonLarsonAllen (CLA). 2022a. *State of skilled nursing facility (SNF) industry*. Washington, DC: American Health Care Association/National Center for Assisted Living. https://publish.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/2022%20State%20of%20the%20SNF%20Industry%20Report.pdf.

CliftonLarsonAllen (CLA). 2022b. *Staffing mandate analysis: In-depth analysis on minimum staffing levels*. Washington, DC: American Health Care Association/National Center for Assisted Living. https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/CLA-Staffing-Mandate-Analysis-Dec2022.pdf.

Coalition of Geriatric Nursing Organizations (CGNO). 2014. *Nursing staffing requirements to meet the demands of today's long term care consumer: Recommendations from the Coalition of Geriatric Nursing Organizations (CGNO)*. Silver Spring, MD: American Nursing Association. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-staffing-requirements-to-meet-the-demands-of-todays-long-term-care-consumer/.

Committee on Finance, U.S. Senate. 1972. Report of the Committee on Finance, United States Senate to accompany H.R. 1 to amend the Social Security Act, and for other purposes (together with additional views). Senate Report 92–1230. https://archive.org/details/socialsecurityam00unit_10/page/59/mode/1up?ref=ol&_autoReadAloud=show&view=theater&q=249.

Dellefield, M.E., N.G. Castle, K.S. McGilton, and K. Spilsbury. 2015. The relationship between registered nurses and nursing home quality: An integrative review (2008–2014). *Nursing Economics* 33, no. 2: 95–108. https://pubmed.ncbi.nlm.nih.gov/26281280/.

Dobson, C., A. Mosey, R. Plasencia, et al. 2021. *Demonstrating the value of Medicaid MLTSS programs*. Washington, DC: ADvancing States. http://www.advancingstates.org/sites/nasuad/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf.

Feng, Z., Y.S. Lee, S. Kuo, et al. 2010. Do Medicaid wage pass-through payments increase nursing home staffing? *Health Services Research* 45, no. 3: 728–747. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2875757/.

Flinn, B. 2020. *Nursing home closures and trends: June 2015–June 2019*. Washington, DC: Leading Age. https://leadingage.org/wp-content/uploads/drupal/Nursing%20Home%20Closures%20and%20Trends%202020.pdf.

Galewitz, P. 2017. Chasing millions in Medicaid dollars, hospitals buy up nursing homes. October 13, 2017. *Washington Post*. https://www.washingtonpost.com/business/economy/chasing-millions-in-medicaid-dollars-hospitals-buy-up-nursing-homes/2017/10/13/2be823ca-a943-11e7-92d1-58c702d2d975_story.html.

Genworth Financial, Inc. 2015. Cost of care survey: *Home care providers, adult day health care facilities, assisted living facilities and nursing homes*. Richmond, VA: Genworth Financial, Inc. https://secure.wpsic.com/sales-materials/files/supplemental-long-term-cost-of-care-report.pdf.

Gifford, K., E. Ellis, A. Lashbrook, et al. 2019. *A view from the states: Key Medicaid policy changes: Results from a 50-state Medicaid budget survey for state fiscal years 2019 and 2020*. San Francisco, CA: Kaiser Family Foundation. https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-provider-rates-and-taxes/.

Gupta, A., S.T. Howell, C. Yannelis, and A. Gupta. 2021. Does private equity investment in healthcare benefit patients? Evidence from nursing homes. *National Bureau of Economic Research*, working paper 28474. https://www.nber.org/system/files/working_papers/w28474/w28474.pdf.

Hackman, M.B. 2019. Incentivizing better quality of care: The role of Medicaid and competition in the nursing home industry. *American Economic Review* 109, no. 5: 1684–1716. https://www.aeaweb.org/articles?id=10.1257/aer.20151057.

Harrington, C., L. Ross, S. Chapman, et al. 2020a. Nurse staffing and coronavirus infections in California nursing homes. *Policy, Politics, & Nursing Practice* 21, no. 3: 174–186. https://journals.sagepub.com/doi/full/10.1177/1527154420938707.

Harrington, C., M.E. Dellefield, E. Halifax, et al. 2020b. Appropriate nurse staffing levels for U.S. nursing homes. *Health Services Insights* 13: 1–14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/.

Harrington, C., J.H. Swan, and H. Carrillo. 2007. Nurse staffing levels and Medicaid reimbursement rates in nursing facilities. *Health Services Research* 42, no. 3: 1105–1129. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955251/.

Illinois Department of Healthcare and Family Services (IL HFS). 2021. *A comprehensive review of nursing home payment with recommendations for reform*. Springfield, IL: IL HFS. https://www2.illinois.gov/hfs/NursingHomeUpdate/Pages/default.aspx.

Kaiser Family Foundation (KFF). 2020. E-mail to MACPAC staff, April 17, 2020.

Kowalczyk, L. and M. Arsenault. 2020. Potential Medicaid discrimination at Massachusetts nursing homes. *Boston Globe*, September 28. https://www.bostonglobe.com/2020/09/28/metro/spotlight-team-probe-potential-medicaid-discrimination-massachusetts-nursing-homes/.

Lewis, E., S. Eiken, A. Amos, and P. Saucier. 2018. *The growth of managed long-term services and supports programs: 2017 update*. Baltimore, MD: Centers for Medicare & Medicaid Services. https://www.medicaid.gov/media/3406.

Li, Y., H. Temkin-Greener, S. Gao, and X. Cai. 2020. COVID-19 infections and deaths among Connecticut nursing home residents: Facility correlates. *American Journal of Geriatric Psychiatry* 68, no. 9: 1899–1906. https://pubmed.ncbi.nlm.nih.gov/32557542/.

Life Insurance Marketing and Research Association (LIMRA). 2017. Combination products giving life back to long-term care market. November 9, 2017, press release. Windsor, CT: LIMRA. https://www.limra.com/en/newsroom/industry-trends/2017/combination-products-giving-life-back-to-long-term-care-market/.

L&M Policy Research. 2013. *Evaluation of the nursing home value-based purchasing demonstration*. Contract no. HHSM-500-2006-00009I/TO#7. Washington, DC: Centers for Medicare & Medicaid Services. https://innovation.cms.gov/files/reports/nursinghomevbp_evalreport.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023a. *Estimates of Medicaid nursing facility payments relative to costs*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2023/01/Estimates-of-Medicaid-Nursing-Facility-Payments-Relative-to-Costs-1-6-23.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023b. *Analysis of state upper payment limit demonstrations*.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023c. *Analysis of Medicare.gov Care Compare*.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. *Compendium: State policies related to nursing facility staffing*. Washington, DC: MACPAC. https://www.macpac.gov/publication/state-policies-related-to-nursing-facility-staffing/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022b. *State policy levers to address nursing facility staffing issues*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/03/State-Policy-Levers-to-Address-Nursing-Facility-Staffing-Issues.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. *COVID relief funding for Medicaid providers*. Washington, DC: MACPAC. https://www.macpac.gov/publication/covid-relief-funding-for-medicaid-providers/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *Health care-related taxes in Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/publication/health-care-related-taxes-in-medicaid/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. *Themes from interviews on the development of nursing facility payment methods*. Washington, DC: MACPAC. https://www.macpac.gov/publication/themes-from-interviews-on-the-development-of-nursing-facility-payment-methods/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Exhibit 25: Medicaid supplemental payments to non-hospital providers by state, FY 2019 (millions). In *MACStats: Medicaid and CHIP Databook*. December 2020. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2020.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. *States' Medicaid fee-for-service nursing facility payment policies*. Washington, DC: MACPAC. https://www.macpac.gov/publication/nursing-facility-payment-policies/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. *Twenty years later: Implications of Olmstead v. L.C. on Medicaid's role in providing long-term services and supports*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2019/07/Twenty-Years-Later-Implications-of-Olmstead-on-Medicaids-Role-in-LTSS.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. *Report to Congress on Medicaid Disproportionate Share Hospital Payments*. Washington, DC: MACPAC. https://www.macpac.gov/publication/report-to-congress-on-medicaid-disproportionate-share-hospital-payments/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014. *Framework for evaluating Medicaid provider payment policy*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2014/10/Framework-for-Evaluating-Medicaid-Provider-Payment-Policy-October-2014.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013. Chapter 4: Medicaid coverage of premiums and cost sharing for low-income Medicare beneficiaries. In *Report to the Congress on Medicaid and CHIP*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2013/03/Medicaid-Coverage-of-Premiums-and-Cost-Sharing-for-Low-Income-Medicare-Beneficiaries.pdf.

Medicare Payment Advisory Commission (MedPAC). 2022a. Chart 8-3: Use of skilled nursing facilities and home health agencies after an inpatient hospital stay shifted in 2020. In *Data Book: Health Care Spending and the Medicare Program*. June 2022. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec8_SEC.pdf.

Medicare Payment Advisory Commission (MedPAC). 2022b. Chapter 7: Skilled nursing facility services: Assessing payment adequacy and updating payments. In *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch7_SEC.pdf.

Medicare Payment Advisory Commission (MedPAC). 2022c. Section 9: Medicare Advantage. In *Data Book: Health Care Spending and the Medicare Program*. June 2022. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec9_SEC.pdf.

Medicare Payment Advisory Commission (MedPAC). 2021. E-mail to MACPAC, August 21.

Murray, C., A. Tourtellotte, D. Lipson, and A. Wysocki. 2021. *Medicaid long term services and supports annual expenditures report: Federal fiscal year 2019*. Report to CMS, contract no. HHSM-500-2014-00034I/75FCMC19F0007. Chicago, IL: Mathematica. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.

Musumeci, M., P. Chidambaram, and M. Watts. 2019. *Medicaid financial eligibility for seniors and people with disabilities: Findings from a 50-state survey*. Washington, DC: Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-issue-brief.

National Academies of Sciences, Engineering, and Medicine (National Academies). 2022. *The national imperative to improve nursing home quality*. Washington, DC: National Academies Press. https://nap.nationalacademies.org/catalog/26526/the-national-imperative-to-improve-nursing-home-quality-honoring-our.

Nolen, L.T., A.L. Beckman, and E. Sandoe. 2020. How foundational moments in Medicaid's history reinforced rather than eliminated racial health disparities. *Health Affairs Blog*, September 1. https://www.healthaffairs.org/do/10.1377/hblog20200828.661111/full/.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services. 2022. *National health expenditures by type of service and source of funds: CY 1960–2020*. Baltimore, MD: OACT. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

Paul, D.P., T. Godby, S. Saldanha, et al. 2016. *Quality of care and profitability in not-for-profit versus for-profit nursing homes*. Proceedings of the Business and Health Administration Association annual conference, May 3, 2016, Chicago, IL. https://mds.marshall.edu/mgmt_faculty/155/.

Reiland, J. 2022. Nursing home staffing minimum law takes effect in New York. *Skilled Nursing News*. April 3. https://skillednursingnews.com/2022/04/nursing-home-staffing-minimum-law-takes-effect-in-new-york/.

RTI International (RTI). 2019. *Evaluation of the initiative to reduce avoidable hospitalizations among nursing facility residents—payment reform*. Baltimore, MD: Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/Evaluation-.

Schnelle, J.F., L.D. Schroyer, A.A. Saraf, and S.F. Simmons. 2016. Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. *JAMDA* 17, no. 11: 970–977. https://www.promodel.com/media/pdf/Determine%20Nurse%20Aide%20Staffing%20Rqt%20with%20MedModel.pdf.

Sharma, H., R. Bin Abdul Baten, F. Ullrich, et al. 2021. *Trends in nursing home closures in nonmetropolitan and metropolitan counties in the United States*, 2008–2018. Issue brief no. 2021-1. Iowa City, IA: RUPRI. https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf.

Sharma, H., M.C. Perraillon, R.M. Werner, et al. 2020. Medicaid and nursing home choice: Why do duals end up in low-quality facilities? *Journal of Applied Gerontology* 76, no. 6: 758–783. https://pubmed.ncbi.nlm.nih.gov/30957619/.

U.S. Government Accountability Office (GAO). 2023. Nursing homes: *CMS should make ownership information more transparent for consumers*. Report no. GAO-23-104813. Washington, DC: GAO. https://www.gao.gov/products/gao-23-104813.

U.S. Government Accountability Office (GAO). 2022. *COVID-19 in nursing homes: Outbreak duration averaged 4 weeks and was strongly associated with community spread*. Report no. GAO-23-104291. Washington, DC: GAO. https://www.gao.gov/products/gao-23-104291.

Waters, R. 2021. The big idea behind a new model of small nursing homes. *Health Affairs* 40, no. 3: 378–383. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00081.

Weech-Maldonado, R., J. Lord, G. Davlyatov, et al. 2021. High-minority nursing homes disproportionately affected by COVID-19 deaths. *Frontiers in Public Health* 22, no. 9: 1–8. https://www.frontiersin.org/articles/10.3389/fpubh.2021.606364/full.

Wenzlow, A.T., R. Schmitz, and J. Gurvey. 2008. *Medicaid-financed nursing home services: Characteristics of people served and their patterns of care*, 2001–2002. Report to ASPE, contract no. HHS-100-97-0013. Washington, DC: ASPE. https://aspe.hhs.gov/reports/medicaid-financed-nursing-home-services-characteristics-people-served-their-patterns-care-2001-2002.

Werner, R.M., and N.B. Coe. 2021. Nursing home staffing levels did not change significantly during COVID-19. *Health Affairs* 40, no. 5: 795–801. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02351.

Werner, R.M., R.T. Konetzka, and D. Polsky. 2013. The effect of P4P in nursing homes: Evidence from state Medicaid programs. *Health Services Research* 48, no. 4: 1393–1414. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3657568/pdf/hesr0048-1393.pdf.

Wiener, J.M., and D.G. Stevenson. 1998. *Repeal of the "Boren amendment": Implications for quality of care in nursing homes*. Series A, No. A-30. Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/70621/308020-Repeal-of-the-Boren-Amendment.PDF.

Zuckerman, R.B., S. Wu, L.M. Chen, et al. 2018. The five-star skilled nursing facility rating system and care of disadvantaged populations. *Journal of American Geriatric Society* 67, no. 1: 108–114. https://deepblue.lib.umich.edu/handle/2027.42/146941.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on January 27, 2023.

Nursing Facility Provider Payment Principles

2.1 To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to collect and report the following data in a standard format that enables analysis:

- facility-level data on all types of Medicaid payments to nursing facilities, including resident contributions to their cost of care;
- data on the sources of non-federal share of spending necessary to determine net Medicaid payment at the facility level; and
- comprehensive data on nursing facility finances and ownership necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and to examine the effects of real estate ownership models and related-party transactions.

2.2 To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS 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 CMS should make facility-level findings publicly available in a format that enables analysis.

2.1-2.2 voting results	#	Commissioner
Yes	16	Allen, Bella, Bjork, Brooks, Carter, Cerise, Davis, Duncan, Gerstorff, Giardino, Gordon, Heaphy, Johnson, Medows, Scanlon, Weno
Not present	1	Herrera Scott

Chapter 3:

Strengthening Evidence under Medicaid Drug Coverage

Strengthening Evidence under Medicaid Drug Coverage

Recommendations

3.1 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 coverage with evidence development requirements implemented under a Medicare national coverage determination.

3.2 Congress should amend Section 1903(m)(2)(A)(xiii) to require the managed care contract conform to the state's policy with respect to any exclusion or restriction of coverage of a covered outpatient drug based on coverage with evidence development requirements implemented under a Medicare national coverage determination.

Key Points

- Under Medicare Part A and Part B, the Centers for Medicare & Medicaid Services can link coverage of an item or service to participation in an approved clinical study or the collection of additional clinical data. This policy is referred to as coverage with evidence development (CED).
- Under the Medicaid Drug Rebate Program, state Medicaid programs generally must cover all of a participating manufacturer's drugs when prescribed for a medically accepted indication. Unlike Medicare Part A and Part B, Medicaid is not allowed to link drug coverage to the collection of additional evidence through a clinical trial or comparative study.
- States have expressed concerns about paying for prescription drugs that have yet to verify a clinical benefit. Allowing states to follow Medicare's CED requirement to link coverage of a particular drug to participation in a clinical trial or a comparative study would help ensure that evidence of the clinical benefit can be developed in a timely manner.
- Extending a Medicare CED policy to Medicaid would help provide additional evidence on the clinical benefits of a drug for populations prevalent in Medicaid and whether there are occurrences of adverse events that need to be monitored and managed.
- Requiring managed care organizations follow the state's decision on whether to implement a CED requirement would apply a consistent coverage policy across all beneficiaries, whether they receive services through fee for service or managed care.
- These recommendations would not automatically apply current or future Medicare CED requirements to the Medicaid program. States would have the option to follow Medicare requirements, but nothing in these recommendations would prohibit a state from providing broader coverage than allowed under Medicare.

CHAPTER 3: Strengthening Evidence under Medicaid Drug Coverage

Introduction

In fiscal year 2021, Medicaid spent approximately $80.6 billion on outpatient prescription drugs and collected $42.5 billion in rebates, bringing net drug spending to $38.1 billion. This net spending on outpatient prescription drugs accounted for about 5.3 percent of Medicaid benefit spending (MACPAC 2022a). The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary projects Medicaid drug spending to increase between 5 and 6 percent annually over the next several years (OACT 2022).

While Medicaid drug spending is growing overall, it is increasingly being driven by high-cost specialty drugs. From 2010 to 2015, net spending on specialty drugs in Medicaid almost doubled, growing from $4.8 billion (25 percent of total net drug spending) to $9.9 billion (35 percent of total net drug spending) (CBO 2019). According to Magellan Rx Management, a leading Medicaid pharmacy benefit administrator, the net cost per claim for traditional drugs in fee-for-service Medicaid increased 5.8 percent from 2020 to 2021, while the net cost per claim for specialty drugs increased 13.0 percent over the same period (Magellan 2022). In 2021, high-cost specialty drugs accounted for less than 2 percent of drug utilization but more than half of Medicaid pharmacy spending (MACPAC 2022a, Magellan 2022).

States have expressed concern about paying high prices for drugs approved through the accelerated approval pathway (CMS 2022a, 2019a, 2017). These drugs have been approved by the U.S. Food and Drug Administration (FDA) on the basis of surrogate endpoints that are reasonably likely to predict a clinical benefit but are not a verified measure of a clinical benefit.[1] The FDA typically requires that manufacturers conduct confirmatory trials to verify the clinical benefit of a drug receiving accelerated approval, but these trials are often delayed beyond the scheduled completion date, and some trials can take more than 10 years to complete (Chen 2018, Naci et al. 2017).[2] The U.S. Department of Health and Human Services Office of the Inspector General estimated that Medicaid spent $3.6 billion between 2018 and 2021 on drugs approved through the accelerated pathway that had at least one confirmatory trial past its original planned completion date (OIG 2022). In its June 2021 report to Congress, the Commission raised these concerns about accelerated approval drugs and made recommendations to increase the Medicaid statutory rebates on these products until the manufacturer has demonstrated the clinical benefit and received traditional approval from the FDA. To date, Congress has not acted on these recommendations.

The approval of Aduhelm (aducanumab) for the treatment of Alzheimer's disease in June 2021 drew attention to the concerns over paying for a drug that has yet to verify a clinical benefit. The FDA's decision to grant accelerated approval of Aduhelm was considered controversial by many in the scientific, medical, and health policy communities after the almost unanimous recommendation against traditional approval from the FDA advisory committee based on its determination that there was insufficient evidence of a clinical benefit (Belluck 2021). Many stakeholders expressed concern with the price and potential cost to the health care system, particularly in light of the uncertain clinical benefit (Joseph and Cohrs 2021). Due to these concerns, CMS initiated a Medicare national coverage determination (NCD) to establish coverage parameters for monoclonal antibodies targeted against amyloid (antiamyloid monoclonal antibodies) for the treatment of Alzheimer's disease (e.g., Aduhelm) and in April 2022 decided to allow Medicare Part B coverage only under a coverage with evidence development (CED) policy that requires that the beneficiary participates in a clinical trial or other approved comparative study (CMS 2022b). Unlike Medicare Part A and Part B, state Medicaid programs are generally required by the Medicaid Drug Rebate Program (MDRP) to cover all of a participating manufacturer's drugs when prescribed for a medically accepted indication and are not allowed to link drug coverage to participation in a clinical trial or comparative study. Medicaid does not have to cover a drug for full-benefit dually eligible beneficiaries if it is excluded or limited by Medicare Part A or Part B, such as under an NCD (CMS 2022b).

This chapter presents the Commission's recommendations on allowing states to exclude or otherwise restrict coverage of a drug for Medicaid-only beneficiaries based on CED requirements included in a Medicare NCD. Specifically, the Commission recommends the following:

- 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 coverage with evidence development requirements implemented under a Medicare national coverage determination.
- Congress should amend Section 1903(m)(2)(A)(xiii) to require the managed care contract conform to the state's policy with respect to any exclusion or restriction of coverage of a covered outpatient drug based on coverage with evidence development requirements implemented under a Medicare national coverage determination.

The recommendations would provide statutory authority for states, at their option, to link coverage of a particular drug to participation in a clinical trial or comparative study following CED requirements that have been implemented under a Medicare NCD. Allowing states to link coverage of a particular drug to the collection of additional clinical data would help ensure that evidence of the clinical benefit can be developed in a timely manner and provide additional information on the benefits and risks of treatment in the Medicaid population. The recommendations would also require Medicaid managed care organizations (MCOs) to follow the state's decision on whether to implement any CED requirements to ensure that coverage is consistent across all beneficiaries, whether they receive services through fee for service or managed care.

This chapter begins with an overview of drug coverage under Medicaid and Medicare. It provides background on the different coverage requirements under the MDRP and Medicare Part A and Part B. The chapter then presents the rationale for the Commission's recommendations for Congress to allow states to implement coverage criteria that follow CED requirements implemented under a Medicare NCD. The chapter concludes by outlining the Commission's future work on prescription drugs.

Medicaid Drug Coverage

The MDRP was created under the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) with the purpose of ensuring that Medicaid pays a net price that is consistent with the lowest or best price that manufacturers charge other payers for the drug. Under the program, a drug manufacturer must enter into a Medicaid national drug rebate agreement with the Secretary of the U.S. Department of Health and Human Services (the Secretary) for states to receive federal funding for using the manufacturer's products (§ 1927(a)(1) of the Social Security Act (the Act)).[3] In exchange for the rebates, state Medicaid programs generally must cover all of a participating manufacturer's drugs when prescribed for a medically accepted indication, although the states may limit the use of some drugs through preferred drug lists (PDLs), prior authorization, and quantity limits.[4]

Under the MDRP, a drug meets the definition of a covered outpatient drug if its manufacturer has in place a rebate agreement with the Secretary and the drug has been approved by the FDA (§ 1927(k) of the Act). Although a state can use prior authorization, clinical criteria, or other utilization management tools to manage the use of a particular drug, the effect of these limitations "should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments" (CMS 2015, p. 3).

States must follow a prescribed process to publish and implement formal coverage criteria. The statute requires that the PDL and other coverage criteria (e.g., prior authorization) must be developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the governor of the state (§ 1927(d)(4)(A) of the Act). To fulfill this requirement, states typically use a pharmacy and therapeutics (P&T) committee to develop their PDLs and make recommendations on appropriate utilization protocols, such as prior authorization, for each drug.[5] The process of P&T committee deliberations varies from state to state. P&T committee meetings are typically open to the public for comment and testimony, and states may require public notice and the publication of the meeting agenda a few weeks in advance of the meeting.

The statutory requirement for Medicaid to cover essentially all FDA-approved drugs makes the program unique among payers by limiting states' ability to manage utilization and spending and to negotiate rebates with manufacturers compared with other payers. In general, plans sold on health insurance exchanges and Medicare Part D plans have minimum requirements for drug coverage, but they are allowed to exclude coverage for some drugs.[6] Likewise, self-insured plans, large group plans, and grandfathered health plans not subject to essential health benefit requirements can exclude coverage for some drugs.

Additionally, the coverage requirement under the MDRP means that a state is generally required to cover all of a participating manufacturer's products as soon as they have been approved by the FDA and enter the market.[7] In contrast, exchange and Medicare Part D plans are allowed a period of time after a new drug's release onto the market to evaluate it and make coverage decisions. Exchange plans are required to make a reasonable effort to review new drugs within 90 days of approval and make coverage determinations within 180 days (HHS 2015). Medicare Part D plans are similarly required to make a reasonable effort to review new drugs within 90 days and make coverage decisions within 180 days of a drug's release onto the market (CMS 2016a).[8]

This statutory requirement to cover new drugs upon market entry creates both operational and fiscal challenges for states.[9] A state must quickly determine under what circumstances coverage is supported by the FDA label. For novel drugs or first-in-class therapies, state officials and providers may not know in advance what uses will be supported by its label or if professional societies will release additional clinical guidelines regarding appropriate dosing, potential drug interactions, or clinical monitoring. Furthermore, new high-cost drugs (e.g., hepatitis C treatments) can be released at any time, but if they were unanticipated at the start of the fiscal year, they can exert fiscal pressures on annual state budgets. Last, states with managed care programs may need to make midyear contract (e.g., carve-out) or capitation rate changes (e.g., kick payment, rate adjustment) to ensure that plans are paid appropriately to cover the cost of the new drug.

Statutory rebates

Medicaid drug rebates are calculated based on average manufacturer price (AMP). AMP is defined as the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to retail community pharmacies and by retail community pharmacies that purchase drugs directly from the manufacturer (§ 1927(k)(1) of the Act).[10]

The rebate formula for single-source and innovator multiple-source drugs (i.e., brand-name drugs) differs from the formula for non-innovator multiple-source drugs (i.e., generic drugs).[11] For purposes of simplicity, this chapter refers to single-source and innovator multiple-source drugs as brand drugs and refers to non-innovator multiple-source drugs as generic drugs or generics.

The rebate amount for covered outpatient drugs has two components: a basic rebate amount and an additional inflationary component. For most brand drugs, the basic rebate amount is equal to either 23.1 percent of AMP or AMP minus best price, whichever is greater.[12] Best price is statutorily defined as the lowest price available to any wholesaler, retailer, provider, or paying entity, excluding certain governmental payers (§ 1927(c)(1)(C) of the Act).[13] For generic drugs, the basic rebate amount is calculated as 13 percent of AMP with no best price provision.

An additional rebate based on an inflationary component is added to both brand and generic drugs if the increase in a drug's AMP exceeds the increase in the Consumer Price Index for All Urban Consumers (CPI-U) over time. The inflationary component is equal to the amount that the drug's current quarter AMP exceeds its baseline AMP trended to the current period by the CPI-U.[14] This inflationary rebate is designed to limit the increase in the net price of any drug to the rate of inflation.

Until January 1, 2024, the total rebate amount (the sum of the basic and inflationary components) cannot exceed 100 percent of AMP (§ 1927(c)(2)(D) of the Act). This rebate cap can limit the inflationary rebate if the price increases substantially over time and restricts the dollar amount of rebates that Medicaid can receive. The American Rescue Plan Act of 2021 (ARP, P.L. 117-2) removes this cap on Medicaid rebates beginning January 1, 2024 (§ 9816 of ARP).[15]

Supplemental rebates

A state can negotiate with each participating manufacturer to obtain supplemental rebates for one or more of that manufacturer's drugs, which manufacturers provide to ensure that their products are placed on the state's PDL. As of September 2022, almost all states (46 states and the District of Columbia) were receiving supplemental rebates in addition to mandated federal rebates (CMS 2022c).[16] Preferred drugs typically face fewer utilization management requirements (e.g., prior authorization) than therapeutically equivalent drugs that are not on the list, and this results in a shift in market share to the preferred drugs. Some states pursue supplemental rebate agreements on their own, while others have joined multistate coalitions for negotiation purposes (CMS 2022c).

Both the statutory rebates and supplemental rebates are treated as an offset to drug expenditures and are shared by the federal government and state based on each state's current federal medical assistance percentage (FMAP).

Physician-administered drugs

A physician-administered drug is an outpatient drug (other than a vaccine) that is typically administered by a health care provider in a physician's office or other clinical setting. For example, drugs that are infused or injected are typically physician-administered drugs. The provider bills the state Medicaid program for the drug using the appropriate national drug code (NDC) and billing code, such as a Healthcare Common Procedure Coding System code. States may maintain a list of (1) which drugs are considered physician-administered drugs and must be provided in a clinical setting and (2) which drugs are considered outpatient drugs and must be dispensed by a pharmacy.

Physician-administered drugs may also be eligible for the statutory rebate as long as the drug meets the definition of a covered outpatient drug. The statute contains language that limits the definition of covered outpatient drugs to exclude drugs that are billed as part of a bundled service within certain settings (e.g., drugs provided as part of a clinic visit or hospital stay) and are paid for as part of those services (§ 1927(k)(3) of the Act). This means that if a drug is provided as part of services received in one of the settings listed in the statute and is paid as part of those services (i.e., there is not direct payment for the drug), it is not subject to the MDRP rebate. However, if a state authorizes and makes a direct payment for the drug separately from the service in one of those settings, it can claim a rebate for that drug. This means that whether a physician-administered drug is considered an outpatient drug subject to a rebate can vary from state to state, depending on how a state pays for the drug (CMS 2016b).

For states to receive federal matching funds for physician-administered drugs, they are required to collect NDCs to claim rebates (§ 1927(a)(7) of the Act). NDCs identify the drug and manufacturer, which are needed to ensure that the correct manufacturer is billed for a rebate in the event that multiple manufacturers produce the same drug (as is the case for generic drugs). The statute requires states to collect NDCs for all brand drugs and for the 20 generic drugs that have the highest annual dollar value. In practice, however, states typically collect NDC information for all brand and generic physician-administered drugs.

Medicare Drug Coverage

Under Medicare, prescription drugs can be covered under either Part A, Part B, or Part D. Covered Part D drugs are defined as those that may be dispensed only upon a prescription, are defined as a covered outpatient drug under the MDRP, and are otherwise not already covered under Part A or Part B (§ 1860D-2(e) of the Act).[17] This means that the vast majority of prescription drugs—those typically obtained from a pharmacy—are covered under the Part D benefit. Drugs that are not covered under Part D can be covered under Part A or Part B depending on whether it is provided in an inpatient (Part A) or outpatient (Part B) setting.

Medicare Part A and Part B

Medicare Part B covers drugs that are not usually self-administered by the patient and are furnished as part of a physician's services in an outpatient setting (§ 1861(s)(2) of the Act). Drugs administered by infusion or injection in physician offices and hospital outpatient departments are the largest category of Part B drugs (MedPAC 2022a).[18]

Most Part B drugs are paid based on average sales price (ASP). ASP reflects the average price based on manufacturers' sales to most purchasers, net of manufacturer rebates, discounts, and price concessions, with exceptions such as those sales excluded from Medicaid best price (§ 1847A(c) of the Act). Medicare pays ASP plus 6 percent for most Part B drugs (§ 1847A(b) of the Act).[19] Medicare also makes a separate payment to the physician or hospital for administering the drug. The drug administration payment rates are determined under the physician fee schedule or outpatient prospective payment system, depending on the location of the service. For Part B drugs, beneficiaries generally face 20 percent cost sharing, except for preventive vaccines, which have no cost sharing (MedPAC 2022a).

Some drugs could also be covered under Part A if provided as part of an inpatient stay in a hospital or skilled nursing facility. Under Part A, the cost of the drug generally would be included in the payment made under the prospective payment system for inpatient hospitals or skilled nursing facilities.

Medicare Part A and Part B drugs are generally the same as those considered physician-administered drugs in the Medicaid program.

National coverage determination

Medicare Part A and Part B must cover services (unless specifically excluded in statute) included in a Medicare benefit category that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (§ 1862(a)(1)(A) of the Act). This means that Medicare generally covers Part A and Part B drugs approved by the FDA for on-label indications or uses supported in CMS-approved compendia that are considered to be reasonable and necessary for the beneficiary (CMS 2021a, 2019b).[20]

CMS or Medicare administrative contractors can make explicit coverage determinations to evaluate the relevance, usefulness, and medical benefits of an item or service to Medicare beneficiaries (§ 1869(f)(1)(B), (2)(B) of the Act). This process involves a formal review of the medical and scientific evidence and includes a process for public comments. Medicare administrative contractors are responsible for making local coverage determinations, which determine coverage of items and services that apply only in the contractor's regional jurisdiction. The majority of explicit coverage policies are local coverage determinations (MedPAC 2022b). CMS can develop coverage determinations for items and services that apply nationwide through the NCD process. CMS can initiate an NCD internally, or one can be initiated at a stakeholder's request (CMS 2013). To date, fewer than 20 NCDs have been issued for drugs, and these coverage policies have largely aligned coverage with the FDA-approved label indications. In some cases, an NCD has clarified what off-label indications and types of providers Medicare will cover (MACPAC 2022b, MedPAC 2022b).

Coverage with evidence development

Under certain circumstances, CMS can link coverage of an item or service under an NCD to participation in an approved clinical study or the collection of additional clinical data (§ 1862(a)(1)(E) of the Act) (CMS 2022b). This policy is referred to as CED. CED is used when there are outstanding questions about the service's health benefit in the Medicare population, and it allows CMS to gather additional data that would further clarify the effect of these items and services on the health of Medicare beneficiaries. CMS currently applies CED to 21 items and services, but few apply to drug therapies. To date, CED has been used only three times on prescription drugs (MedPAC 2022b).[21]

The most recent example of a Medicare CED for prescription drugs was for the class of antiamyloid monoclonal antibodies for the treatment of Alzheimer's disease after the approval of Aduhelm. CMS limited coverage to participation in a clinical trial or other approved comparative study, depending on the pathway under which the FDA approved the drug (Box 3-1).

BOX 3-1. Accelerated Approval of Aduhelm

On June 7, 2021, the U.S. Food and Drug Administration (FDA) granted accelerated approval to Aduhelm (aducanumab) for the treatment of Alzheimer's disease (FDA 2021a). This approval was granted even though the FDA's Peripheral and Central Nervous System Drugs Advisory Committee recommended against traditional approval (FDA 2021b). The advisory committee decision, made during its November 6, 2020, meeting, was almost unanimous (10 votes against approval, 1 uncertain) against traditional approval, determining that there was insufficient evidence of a clinical benefit due to the conflicting results of the two clinical trials. Subsequent to the advisory committee meeting, further discussion within the FDA raised consideration of the accelerated approval pathway, which had not been presented as a consideration for the advisory committee at the November 2020 meeting (FDA 2021c).

This accelerated approval of Aduhelm has been considered controversial by many in the scientific, medical, and health policy communities. Opponents of the FDA approval highlighted three major concerns:

- **Lack of clinical evidence.** Based on the conflicting results from the two trials, the FDA advisory committee concluded that the totality of the evidence did not amount to the substantial evidence of efficacy required for traditional approval. Several members of the advisory committee commented that the results of studies 301 and 302 did not suggest a reduction of beta-amyloid is reasonably likely to predict a clinical benefit, citing an FDA statistical review that found no evidence that amyloid changes correlated with cognitive or functional changes (Alexander et al. 2021). Additionally, many researchers and clinicians have expressed concern with the potential risks, namely the presence of brain swelling, in light of the limited evidence on efficacy (Belluck 2021, Belluck et al. 2021).
- **Overly broad indication.** The FDA approval stated that the drug was indicated "for the treatment of Alzheimer's disease" with no limitations on severity or restrictions on how the disease should be diagnosed. This indication was broader than the populations included in the clinical trials, which focused on patients with mild cognitive impairment or mild dementia due to Alzheimer's disease (Alexander et al. 2021, Sachs 2021). In July 2021, Biogen (the manufacturer) responded to these concerns by updating the label indication to target patients with mild cognitive impairment or mild dementia stage of disease, the population in which treatment was initiated in clinical trials (Biogen 2021). Even so, many researchers still had concerns that the label did not specify that patients should have verification of elevated beta-amyloid or any other specific biomarker evidence (Alexander et al. 2021).
- **Lengthy timeline for confirmatory trial.** Under the terms of the accelerated approval, Biogen is required to perform a confirmatory trial to verify and describe the clinical benefit. In the approval letter, the FDA has given Biogen until February 2030 for a final report submission, approximately nine years after approval (FDA 2021a). Many stakeholders expressed concern with the lengthy amount of time to complete the clinical trial and noted that many drugs approved under the accelerated approval pathway have not demonstrated meaningful evidence of clinical effectiveness in the confirmatory trial (Alexander et al. 2021, Sachs 2021).

BOX 3-1. (continued)

In July 2021, at stakeholder request, the Centers for Medicare & Medicaid Services (CMS) announced that they would initiate a national coverage determination (NCD) analysis for Medicare, with a 30-day public comment period (CMS 2021b). CMS posted a proposed NCD decision in January 2022, and after another 30-day public comment period, finalized its NCD decision in April 2022 (CMS 2022b). CMS ultimately decided to cover Aduhelm under a coverage with evidence development (CED) policy to allow for the collection of additional clinical data. In addition, CMS made this NCD applicable to the entire class of antiamyloid monoclonal antibodies for the treatment of Alzheimer's disease. Aduhelm was the first approved drug in this class, and another drug, Leqembi (lecanemab), was granted accelerated approval on January 6, 2023 (FDA 2023).[22] At the time of the NCD decision, two other antiamyloid monoclonal antibodies (gantenerumab and donanemab) were undergoing phase three clinical trials (CMS 2022b).[23]

The NCD with CED requirement limited coverage to participation in a clinical trial or other approved comparative study, depending on the pathway under which the FDA approved the drug, as follows (CMS 2022b):

- Antiamyloid monoclonal antibodies approved under accelerated approval—that is, based on a change in a surrogate endpoint—may be covered in a randomized controlled trial conducted under an investigational new drug application.
- Antiamyloid monoclonal antibodies approved under traditional approval—that is, based on a direct measure of clinical benefit—may be covered in CMS-approved prospective comparative studies. The study may be collected in a registry.
- Coverage is also allowed when furnished according to the FDA-approved indication in National Institutes of Health-supported trials.

Medicare will not cover antiamyloid monoclonal antibodies for the treatment of Alzheimer's disease when provided outside of an FDA-approved randomized controlled trial, CMS-approved studies, or studies supported by the National Institutes of Health (CMS 2022b).

Coverage for dually eligible beneficiaries

Under mandatory Medicaid eligibility pathways, referred to as Medicare Savings Programs, beneficiaries dually eligible for Medicare and Medicaid may qualify for assistance with payment of Medicare premiums and, in some cases, Medicare cost sharing.[24] This means that for many dually eligible beneficiaries, Medicaid pays the beneficiary's cost for Part A or Part B drugs through coverage of the Part A or Part B premium and any applicable coinsurance. Under statute, Medicaid does not pay for Part D drugs, or any associated cost sharing, for full-benefit dually eligible individuals (§ 1935(d)(1) of the Act).

When CMS first announced it would proceed with an NCD for Aduhelm, many stakeholders expressed concern that a Medicare coverage decision could potentially shift costs to Medicaid. Because Medicaid must cover all FDA-approved drugs under the MDRP, the concern was that any exclusion of Aduhelm under Medicare Part B would shift that responsibility to Medicaid, as states would be liable to cover Aduhelm for full-benefit dually eligible beneficiaries and pay the full cost of treatment (NAMD 2021). In the April 2022 NCD decision memo on antiamyloid monoclonal antibodies for the treatment of Alzheimer's disease, CMS addressed these concerns by clarifying that when these drugs are not covered under the terms of the NCD, they are considered Part D drugs.

This ties back to the definition of Part D drugs as covered outpatient drugs under the MDRP that are otherwise not already covered under Part A or Part B (§ 1860D-2(e) of the Act). Because Medicaid does not pay for Part D drugs, this means that Medicaid is not a payor of last resort when Part A or Part B drugs are not covered under an NCD, and coverage would not shift from Medicare to Medicaid for full-benefit dually eligible beneficiaries (CMS 2022b).

Commission Recommendations

In this report, the Commission recommends a change to the MDRP to allow states to follow CED requirements that have been implemented under a Medicare NCD. Because full-benefit dually eligible beneficiaries would already be subject to CED requirements under Medicare, the recommendations would apply to Medicaid-only beneficiaries. Additionally, the Commission recommends that Medicaid MCOs be required to follow the state's decision on whether to implement any CED requirements. The recommendations were voted on as a package and should be taken together. The rationale and implications of these recommendations are described in the following sections.

Recommendation 3.1

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 coverage with evidence development requirements implemented under a Medicare national coverage determination.

Recommendation 3.2

Congress should amend Section 1903(m)(2)(A)(xiii) to require the managed care contract conform to the state's policy with respect to any exclusion or restriction of coverage of a covered outpatient drug based on coverage with evidence development requirements implemented under a Medicare national coverage determination.

Rationale

Under a Medicare NCD, CMS has gone through a formal process to review the clinical evidence and establish criteria for which coverage is considered reasonable and necessary. This process is similar to the P&T committee process that states use to make recommendations on appropriate utilization protocols, such as prior authorization. However, unlike Medicare Part A and Part B, Medicaid is not allowed to link drug coverage to the collection of additional evidence through a clinical trial or comparative study. In the case of Aduhelm, the National Association of Medicaid Directors asked CMS for the flexibility to apply the same coverage requirements as Medicare—that is, to cover it under a CED policy by limiting its use to persons enrolled in a clinical trial or other comparative study (NAMD 2021). It is conceivable that CMS could exercise its administrative authority and allow states to apply Medicare CED policies as prior authorization requirements for Medicaid, but a CMS policy that limits that application of the statutory MDRP may not stand up to legal challenge by a beneficiary or drug manufacturer. The recommendations would provide statutory authority for states, at their option, to implement CED requirements that have been established under a Medicare NCD.

In its prior work, the Commission has highlighted the need to verify a drug's clinical benefit in a timely manner (MACPAC 2021). State Medicaid officials have expressed concern about the requirement that Medicaid cover accelerated approval drugs that have been approved under surrogate endpoints (CMS 2022a, 2019a, 2017). In particular, they have shared concerns about paying for products that do not have a verified clinical benefit, and in some cases, may have adverse side effects in vulnerable populations. In addition, the length of time it has taken to complete some confirmatory trials means that states may be paying for treatments for several years before the benefit is verified. Allowing states to follow Medicare's requirement to link coverage of a particular drug to participation in a clinical trial or the collection of additional clinical data would help ensure that evidence of the clinical benefit can be developed in a timely manner.

CED has the potential to improve data collection on the outcomes for women, people of color, and low-income populations—groups that historically have been underrepresented in clinical trials (Duma et al.

2018, Unger et al. 2013). Extending the CED policy to Medicaid would help provide additional evidence on the clinical benefits of a drug in the Medicaid population, which may reflect a different mix of health status, demographic, and other socioeconomic characteristics than found in either the initial clinical trial or Medicare populations. For drugs that are more broadly applicable to both Medicare and Medicaid (e.g., oncology treatments), drug manufacturers or CMS may not set priorities for data collection in a manner that considers any differences in the composition of the Medicare and Medicaid populations. Clinical trials and studies can be designed to reflect the diversity of the patient population eligible for treatment beyond the Medicare population. For example, CMS included a requirement in its CED for antiamyloid monoclonal antibodies that the diversity of patients included in each study must be representative of the national population, including racial and ethnic groups (CMS 2022b). CED requirements in Medicaid can encourage drug manufacturers, CMS, and NIH to recruit a more diverse Medicaid population (e.g., individuals with disabilities) in clinical trials and prospective studies. Furthermore, a CED option could spur the negotiation of outcomes-based contracts. Better data collection on the Medicaid population could give states additional leverage to negotiate an outcomes-based contract that provides larger supplemental rebates if the drug does not provide the expected clinical outcomes.

It is important to note that these recommendations would not automatically apply current or future Medicare CED requirements to the Medicaid program. States would have the option to follow Medicare requirements, but nothing in these recommendations would prohibit a state from providing broader coverage than allowed under Medicare.

It is the Commission's belief that the authority to implement CED requirements should be given only to the state. Under the recommendations, the state would be required to have terms in its managed care contract that MCOs follow the state's decision as to whether to implement a CED requirement. This recommendation would apply a consistent coverage policy for any drug subject to CED requirements under a Medicare NCD across all beneficiaries, whether they receive services through fee for service or managed care. Aligning the policy would provide equal coverage across all plans and beneficiaries in the state. A consistent coverage policy would also reduce the administrative complexity for providers who would be required to collect and submit data. Furthermore, states should periodically review the clinical evidence as it is developed and revise their coverage policies to provide appropriate access to effective, clinically appropriate treatments.

Allowing states to follow a Medicare coverage decision is unlikely to affect many drugs. A CED requirement is applicable only to Medicare Part A or Part B drugs, so this option would be available only for drugs administered by a health care provider in an inpatient or outpatient setting. To date, CED has been used only three times on prescription drugs (MedPAC 2022b). Additionally, CMS officials have indicated that Medicare does not expect to implement CED requirements on prescription drugs frequently in the future (Wilkerson 2022). Furthermore, states would have the option to follow each Medicare coverage decision or not.

These recommendations would not address broader concerns states may have with the effect of high-cost drugs on state spending or the accelerated approval pathway. CMS is unlikely to evaluate or implement CED policies for drugs that are not significant to the Medicare population, and therefore, these recommendations likely would not address concerns for many drugs that are significant to Medicaid—for example, treatments for conditions prevalent in childhood, such as cystic fibrosis. Even so, drugs for which Medicare is the primary payer could still create substantial expenditures and corresponding budget pressure for states. MACPAC analysis of the prevalence of Alzheimer's disease in the non-dually eligible Medicaid population indicates that gross spending before rebates could reach as high as $1.7 to $3.3 billion a year, depending on the breadth of the label indication, uptake, and the price of the drugs (MACPAC 2022c). For context, that spending range would be similar to the annual gross spending on hepatitis C drugs.

Drug manufacturers and patient advocates have expressed concern over coverage restrictions that could limit patient access and the potential administrative burden of CED requirements (PhRMA 2022, ASGCT 2019, Twachtman 2019). CED requirements to enroll in a clinical trial might delay or restrict access and might result in beneficiaries not receiving a potentially beneficial treatment. Participation in a clinical trial can introduce additional burdens (e.g., travel) that may disproportionally affect

already underrepresented populations (e.g., low income, rural populations). CED requirements can also be carried out using prospective comparative studies or registries, which would provide broader coverage and are not as burdensome to patients as clinical trials. Drug manufacturers and patient advocates still have concerns that comparative studies or registries could delay access due to the effort it takes to set up the registry and report data.

Manufacturers and patient advocates have the opportunity to express their concerns during the Medicare NCD process. The Medicare NCD process includes formal periods for public comments after the announcement of an NCD consideration and after the publication of the proposed NCD. CMS has acknowledged the need to strike an appropriate balance of providing patient access with the collection of additional information on the clinical benefit and potential harms in the covered population (CMS 2022b). In past NCD decisions, CMS has demonstrated a willingness to alter its proposed criteria in response to concerns over beneficiary access. For example, in its 2019 NCD for chimeric antigen receptor T-cell (CAR–T) therapy, CMS proposed to apply CED that would require the beneficiary be enrolled in a prospective, national, audited registry. However, in response to public comments, it removed the CED requirement and ultimately finalized an NCD that covers CAR–T therapies when they are administered at health care facilities enrolled in the FDA risk evaluation and mitigation strategies and used for an FDA-approved indication or other use that is supported in one or more CMS-approved compendia (CMS 2019c). Upon approval of Leqembi, the second antiamyloid monoclonal antibody for the treatment of Alzheimer's disease, CMS indicated that it would engage with stakeholders and review data on the effectiveness of the drug to determine if it should reconsider the NCD on antiamyloid monoclonal antibodies for the treatment of Alzheimer's disease (CMS 2023).

Furthermore, states would be expected to make the decision to implement CED requirements using the P&T committee process they are required to use in establishing drug coverage criteria. P&T committee meetings are typically open to the public for comment and testimony, so stakeholders would have the opportunity to voice concerns before the state makes its coverage decision.

Implications

Federal spending. Allowing states to follow a Medicare CED requirement would likely reduce federal spending on those drugs. CED requirements would likely reduce utilization for those drugs, and thus, spending would also decrease. The Congressional Budget Office estimates that these recommendations would decrease federal spending by $0 to $5 billion over 10 years compared with the current law baseline.

States. For states that choose to follow a Medicare CED requirement, spending would decrease as use of drugs decreased. States would have another tool to gather evidence of a drug's clinical benefit in the Medicaid population. States could use CED requirements to negotiate outcomes-based contracts that provide larger supplemental rebates when a drug does not provide the desired outcome.

Enrollees. Generally, beneficiaries have been opposed to the CED requirements proposed under Medicare NCDs and are likely to oppose this policy to the extent it reduces access to particular drugs. A requirement to enroll in a clinical trial might restrict the number of people able to access the drug and delay access, which could result in some beneficiaries not receiving a potentially beneficial treatment. A Medicare CED can also require enrollment in a comparative study or registry, which would provide broader access than a clinical trial. A CED requirement could provide additional information about the benefits of treatment in specific subpopulations prevalent in Medicaid and whether there are occurrences of adverse events (e.g., brain swelling) that need to be monitored and managed.

Drug manufacturers. Manufacturers have been opposed to the CED requirements proposed under Medicare NCDs and oppose a policy that allows the extension of CED requirements to the Medicaid population. They argue that CED requirements can substantially restrict access to prescription drugs, and Medicaid coverage should not be restricted further than currently allowed under the MDRP. CED requirements could change manufacturer decisions about the pathway under which they seek FDA approval. For example, the CED requirements applied to the antiamyloid monoclonal antibodies for the treatment of Alzheimer's disease provide an incentive to seek traditional approval because the prospective study requirement allows for broader coverage than the randomized controlled trial requirement under

accelerated approval. Similarly, manufacturers would have an incentive to complete confirmatory trials and verify the clinical benefit in a more timely manner to obtain broader coverage.

Providers. Providers could face an administrative burden in the collection and reporting of data required under a Medicare CED policy. To the extent that these providers also serve Medicare beneficiaries, then they already need to have procedures in place to collect and report data. Including Medicaid beneficiaries in the data collection and reporting process may not be a substantial burden.

Next Steps

The Commission will continue to focus attention on prescription drugs, including physician-administered drugs. Many of the new drug therapies in the pipeline, such as cell and gene therapies, are likely to be administered by a professional in an office or facility setting. The different payment methodologies and administrative processes for physician-administered drugs may require different utilization management tools and payment models than those states currently use for other outpatient prescription drugs. We plan to continue monitoring the development of new proposals for alternative coverage or payment models and to reach out to stakeholders on the strengths and weaknesses of various policy options that could be used to address the challenges of high-cost drugs.

Endnotes

[1] The accelerated approval pathway allows the FDA to grant approval more quickly than the traditional approach because it allows approval based on whether the drug has an effect on a surrogate endpoint that is reasonably likely to predict a clinical benefit (§ 506(c) of the Federal Food, Drug, and Cosmetic Act). A surrogate endpoint is a marker—a laboratory measurement, radiographic image, physical sign, or other measure—that is thought to predict clinical benefit but is not itself a measure of clinical benefit (FDA 2014).

[2] When the FDA approves a drug through the accelerated approval pathway, it generally requires manufacturers to conduct additional postmarketing studies (sometimes called phase IV studies) to verify that the drug achieves a clinical benefit (21 CFR 314.510, 21 CFR 601.41, FDA 2014).

[3] In addition to executing a Medicaid drug rebate agreement as a condition for Medicaid coverage of their products, drug manufacturers must enter into an agreement that meets the requirements of Section 340B of the Public Health Service Act (P.L. 102-585) and a master agreement with the Secretary of Veterans Affairs (§ 1927(a)(1) of the Act). Additionally, the manufacturer must enter into a Medicaid drug rebate agreement for payment to be made under Medicare Part B. A drug not covered under a rebate agreement may be eligible for federal Medicaid funding in limited circumstances if the state has determined that the drug is essential to the health of its beneficiaries.

[4] A medically accepted indication means any use for a covered outpatient drug that is approved under the Federal Food, Drug, and Cosmetic Act (P.L. 75-717) or that is supported by one or more citations included or approved for inclusion in one of the following three compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, or the DRUGDEX Information System (§ 1927(k)(6) of the Act).

[5] The P&T committee examines the scientific literature (e.g., drug labeling, drug compendia, peer reviewed clinical literature, and professional association guidelines) for evidence that supports including a specific drug on the PDL based on the drug's safety, efficacy, and effectiveness relative to other drugs in its class. Price may also be considered once a drug's safety, efficacy, and effectiveness have been evaluated. For instance, inclusion on the PDL may be related to whether the state receives supplemental rebates from the drug's manufacturer. The P&T committee also makes recommendations on the appropriate utilization protocols, such as prior authorization or quantity limits for individual medications or for therapeutic categories.

[6] For Medicare Part D formularies, each drug category or class must include at least two drugs (regardless of the classification system used). Part D plan formularies must include all or substantially all drugs for the following six protected classes: immunosuppressants (for prophylaxis of organ transplant rejection), antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics (CMS 2016a). Exchange plans must cover one drug in every United States Pharmacopeia category and class or the same number of drugs in each category and class as the state benchmark plan (45 CFR 156.122(a)(1)).

[7] A drug manufacturer must have a signed Medicaid drug rebate agreement in place for its products to be covered by Medicaid. If a manufacturer does not have a rebate agreement with the Secretary, a state does not have to cover that manufacturer's products until the rebate agreement is effective.

[8] If a drug is in one of the six protected classes, Medicare Part D plans are required to conduct an expedited review and render a coverage decision 90 days after it comes onto the market. At the end of the 90-day period, the drug must be added to the plan's formulary (CMS 2016a).

[9] In its June 2019 report to Congress, the Commission recommended allowing states to exclude or otherwise restrict coverage of a covered outpatient drug for 180 days after a new drug or new formulation of a drug has been approved by the FDA and entered the market (similar to the requirements for exchange plans and Medicare Part D plans). Congress has not acted on this recommendation.

[10] The covered outpatient drug rule finalized in 2016 includes a separate definition of AMP for the so-called 5i drugs—inhalation, infusion, instilled, implanted, or injectable drugs. These drugs are not generally sold through the same distribution channels as other drugs, so the AMP for 5i drugs includes sales of a type not included in AMP calculations of non-5i drugs.

[11] Generally, an innovator drug is a drug produced or distributed under a new drug application approved by the FDA. Single-source drugs are innovator drugs manufactured by only one company, and innovator multiple-source drugs are innovator drugs that have at least one generic equivalent available. Non-innovator multiple-source drugs are multiple-source drugs that are not innovator drugs—generally, these are drugs that have been approved by the FDA under an abbreviated new drug application.

[12] For blood clotting factor drugs and drugs approved by the FDA exclusively for pediatric indications, the rebate percentage is 17.1 percent of AMP, instead of 23.1 percent of AMP.

[13] Best price excludes certain governmental payers, such as the Indian Health Service, U.S. Department of Veterans Affairs, U.S. Department of Defense, Public Health Service (including 340B), Federal Supply Schedule, and Medicare Part D plans.

[14] The baseline AMP is the AMP during the quarter before the MDRP was started or, for new drugs, the first full quarter after the drug's market date. For generic drugs marketed on or before April 1, 2013, the baseline AMP is equal to the AMP for the third quarter of 2014, and the baseline CPI-U is the CPI-U for September 2014. For generic drugs marketed after April 1, 2013, the baseline AMP is equal to the AMP for the fifth full calendar quarter after which the drug is marketed as a drug other than a brand drug, and the baseline CPI-U is equal to the CPI-U for the last month of the baseline AMP quarter (CMS 2016c).

[15] The Commission recommended removing the rebate cap in its June 2019 report to Congress.

[16] In accordance with Section 2501(c) of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), 24 states—Arizona, Arkansas, California, Delaware, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New York, North Dakota, Ohio, Oregon, Pennsylvania, Texas, Virginia, Washington, and West Virginia—are expanding supplemental rebate collections to include drugs dispensed to beneficiaries who receive drugs through an MCO. Minnesota limits its collection of supplemental rebates for MCO enrollees to direct-acting antivirals for the treatment of hepatitis C (CMS 2022c).

[17] Certain vaccines are considered covered drugs under Part D but are not considered covered outpatient drugs under the MDRP (§860D-2(e) of the Act).

[18] Medicare Part B also covers certain preventive vaccines that are explicitly listed in statute (influenza, pneumococcal, hepatitis B, and COVID-19); certain oral anticancer drugs, oral antiemetic drugs, and immunosuppressive drugs; some home infusion drugs; and clotting factor when self-administered by beneficiaries with hemophilia (MedPAC 2022a).

[19] The Inflation Reduction Act (P.L. 117-169) includes a temporary increase in Medicare Part B payment for certain biosimilars. Qualifying biosimilars may be paid at 100 percent of its own ASP plus 8 percent of the originator's biologic ASP for five years (MedPAC 2022a).

[20] Section 1861(t)(2) requires Part B coverage of anticancer chemotherapeutic regimens for indications not approved by the FDA if the drug's off-label use is supported by selected third-party compendia (MedPAC 2022a).

[21] Most recently, CMS applied CED to coverage of monoclonal antibodies directed against amyloid treatment of Alzheimer's disease (e.g., Aduhelm). In 2005, CMS

applied CED to cover off-label use of colorectal cancer drugs (oxaliplatin, irinotecan, cetuximab, or bevacizumab), linking coverage to participation in nine clinical trials sponsored by the National Cancer Institute. In 2009, Medicare applied CED for pharmacogenomic testing for warfarin response (MedPAC 2022b).

[22] The manufacturer, Eisai, Inc., has completed the confirmatory trial and submitted a supplemental biologic drug application to the FDA for traditional approval on January 6, 2023 (Eisai 2023).

[23] On January 19, 2023, the FDA did not grant accelerated approval for donanemab due to the limited number of patients with at least 12 months of drug exposure data in the phase two trial. Lilly, the manufacturer, has stated that the confirmatory phase three clinical trial is scheduled to be completed in the second quarter of 2023, and it will seek traditional approval after completion of that trial (Lilly 2023). On November 14, 2022, Roche announced that the phase three clinical trials for gantenerumab did not meet their clinical endpoints of slowing clinical decline (Roche 2022).

[24] Individuals who receive assistance only through the Medicare Savings Programs (MSPs), but do not receive full Medicaid benefits, are referred to as partial-benefit dually eligible beneficiaries. In addition, individuals may qualify for full Medicaid benefits under separate non-MSP pathways. Those who qualify for full Medicaid benefits, who may or may not receive assistance through the MSPs, are referred to as full-benefit dually eligible beneficiaries.

References

Alexander, C., D. Knopman, S. Emerson, et al. 2021. Revisiting FDA approval of aducanumab. *New England Journal of Medicine* 385: 769–771. https://www.nejm.org/doi/full/10.1056/NEJMp2110468.

American Society of Gene + Cell Therapies (ASGCT). 2019. *CAR T-cell therapy covered by Medicare, but still inadequately reimbursed*. August 14. https://asgct.org/publications/news/august-2019/cms-car-t-cell-therapy-reimbursement.

Belluck, P. 2021. Concerns grow over safety of Aduhelm after death of patient who got the drug. *New York Times*, November 21. https://www.nytimes.com/2021/11/22/health/aduhelm-death-safety.html.

Belluck, P., S. Kaplan, and R. Robbins. 2021. How an unproven Alzheimer's drug got approved. *New York Times*, July 19. https://www.nytimes.com/2021/07/19/health/alzheimers-drug-aduhelm-fda.html.

Biogen. 2021. FDA approves updated Aduhelm prescribing information to emphasize population studied in clinical trials. July 8, 2021, press release. Cambridge, MA: Biogen. https://investors.biogen.com/news-releases/news-release-details/fda-approves-updated-aduhelmtm-prescribing-information-emphasize.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. CMS statement on FDA accelerated approval of lecanemab. January 6, 2023, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/press-releases/cms-statement-fda-accelerated-approval-lecanemab.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. Section 1115 of the Social Security Act Medicaid demonstration application: Oregon Health Plan extension application. February 8, 2022. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-pln-extnsion-appl-2022-2027.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. Monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease. Memo no. CAG-00460N. Baltimore, MD: CMS. https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=305.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Medicaid pharmacy supplemental rebate agreements (SRA) as of September 19, 2022. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/medicaid-pharmacy-supplemental-rebate-agreements-table-091922.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. Chapter 15: Covered medical and other health services. In *Medicare Benefit Policy Manual*. Baltimore, MD: CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. CMS opens national coverage determination analysis on treatment for Alzheimer's disease. July 12, 2021, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/press-releases/cms-opens-national-coverage-determination-analysis-treatment-alzheimers-disease.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. Section 1115 of the Social Security Act Medicaid demonstration application: TennCare II demonstration, amendment 42. November 20, 2019. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. Chapter 13: Local coverage determinations. In *Medicare Program Integrity Manual*. Baltimore, MD: CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019c. Chimeric antigen receptor (CAR) T-cell therapy for cancers. Memo no. CAG-00451N. https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=291.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Section 1115 of the Social Security Act Medicaid demonstration application: MassHealth. September 20, 2017. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-pa3.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. Chapter 6: Part D drugs and formulary requirements. In *Medicare Prescription Drug Benefit Manual*. Baltimore, MD: CMS. https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. Medicaid program: Covered outpatient drugs. Final Rule with comment period. *Federal Register* 81, no. 20 (February 1): 5170–5357. https://www.govinfo.gov/content/pkg/FR-2016-02-01/pdf/2016-01274.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016c. CMCS Medicaid drug rebate program notice regarding "New additional inflation-adjusted rebate requirement for non-innovator multiple source drugs." April 15, 2016. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Prescription-Drugs/Downloads/Rx-Releases/State-Releases/state-rel-175.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Medicaid drug rebate program notice regarding "Assuring Medicaid beneficiaries access to hepatitis C (HCV) drugs." November 5, 2015. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/rx-releases/state-releases/state-rel-172.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. Medicare program; revised process for making national coverage determinations. *Federal Register* 78, no. 152 (August 7): 48164–48169. https://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/FR08072013.pdf.

Chen, C. 2018. FDA repays industry by rushing risky drugs to market. *ProPublica*, June 26. https://www.propublica.org/article/fda-repays-industry-by-rushing-risky-drugs-to-market.

Congressional Budget Office (CBO). 2019. *Prices for and spending on specialty drugs in Medicare Part D and Medicaid*. Washington, DC: CBO. https://www.cbo.gov/system/files/2019-03/54964-Specialty_Drugs.pdf.

Duma, N., J.V. Aguilera, J. Paludo, et al. 2018. Representation of minorities and women in oncology clinical trials: Review of the past 14 years. *Journal of Oncology Practice* 14, no. 1: e1–e10. https://ascopubs.org/doi/10.1200/JOP.2017.025288.

Eisai. 2023. Eisai submits supplemental biologics license application to FDA for traditional approval of Leqembi (lecanemab-irmb) for the treatment of Alzheimer's disease. January 7, 2023, press release. Tokyo and Cambridge, MA: Eisai. https://www.eisai.com/news/2023/pdf/enews202304pdf.pdf.

Joseph, A., and R. Cohrs. 2021. Alzheimer's patients are in limbo as hospitals, insurers grapple with whether to offer Aduhelm. *Stat*, August 4. https://www.statnews.com/2021/08/04/alzheimers-patients-in-limbo-as-hospitals-insurers-grapple-aduhelm/.

Lilly. 2023. U.S. Food and Drug Administration issues complete response letter for accelerated approval of donanemab. January 19, 2023, press release. Indianapolis, IN: Lilly. https://investor.lilly.com/node/48206/pdf.

Magellan Rx Management (Magellan). 2022. *Medicaid pharmacy trend report*. Scottsdale, AZ: Magellan. https://issuu.com/magellanrx/docs/mrx-05_medicaid_trend_report_v7?fr=sZTNkNTU1NTUwMjE.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. *Trends in Medicaid drug spending and rebates*. https://www.macpac.gov/wp-content/uploads/2022/10/07_Trends-in-Medicaid-Drug-Spending-and-Rebates-Chris.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022b. *Analysis of Medicare coverage database as of December 18, 2022*. https://www.cms.gov/medicare-coverage-database/downloads/downloads.aspx.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022c. *Analysis of T-MSIS data as of December 2020 and Medicare data from the Medicare Enrollment Database, Common Medicare Environment, and Medicare Common Working File*.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. Chapter 1: Addressing high-cost specialty drugs. In *Report to the Congress on Medicaid and CHIP*. June 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-1-Addressing-High-Cost-Specialty-Drugs.pdf.

Medicare Payment Advisory Commission (MedPAC). 2022a. *Payment basics: Part B drugs payment systems*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_PartB_FINAL_SEC.pdf.

Medicare Payment Advisory Commission (MedPAC). 2022b. Chapter 4: Addressing high prices of drugs covered under Medicare Part B. In *Report to the Congress: Medicare and the health care delivery system*. June 2022. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch4_MedPAC_Report_to_Congress_SEC.pdf.

Naci, H., K.R. Smalley, and A.S. Kesselheim. 2017. Characteristics of preapproval and postapproval studies for drugs granted accelerated approval by the US Food and Drug Administration. *Journal of the American Medical Association* 318, no. 7: 626–636. https://jamanetwork.com/journals/jama/fullarticle/2648631.

National Association of Medicaid Directors (NAMD). 2021. Letter from Jami Snyder to Chiquita Brooks-LaSure regarding shifting the cost of Alzheimer's drug from Medicare to Medicaid. https://medicaiddirectors.org/wp-content/uploads/2022/02/NAMD-Urges-Medicare-to-Not-to-Shift-Cost-of-Alzheimers-Drug-to-Medicaid-updated_pdf.pdf.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. 2022. National health expenditures by type of expenditure and source of funds: Calendar years 1960 to 2030. Baltimore, MD: OACT. https://www.cms.gov/files/zip/nhe-historical-and-projections-data.zip.

Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2022. *Delays in confirmatory trials for drug applications granted FDA's accelerated approval raise concerns*. Report no. OEI-01-21-00401. Washington, DC: OIG. https://oig.hhs.gov/oei/reports/OEI-01-21-00401.pdf.

Pharmaceutical Research and Manufacturers of America (PhRMA). 2022. Letter to Tamara Syrek Jensen regarding "proposed decision memo for monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease." February 10, 2022. https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/A-C/PhRMA-Comments-on-Proposed-NCD-for-Alzheimers-Treatments.pdf.

Roche. 2022. Roche provides update on phase III GRADUATE programme evaluating gantenerumab in early Alzheimer's disease. November 14, 2022, press release. Basel, Switzerland: Roche. https://assets.roche.com/imported/01_14112022_MR_GRADUATE_En.pdf.

Sachs, R. 2021. The FDA's approval of Aduhelm: Potential implications across a wide range of health policy issues and stakeholders. *Health Affairs Blog*, June 10, 2021. https://www.healthaffairs.org/do/10.1377/hblog20210609.921363/full/.

Twachtman, G. 2019. Medicare's CAR T-cell coverage decision draws praise, but cost issues linger. *Hematology News*, August 13. https://www.mdedge.com/hematology-oncology/article/206374/business-medicine/medicares-car-t-cell-coverage-decision-draws.

Unger, J.M., J.R. Gralow, K.S. Albain, et al. 2013. Patient income level and cancer clinical trial participation. *Journal of Clinical Oncology* 31, no. 5: 536–542. https://pubmed.ncbi.nlm.nih.gov/26468994/.

U.S. Department of Health and Human Services (HHS). 2015. Patient Protection and Affordable Care Act; HHS notice of benefit and payment parameters for 2016. Final rule. *Federal Register* 80, no. 39 (February 27): 10750–10877. https://www.govinfo.gov/content/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

U.S. Food and Drug Administration (FDA), U.S. Department of Health and Human Services. 2023. Letter to Eisai, Inc. regarding accelerated approval for BLA 761269. January 6, 2023. https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2023/761269Orig1s000ltr.pdf.

U.S. Food and Drug Administration (FDA), U.S. Department of Health and Human Services. 2021a. Letter to Biogen, Inc. regarding accelerated approval for BLA 761178. June 7, 2021. https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2021/761178Orig1s000ltr.pdf.

U.S. Food and Drug Administration (FDA), U.S. Department of Health and Human Services. 2021b. Final summary minutes of the peripheral and central nervous system drugs advisory committee meeting. November 6, 2020. https://www.fda.gov/media/145690/download.

U.S. Food and Drug Administration (FDA), U.S. Department of Health and Human Services. 2021c. Letter to Peripheral and Central Nervous System Drugs Advisory Committee chairperson. June 7, 2021. https://www.fda.gov/media/149903/download.

U.S. Food and Drug Administration (FDA), U.S. Department of Health and Human Services. 2014. *Guidance for industry: expedited programs for serious conditions—drugs and biologics*. Silver Spring, MD: FDA. https://www.fda.gov/media/86377/download.

Wilkerson, J. 2022. CMS official: Medicare will rarely restrict drug coverage again. *InsideHealthPolicy*, May 11. https://insidehealthpolicy.com/inside-drug-pricing-daily-news/cms-official-medicare-will-rarely-restrict-drug-coverage-again.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on January 27, 2023.

Medicaid Coverage Based on Medicare National Coverage Determination

3.1 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 coverage with evidence development requirements implemented under a Medicare national coverage determination.

3.2 Congress should amend Section 1903(m)(2)(A)(xiii) to require the managed care contract conform to the state's policy with respect to any exclusion or restriction of coverage of a covered outpatient drug based on coverage with evidence development requirements implemented under a Medicare national coverage determination.

3.1-3.2 voting results	#	Commissioner
Yes	15	Bella, Bjork, Brooks, Carter, Cerise, Davis, Duncan, Gerstorff, Giardino, Gordon, Heaphy, Johnson, Medows, Scanlon, Weno
No	1	Allen
Not present	1	Herrera Scott

Chapter 4:

Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

Key Points

- MACPAC continues to find no meaningful relationship between disproportionate share hospital (DSH) allotments to states and the following three factors that Congress has asked the Commission to study:
  - the number of uninsured individuals;
  - the amount and sources of hospitals' uncompensated care costs; and
  - the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.
- The U.S. Department of Health and Human Services used several authorities under the COVID-19 public health emergency (PHE), which helped lower the uninsured rate, improve hospital finances, and increase DSH allotments.
  - The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) continuous coverage requirement helped to lower the uninsured rate in 2021. In 2021, 27.2 million people, or 8.3 percent of the U.S. population, were uninsured, a statistically significant decline from 2020 (28.3 million or 8.6 percent).
  - Fiscal year (FY) 2020 federal provider relief funding improved hospital finances during the PHE. Aggregate operating margin, which mostly accounts for patient care, was negative across all hospitals after accounting for DSH payments (-4 percent). However, aggregate total margin, which accounts for relief funding, DSH payments, and other government appropriations, was positive for all hospitals (7 percent).
  - The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) increased FY 2023 DSH allotments by $1.5 billion. The ARPA-increased DSH allotments will phase out in FY 2024.
- Medicaid shortfall, the difference between the Medicaid base payments a hospital receives and its costs of providing services to Medicaid-enrolled patients, increased from $5.8 billion (31 percent) to $25 billion between 2019 and 2020, according to the American Hospital Association annual survey. However, the Medicaid payment-to-cost ratio has largely remained unchanged since 2013.
- Medicaid shortfall also varies quite extensively by state. Nationally among DSH hospitals in 2018, Medicaid shortfall was 86 percent of costs before accounting for DSH payments and 95 percent of costs after accounting for DSH payments. The 12 highest paying states paid DSH hospitals 99 percent of costs before DSH payments and 112 percent of costs after DSH payments. The 12 lowest paying states paid DSH hospitals 77 percent of costs before DSH payments and 85 percent of costs after DSH payments.
- DSH allotments are scheduled to be reduced by $8 billion in FY 2024, starting October 1, 2023. The Commission is concerned that the magnitude of cuts (54 percent in FY 2024) in DSH allotments under current law may disrupt the financial viability of some safety-net hospitals. The Commission previously recommended that should DSH allotment reductions go into effect, they should be phased in gradually to mitigate disruptions to DSH hospital finances.

CHAPTER 4: Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients. The total amount of such payments is limited by annual federal DSH allotments, which vary widely by state. States can distribute DSH payments to virtually any hospital in their state, but total DSH payments to a hospital cannot exceed the total amount of uncompensated care that the hospital provides. DSH payments help offset two types of uncompensated care: Medicaid shortfall (the difference between the payments for care a hospital receives and its costs of providing services to Medicaid-enrolled patients) and unpaid costs of care for uninsured individuals. More generally, DSH payments also help support the financial viability of safety-net hospitals.

MACPAC is statutorily required to report annually on the relationship between state allotments and several potential indicators of the need for DSH funds:

- changes in the number of uninsured individuals;
- the amounts and sources of hospitals' uncompensated care costs; and
- the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations (§ 1900 of the Social Security Act (the Act)).[1]

As in our previous DSH reports, we find little meaningful relationship between DSH allotments and the factors that Congress asked the Commission to study because DSH allotments are largely based on states' historical DSH spending before federal limits were established in 1992. Moreover, the variation is projected to continue after federal DSH allotment reductions take effect in FY 2024.

In this report, we update our previous findings to reflect new information on changes in the number of uninsured individuals and levels of hospital uncompensated care. We also provide updated information on deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. We also update our findings with data from the first year of the COVID-19 pandemic. Overall, we observed that the COVID-19 pandemic had a considerable effect on hospital finances. The policy response to COVID-19 through various authorities granted to the U.S. Department of Health and Human Services (HHS) through the COVID-19 public health emergency (PHE) helped lower the uninsured rate, improve hospital finances, and increase DSH allotments. Specifically, we find the following:

- A total of 27.2 million people, or 8.3 percent of the U.S. population, were uninsured in 2021, a 0.3 percentage point decline from 2020 (Keisler-Starkey and Bunch 2022). Some of the decline in the uninsured rate may be attributed to the continuous coverage requirements implemented during the PHE (MACPAC 2022a).
- Hospitals reported $41.9 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2020. This represented a $1.4 billion (3.4 percent) increase in uncompensated care costs from FY 2019. While uncompensated care as a share of hospital operating expense dropped substantially after coverage provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) went into effect, it has largely remained unchanged since 2015.
- Hospitals reported $24.8 billion in Medicaid shortfall on the American Hospital Association (AHA) annual survey for 2020, a 30.5 percent increase from 2019 (AHA 2021a, 2020). However, the Medicaid payment-to-cost ratio has largely remained unchanged since 2013, indicating the increase in Medicaid shortfall may be increasing Medicaid enrollment due to the continuous coverage requirements implemented during the PHE (AHA 2015).
- In FY 2020, the aggregate operating margin for all hospitals was much lower than it has been in previous years because of the financial

disruptions from the COVID-19 pandemic, but deemed DSH hospitals continued to report a lower aggregate operating margin than other hospitals (-7.4 percent for deemed DSH hospitals vs. -4.0 percent for all hospitals). However, after accounting for DSH payments and federal provider relief funding authorized during the PHE, the aggregate total margin was similar for both deemed DSH and other hospitals (7.0 vs. 7.1 percent, respectively). Aggregate operating and total margins for deemed DSH hospitals would have been 3 to 4 percentage points lower without DSH payments.

In this report, we project DSH allotments before and after implementation of federal DSH allotment reductions, which are currently scheduled to take effect on October 1, 2023. DSH allotment reductions were included in the ACA under the assumption that increased insurance coverage through Medicaid and the health insurance exchanges would lead to reductions in hospital uncompensated care and thereby lessen the need for DSH payments. DSH allotment reductions have been delayed several times; most recently, the Consolidated Appropriations Act, 2021 (P.L. 116-260), delayed implementation of reductions to FY 2024. The amount of reductions is scheduled to be $8 billion a year between FY 2024 and FY 2027, which in FY 2024 is 54 percent of unreduced allotments.

MACPAC has made several recommendations for statutory changes to improve the Medicaid DSH policy (Box 4-1). In 2019, the Commission recommended changes to the DSH definition of Medicaid shortfall, which Congress enacted in the Consolidated Appropriations Act, 2021.[2] In March 2019, the Commission also made recommendations for how pending DSH allotment reductions should be structured if they take effect; these have not been implemented, and no reductions have been made. The Commission remains concerned that the magnitude of DSH cuts assumed under current law could affect the financial viability of some safety net providers and that the methodology for implementing reductions is abrupt and does not improve the relationship between DSH allotments and measures of need for DSH funds.

In FY 2024, federal DSH allotments will also decline because of the phase out of the increased federal matching assistance percentage (FMAP) applied during the PHE. The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) temporarily increased federal DSH allotments during the PHE so that total state and federal DSH funding would be the same as it was before the application of the increased FMAP. In FY 2023, this ARPA policy increased federal DSH allotments by $1.5 billion. The Consolidated Appropriations Act, 2023 (P.L. 117-328), phases out the increased Medicaid FMAP between April 1, 2023, and December 31, 2023. The Biden administration has stated that the PHE will end in FY 2023. If the PHE does end on May 11, then there will be no ARPA increase in DSH allotments in FY 2024.

BOX 4-1. Prior MACPAC Recommendations Related to Disproportionate Share Hospital Policy

February 2016

Improving data as the first step to a more targeted disproportionate share hospital policy

- The Secretary of the U.S. Department of Health and Human Services (the Secretary) should collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Secretary should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.
  - Note: This recommendation was partially implemented under Consolidated Appropriations Act, 2021 (P.L. 116-260), which requires the U.S. Department of Health and Human Services to establish a system for states to submit non-DSH supplemental payment data in a standard format, beginning October 1, 2021. However, this system does not include managed care payments or information on the sources of non-federal share necessary to determine net Medicaid payments at the provider level.

BOX 4-1. (continued)

March 2019

Improving the structure of disproportionate share hospital allotment reductions

- If Congress chooses to proceed with disproportionate share hospital (DSH) allotment reductions in current law, it should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in fiscal year (FY) 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029, in order to phase in DSH allotment reductions more gradually without increasing federal spending.
  - Note: Since this recommendation was made, Congress has delayed and restructured DSH allotment reductions to be $8 billion per year from FYs 2024–2027 (P.L. 116-260).
- In order to minimize the effects of disproportionate share hospital (DSH) allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states.
- In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

June 2019

Treatment of third-party payments in the definition of Medicaid shortfall

- To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.
  - Note: Consolidated Appropriations Act, 2021 (P.L. 116-260) enacted this recommendation for most DSH hospitals, effective October 1, 2021, while exempting hospitals that treat a large percentage and number of patients who are eligible for Medicare and receive Supplemental Security Income (SSI). The data needed to calculate hospital eligibility for this exemption are not readily available. CMS is developing a data source that states can use to determine which hospitals are exempt from this change to Medicaid shortfall. CMS intends to describe this exemption process in future rulemaking (CMS 2021b).

The Commission has long held the view that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income uninsured patients and have higher levels of uncompensated care, consistent with the original statutory intent. However, development of policy to achieve this goal must be considered in terms of all Medicaid payments that hospitals receive. Medicaid payments generally fall into two broad categories: (1) base payments for services and (2) supplemental payments, which include DSH payments and are typically made in a lump sum for a fixed period of

time.[3] Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid; graduate medical school; supplemental payments authorized under Section 1115 demonstrations; and directed supplemental payments, which flow through managed care organizations.[4] Complete data on these supplemental payments and how they are financed are not publicly available.[5]

This chapter begins with a background on Medicaid DSH policy and then reviews the most recently available data on the number of uninsured individuals, the amounts and sources of hospital uncompensated care, and the number of hospitals with high levels of uncompensated care that also provide essential community services. The chapter concludes with an analysis of DSH allotment reductions under current law and how they relate to the factors that Congress asked us to consider.

Background

Current DSH allotments vary widely among states, reflecting the evolution of federal policy over time. States began making Medicaid DSH payments in 1981, when Medicaid hospital payment methods and amounts were uncoupled from Medicare payment standards.[6,7] Initially, states were slow to make these payments, and in 1987, Congress required states to make payments to hospitals that serve a high share of Medicaid-enrolled and low-income patients, referred to as deemed DSH hospitals. Total state

BOX 4-2. Glossary of Key Medicaid Disproportionate Share Hospital Terminology

DSH hospital. A hospital that receives Medicaid disproportionate share hospital (DSH) payments and meets the minimum statutory requirements to be eligible for DSH payments; that is, a Medicaid inpatient utilization rate (MIUR) of at least 1 percent and at least two obstetricians with staff privileges that treat Medicaid enrollees (with certain exceptions for rural and children's hospitals and those that did not provide obstetric services to the general population in 1987). MIUR is defined as the total number of Medicaid inpatient days divided by the total number of inpatient days.

Deemed DSH hospital. A DSH hospital with a MIUR of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or a low-income utilization rate (LIUR) that exceeds 25 percent. LIUR is defined as the sum of two fractions. The first fraction is total Medicaid revenue for services plus other payments from state and local governments divided by the total amount of hospital revenue for patient services. The second fraction is the total amount of hospital charges for inpatient hospital services minus the total amount of revenue from state and local governments divided by total hospital charges. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Social Security Act (the Act)).

State DSH allotment. The total amount of federal funds available to a state for Medicaid DSH payments. To draw down federal DSH funding, states must provide state matching funds at the same matching rate as other regular Medicaid service expenditures. If a state does not spend the full amount of its allotment for a given year, the unspent portion is not paid to the state and does not carry over to future years. Allotments are determined annually and are generally equal to the prior year's allotment, adjusted for inflation (§ 1923(f) of the Act).

Hospital-specific DSH limit. The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs.

and federal DSH spending grew rapidly in the early 1990s—from $1.3 billion in 1990 to $17.7 billion in 1992—after Congress clarified that DSH payments were not subject to Medicaid hospital upper payment limits (Matherlee 2002, Klem 2000, Holahan et al. 1998).[8] Most of this growth was driven by large DSH spending increases in a small number of states, while the majority of states made relatively level year-over-year DSH payments.

DSH allotments

To limit DSH spending, Congress enacted state-specific caps on the amount of federal funds that could be used to make DSH payments, referred to as allotments (Box 4-2). Allotments were initially established for FY 1993 and were generally based on each state's 1992 DSH spending. Although Congress has subsequently made several adjustments to these allotments, the states that spent the most in 1992 still have the largest allotments, and the states that spent the least in 1992 still have the smallest allotments.[9] However, because Medicaid spending has grown faster than DSH allotments, DSH spending as a share of overall Medicaid spending has declined from 15 percent in FY 1992 to 2.8 percent in FY 2018 (CRS 2020). States are not required to spend their entire allotment but do not receive federal funding for DSH payments that exceed the allotment.

In response to the COVID-19 pandemic, Congress increased the FMAP for all Medicaid expenditures, including DSH, by 6.2 percentage points under the Families First and Coronavirus Response Act of 2020 (FFCRA, P.L. 116-127), but at the time, Congress did not change federal DSH allotment policy. This caused total DSH funding (state and federal amounts) to decrease for FY 2020 since DSH payments are capped by federal allotments and states contributed less to the non-federal share for DSH payments. A year later, Congress increased DSH allotments under ARPA so that the total available state and federal DSH funding remained the same as it would have been before the FMAP increase. The ARPA DSH increases were retroactive to the second quarter of FY 2020.

In FY 2021, allotments to states for DSH payments totaled $14.3 billion.[10] State-specific DSH allotments that year ranged from less than $15 million in 6 states (Delaware, Hawaii, Montana, North Dakota, South Dakota, and Wyoming) to more than $1 billion in 3 states (California, New York, and Texas).

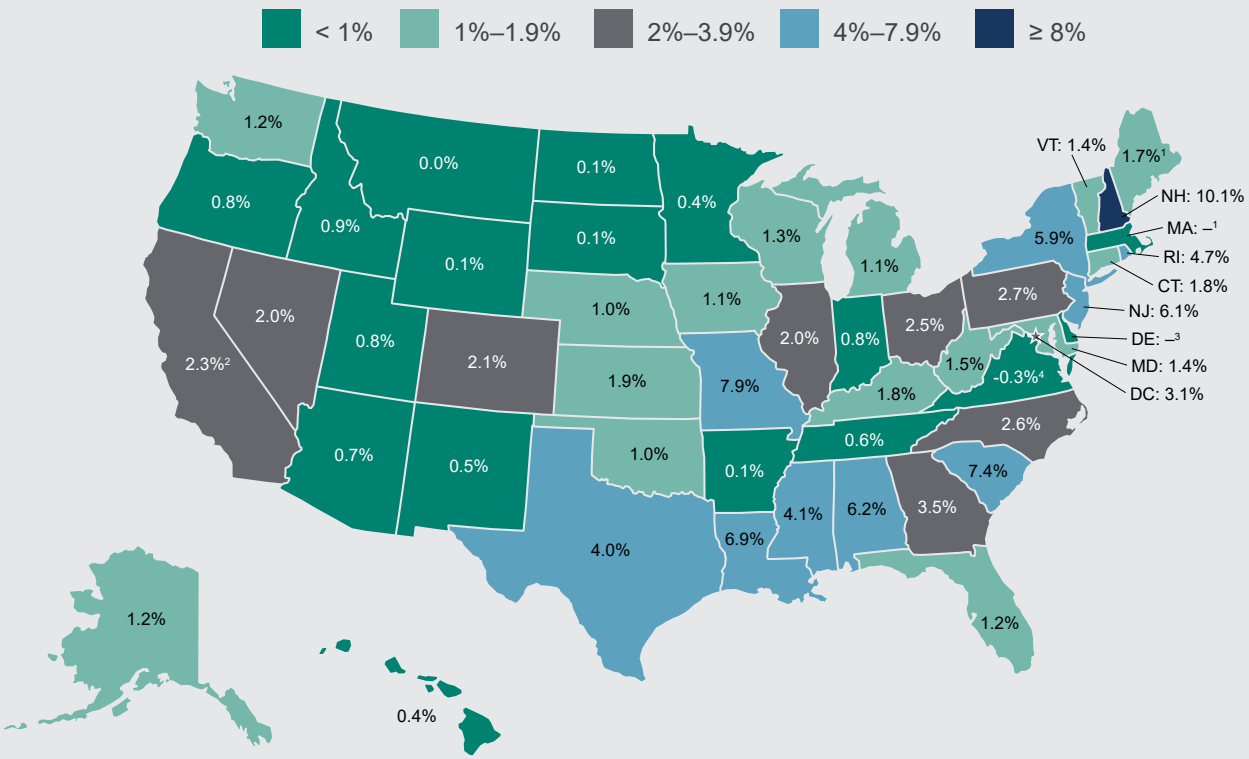
Total federal and state DSH spending was $18.9 billion in FY 2021 and accounted for 3 percent of total Medicaid benefit spending.[11] DSH spending as a share of total Medicaid benefit spending varied widely by state, from less than 1 percent in 17 states to 10 percent in New Hampshire (Figure 4-1).

States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[12] As of the end of FY 2022, $1.9 billion (15 percent) in federal DSH allotments for FY 2020 allotments were unspent.[13]

There are two primary reasons that states do not spend their full DSH allotment: (1) they lack state funds to provide the non-federal share and (2) the DSH allotment exceeds the total amount of hospital uncompensated care in the state. As noted previously, DSH payments to an individual hospital cannot exceed that hospital's level of uncompensated care. In FY 2020, half of unspent DSH allotments were attributable to seven states (Connecticut, Indiana, Louisiana, Maine, New Jersey, Pennsylvania, and Virginia). All of these states, excluding Virginia and Indiana, had FY 2020 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated care in the state reported on 2020 Medicare cost reports, which suggests that these states may not be able to spend their full DSH allotments even if they have sufficient state funds to provide the non-federal share.[14]

There are also regulatory or operational challenges to spending down DSH allotments in a timely manner when there are delays in Centers for Medicare & Medicaid Services (CMS) finalizing DSH allotments.[15] Although CMS provides states with preliminary allotments that they can use to make payments, some states are hesitant to spend their full DSH allotment until it is finalized because of concerns that CMS may later recoup funds if the final allotment is less than projected.[16]

FIGURE 4-1. DSH Spending as a Share of Total Medicaid Benefit Spending by State, FY 2021



Notes: DSH is disproportionate share hospital. FY is fiscal year.

— Dash indicates zero.

[1] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act (the Act) allows it to use all of its DSH funding for the state's safety-net care pool instead.

[2] DSH spending for California includes DSH-financed spending under the state's Global Payment Program, which is authorized under the state's demonstration waiver under Section 1115 of the Act.

[3] Delaware reported no DSH spending in FY 2020. States typically have two years to report DSH spending after the close of the fiscal year.

[4] Virginia's DSH spending in FY 2020 was negative, and therefore, DSH spending as a percent of Medicaid expenditures was also negative. States can have negative spending for a certain category of service if there was a prior period adjustment within the CMS-64 data.

Source: MACPAC, 2023, analysis of CMS-64 financial management report net expenditure data as of June 8, 2022.

DSH payments to hospitals

In state plan rate year (SPRY) 2018, 42 percent of U.S. hospitals received DSH payments (Table 4-1).[17,18] States are allowed to make DSH payments to any hospital that has a Medicaid inpatient utilization rate of at least 1 percent, which is true of almost all U.S. hospitals. More than half of public hospitals (53 percent) and teaching hospitals (63 percent) received DSH payments. Almost half of all rural hospitals (48 percent) received DSH payments, including many critical access hospitals (40 percent), which receive a special payment designation from Medicare because they are small and are supposed to be the only provider in their geographic areas.[19]

The proportion of hospitals receiving DSH payments varies widely by state (Figure 4-2). In SPRY 2018, five states made DSH payments to fewer than 10 percent of the hospitals in their states (Arkansas, Illinois, Iowa, Maine, and North Dakota). Conversely, one state, New York, made DSH payments to more than 90 percent of its hospitals.[20]

TABLE 4-1. Distribution of DSH Spending by Hospital Characteristics, SPRY 2018

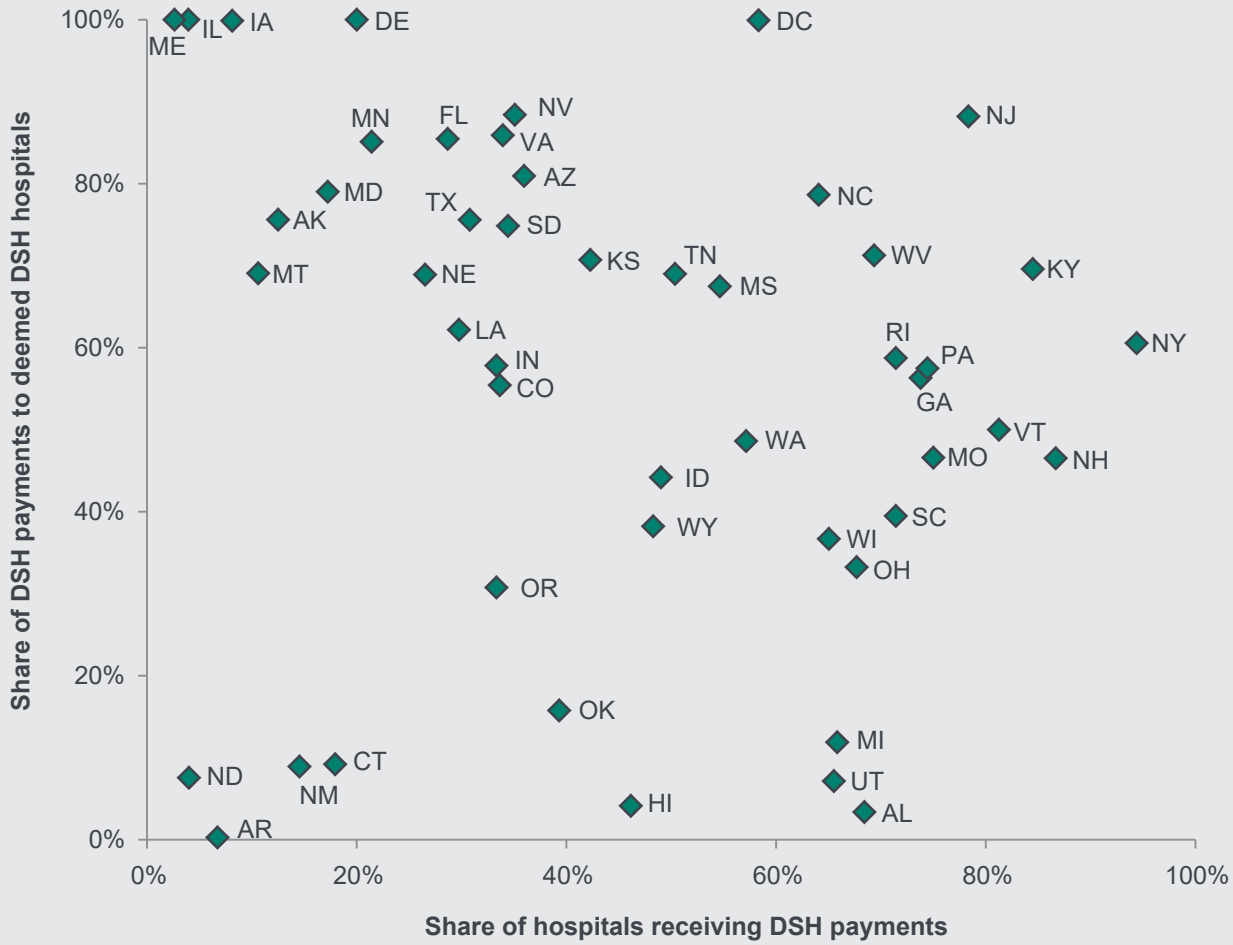
Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as a percentage of all hospitals in category	
Total	**2,507**	**5,957**	**42%**	**$16,775**
Hospital type				
Short-term acute care hospitals	1,754	3,216	55	13,095
Critical access hospitals	540	1,357	40	400
Psychiatric hospitals	141	616	23	2,867
Long-term hospitals	7	359	2	15
Rehabilitation hospitals	15	316	5	6
Children's hospitals	50	93	54	392
Urban or rural				
Urban	1,350	3,539	38	14,764
Rural	1,157	2,417	48	2,010
Hospital ownership				
For-profit	358	1,756	20	867
Non-profit	1,500	2,979	50	5,940
Public	649	1,222	53	9,967
Teaching status				
Non-teaching	1,686	4,665	36	4,763
Low-teaching	524	864	61	3,135
High-teaching	297	428	69	8,876
Deemed DSH status				
Deemed	749	749	100	10,076
Not deemed	1,758	5,208	34	6,699

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. Excludes 80 DSH hospitals that did not submit a fiscal year 2020 Medicare cost report. Low-teaching hospitals have an intern-and-resident-to-bed (IRB) ratio of less than 0.25, and high-teaching hospitals have an IRB ratio of 0.25 or greater. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Total DSH spending includes state and federal funds. Analyses of deemed DSH hospitals are limited to hospitals that received DSH payments and excludes 25 hospitals in California and Massachusetts that received funding from safety-net care pools that are financed with DSH funding in demonstrations authorized under waiver expenditure authority of Section 1115 of the Social Security Act.

Sources: MACPAC, 2023, analysis of FY 2020 Medicare cost reports and SPRY 2017–2018 as-filed Medicaid DSH audits.

As noted previously, states are statutorily required to make DSH payments to deemed DSH hospitals, which serve a high share of Medicaid-enrolled and low-income patients. In SPRY 2018, about 13 percent of U.S. hospitals met this standard. These deemed DSH hospitals constituted just under one-third (30 percent) of DSH hospitals but accounted for nearly two-thirds (60 percent) of all DSH payments, receiving $10 billion in DSH payments. States vary in how they target DSH payments to deemed DSH hospitals, from less than 10 percent of DSH payments to deemed DSH hospitals in 7 states (Alabama, Arkansas, Connecticut, Hawaii,

FIGURE 4-2. Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals, by State, SPRY 2018



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. The share of DSH payments to deemed DSH hospitals shown does not account for provider contributions to the non-federal share; these contributions may reduce net payments. Delaware has yet to submit a Medicaid DSH audit for SPRY 2018, and therefore, we are using Delaware's SPRY 2017 Medicaid DSH audit. The analysis excludes Massachusetts and California, which have demonstration waivers under Section 1115 of the Social Security Act that allow them to distribute DSH funding to hospitals through safety-net care pools.

Sources: MACPAC, 2023, analysis of FY 2020 Medicare cost reports and SPRY 2017–2018 as-filed Medicaid DSH audits.

New Mexico, North Dakota, and Utah) to 100 percent in 4 states (Delaware, Illinois, Iowa, and Maine) and the District of Columbia.

State criteria for identifying eligible DSH hospitals and how much funding they receive vary but are often related to hospital ownership, hospital type, and geographic factors. States that concentrate DSH payments among a small number of hospitals do not necessarily make the largest share of payments to deemed DSH hospitals (e.g., Arkansas, Connecticut, New Mexico, and North Dakota); conversely, some states that distribute DSH payments across most hospitals still target the largest share of DSH payments to deemed DSH hospitals (e.g., Kentucky and New Jersey) (Figure 4-2).

The methods states use to finance the non-federal share of DSH payments may affect their DSH targeting policies. For example, according to data from the U.S. Government Accountability Office, 10 states primarily financed DSH payments through provider contributions from publicly owned hospitals (intergovernmental transfers or certified public expenditures) (GAO 2021a, 2014). These states direct a larger share of their DSH payments to publicly owned providers (72 percent) than states that fund DSH payments through general revenue or a provider tax (43 percent and 34 percent, respectively). Conversely, the 12 states that predominately use a provider tax to generate the non-federal share of DSH payments do not appear to target DSH payments to a particular class of hospital. These states generally distribute DSH payments to a larger share of hospitals in their states (59 percent) than states that predominately fund DSH payments through other methods (39 percent).[21] More information about state DSH targeting policies is included in Chapter 3 of MACPAC's March 2017 report to Congress (MACPAC 2017).

State DSH policies change frequently, often as a function of state budgets. The amounts paid to hospitals are more likely to change than the types of hospitals receiving payments: nearly 95 percent of the hospitals that received DSH payments in SPRY 2018 also received DSH payments in SPRY 2017. However, the amount that hospitals receive can change considerably in subsequent reporting years. For example, 23 percent of hospitals that received DSH payments in SPRY 2017 and SPRY 2018 reported that the amount of DSH payments they received in 2018 increased or decreased by more than 50 percent, compared with 2017.

Changes in the Number of Uninsured Individuals

In 2021, 27.2 million people (8.3 percent of the U.S. population) were uninsured, a statistically significant decrease from the number and share in 2020 (28.3 million and 8.6 percent, respectively) (Table 4-2) (Keisler-Starkey and Bunch 2022). At the beginning of the PHE in 2020, Congress implemented a countercyclical financing policy under FFCRA which provided an enhanced FMAP, contingent on each state maintaining its eligibility standards. CMS interpreted this continuous coverage requirement to prohibit states from disenrolling beneficiaries even if their eligibility circumstances change. MACPAC previously reported that this provision likely contributed to a significant increase in Medicaid enrollment (1 percentage point) and a significant decrease in the uninsured rate (1.1 percentage points) between August 2020 and July 2021 (MACPAC 2022a).

The uninsured rate in 2021 was highest for adults younger than age 65, individuals of Hispanic origin, and individuals with incomes below the federal poverty level (FPL) (Table 4-2). Between 2020 and 2021, the uninsured rate increased significantly for individuals older than age 64. In addition, there was a significant decrease in the uninsured rate for individuals younger than age 19; those who identify as Black, non-Hispanic; those with incomes between 200 and 300 percent FPL; and those living in states that did not expand Medicaid (Keisler-Starkey and Bunch 2022).

In 2021, the uninsured rate in states that did not expand Medicaid under the ACA to adults younger than age 65 with incomes at or below 138 percent FPL was nearly twice as high as the uninsured rate in states that expanded Medicaid (11.9 and 6.4 percent, respectively).[22] Nebraska expanded Medicaid in October 2020 and saw a decline in the uninsured rate of 1.2 percentage points between 2019 and 2021 (8.3 percent and 7.1 percent, respectively).

TABLE 4-2. Uninsured Rates by Selected Characteristics, United States, 2020–2021

Characteristic	2020	2021	Percentage point change
All uninsured	**8.6%**	**8.3%**	**-0.3%***
Age group			
Younger than age 19	5.6	5.0	-0.6*
Age 19–64	11.9	11.6	-0.3
Older than age 64	1.0	1.2	0.2*
Race and ethnicity			
White, non-Hispanic	5.4	5.2	-0.2
Black, non-Hispanic	10.4	9.0	-1.4*
Asian, non-Hispanic	5.9	6.2	0.3
Hispanic (any race)	18.3	18.3	0.0
Income-to-poverty ratio			
Less than 100 percent	17.2	16.2	-1.0
100–199 percent	13.5	13.2	-0.3
200–299 percent	12.0	11.0	-1.0*
300–399 percent	8.9	8.9	0.0
400 percent or more	3.4	3.3	-0.1
Medicaid expansion status in state of residence as of January 1, 2021			
Non-expansion	12.8	11.9	-0.9*
Expansion	6.5	6.4	-0.1

Notes: Uninsured rates are based on the Current Population Survey Annual Social and Economic Supplement. Medicaid expansion status reflects state expansion decisions as of January 1, 2021, and thus excludes Missouri and Oklahoma, which expanded in 2021.

* Indicates change is statistically different from zero at the 90 percent confidence level. MACPAC calculated significance using standard errors from Keisler-Starkey et al. 2022. This statistic includes only states that expanded Medicaid before January 1, 2021.

Sources: MACPAC, 2023, analysis of Keisler-Starkey and Bunch 2022.

Missouri and Oklahoma both expanded Medicaid at some point during 2021, therefore, the full effects of expansion on the uninsured rate may not be reflected in the 2021 American Community Survey (Table 4A-3 in Appendix 4A).[23]

When the continuous coverage requirement, which was enacted during the PHE, ends and states resume Medicaid eligibility redeterminations, Medicaid beneficiaries will be at a high risk of disruptions in coverage. HHS estimated that approximately 15 million Medicaid beneficiaries (including 9.7 million adults and 5.3 million children) could lose coverage when the continuous coverage requirement ends. HHS further estimates that more than 40 percent of these disenrolled individuals will remain eligible for Medicaid but will have lost coverage due to difficulties navigating the renewal process. This type of loss of coverage is known as “administrative churn” (ASPE 2022).

Changes in the Amount of Hospital Uncompensated Care

In considering the impending DSH allotment reductions, it is important to note that DSH payments cover both unpaid costs of care for uninsured individuals and Medicaid shortfall. The Commission has long held that DSH allotments should be allocated based on state levels of need and that states with lower levels of uncompensated care should receive a larger proportion of DSH allotment reductions. Unpaid costs of care for uninsured individuals have declined substantially relative to pre-2014 levels, before coverage was expanded under the ACA, particularly in states that have expanded Medicaid. However, as the number of Medicaid enrollees increased between 2014 and 2017, Medicaid shortfall increased as well.

Definitions of uncompensated care vary among data sources, complicating comparisons at the hospital level and our ability to fully understand the effects of uncompensated care on hospital finances (Box 4-3). The most recently available data on hospital uncompensated care for all hospitals comes from Medicare cost reports, which define uncompensated care as charity care and bad debt.[24] However, Medicare cost reports do not include reliable information on Medicaid shortfall, which is the difference between a hospital's costs of care for Medicaid-enrolled patients and the total payments it receives for those services. Medicaid DSH audits include data on both Medicaid shortfall and unpaid costs of care for uninsured individuals for DSH hospitals, but these audits are not due to CMS until approximately three years after DSH payments are made and then are not published until CMS reviews the data for completeness (42 CFR 455.304). Furthermore, DSH audits are available only for those hospitals that receive Medicaid DSH payments.

BOX 4-3. Definitions and Data Sources for Uncompensated Care Costs

Data sources

American Hospital Association annual survey. An annual survey of hospitals that provides aggregated national estimates of uncompensated care for community hospitals.

Medicare cost report. An annual report on hospital finances that must be submitted by all hospitals that receive Medicare payments (i.e., most U.S. hospitals with the exception of some freestanding children's hospitals). Medicare cost reports define hospital uncompensated care costs as charity care and bad debt.

Medicaid disproportionate share hospital (DSH) audit. A statutorily required audit of a DSH hospital's uncompensated care. The audit ensures that Medicaid DSH payments do not exceed the hospital-specific DSH limit, which is equal to the sum of Medicaid shortfall and the unpaid costs of care for uninsured individuals for allowable inpatient and outpatient costs. Forty-two percent of U.S. hospitals were included on DSH audits in 2018.

Definitions

Medicare cost report components of uncompensated care

Charity care. Health care services for which a hospital determines the patient does not have the capacity to pay and, based on its charity care policy, either does not charge the patient at all for the services or charges the patient a discounted rate below the hospital's cost of delivering the care. Charity care costs cannot exceed a hospital's cost of delivering the care. Medicare cost reports include costs of charity care provided to both uninsured individuals and patients with non-Medicare insurance who cannot pay deductibles, co-payments, or coinsurance.

BOX 4-3. (continued)

Bad debt. Expected payment amounts that a hospital is not able to collect from patients who are determined to have the financial capacity to pay according to the hospital's charity care policy. As noted previously, this amount excludes the bad debt that has been reimbursed by Medicare.

Medicaid DSH audit components of uncompensated care

Unpaid costs of care for uninsured individuals. The difference between a hospital's costs of providing services to individuals without health coverage and the total amount of payment received for those services. This includes charity care and bad debt for individuals without health coverage and generally excludes charity care and bad debt for individuals with health coverage.

Medicaid shortfall. The difference between a hospital's costs of providing services to Medicaid-eligible patients for whom Medicaid is the primary payer and the total amount of Medicaid payment received for those services (under both fee for service and managed care, excluding DSH payments but including most other types of supplemental payments).

In our analysis of Medicaid DSH audits, we found that DSH payments were used to offset different types of uncompensated care in SPRY 2018 and that this was related to whether a state expanded Medicaid under the provisions of the ACA. DSH was primarily used to pay for costs incurred by hospitals related to care provided for the uninsured among non-expansion states, while DSH was used to offset Medicaid costs among expansion states. In the aggregate, Medicaid shortfall was responsible for a larger share of uncompensated care (76 percent) for DSH hospitals among expansion states compared with states that did not expand Medicaid (21 percent).

In the following sections, we review the most recent uncompensated care data available for all hospitals in FY 2020 as well as additional information about Medicaid shortfall reported for DSH hospitals in SPRY 2018.

Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of $41.9 billion in charity care and bad debt in FY 2020, or about 4.1 percent of hospital operating expenses. This is a $1.4 billion increase from FY 2019 and a 0.05 percentage point increase as a share of hospital operating expenses.[25] Some of the increase in uncompensated care was likely offset by provider relief funding that was allocated to pay for COVID-19 testing and treatment for the uninsured (MACPAC 2021d).[26] Uncompensated care as a percentage of hospital operating expenses has remained largely unchanged since FY 2017 (4.3 percent), and uncompensated care no longer appears to be declining year over year as it did in the first few years after the ACA coverage expansions took effect.[27]

Charity care and bad debt, as a share of hospital operating expenses, varied widely by state in FY 2020 (Figure 4-3). In the aggregate, hospitals in states that expanded Medicaid under the ACA before September 30, 2020, reported less than half the uncompensated care that was reported in non-expansion states (2.7 percent of hospital operating expenses in Medicaid expansion states vs. 7.3 percent in states that did not expand Medicaid).

In FY 2020, about 53 percent of reported uncompensated care was for charity care for uninsured individuals ($22.4 billion), 14 percent was for charity care for insured individuals ($6.0 billion), and 33 percent was for bad debt expenses for both insured and uninsured individuals ($13.7 billion).[28] When individuals are unable to pay their cost sharing for medical expenses (e.g., deductibles, coinsurance, and other forms of cost sharing), this is reported as bad debt for the insured. These costs are increasing:

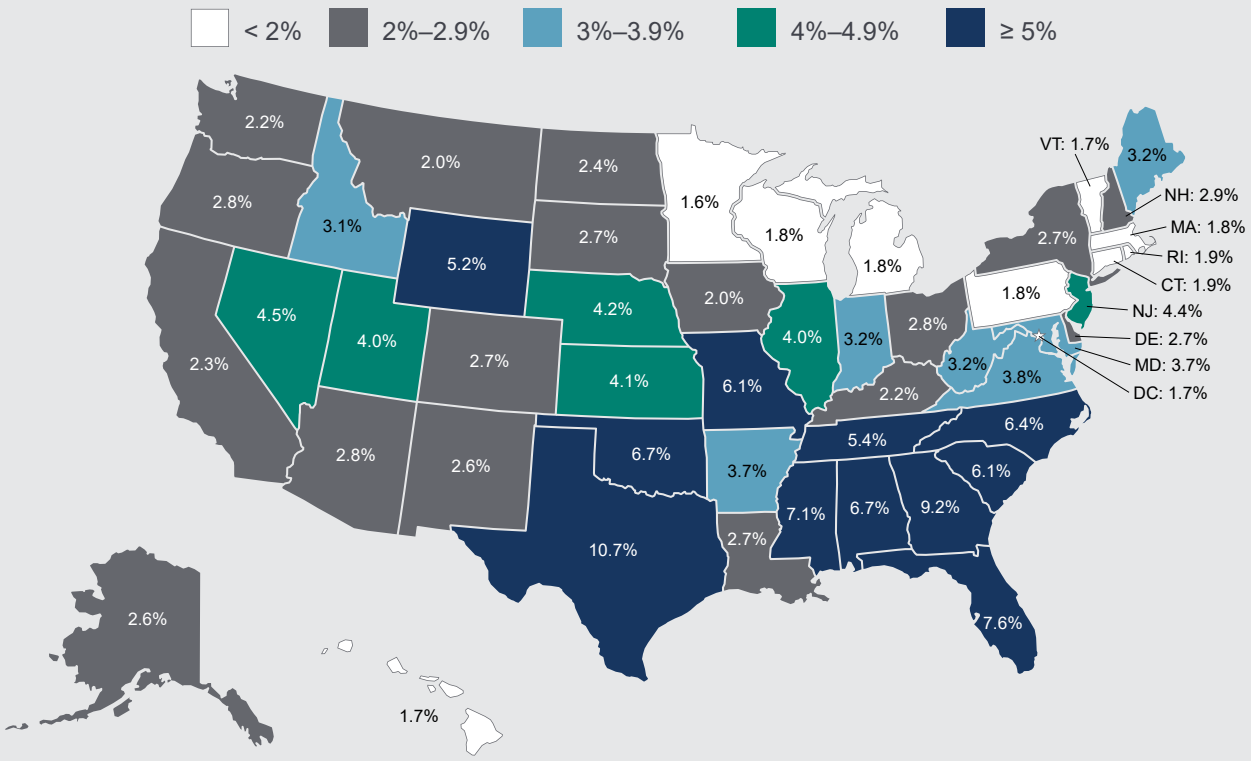
from 2016 to 2020, prices for medical care increased by 16 percent, more than double the rate of inflation (CBO 2022, HCCI 2022). Deductibles are also increasing along with the number of workers in high deductible health plans; for example, the average deductible for workers was $1,763 in 2022, which is an increase of 17 percent over the last 5 years and 61 percent over the last 10 years (KFF 2022a, 2021). Uncompensated care that can be attributed to insured individuals with high costs and high deductibles cannot be covered by Medicaid DSH.

Medicaid shortfall

Medicaid shortfall is the difference between a hospital's costs of providing services to Medicaid-enrolled patients and the total amount of Medicaid payment received for those services. According to the AHA annual survey, Medicaid shortfall for all hospitals increased by $5.8 billion between 2019 and 2020, from $19 billion to $24.8 billion (AHA 2021a, 2022a). In the same survey, the aggregate Medicaid payment-to-cost ratio was 88 percent in 2020, which means national shortfall as a percentage of costs has mostly remained unchanged since 2013 (AHA 2022a, 2021a, 2015).

In contrast to the AHA survey, which provides data for all U.S. hospitals, Medicaid DSH audits provide data on Medicaid shortfall for the subset of hospitals that receive Medicaid DSH payments (42 percent of U.S. hospitals in SPRY 2018). In SPRY 2018, DSH hospitals reported a total of $20.5 billion in Medicaid shortfall and an aggregate Medicaid payment-to-cost ratio of 86 percent before DSH payments.[29]

FIGURE 4-3. Charity Care and Bad Debt as a Share of Hospital Operating Expenses, FY 2020



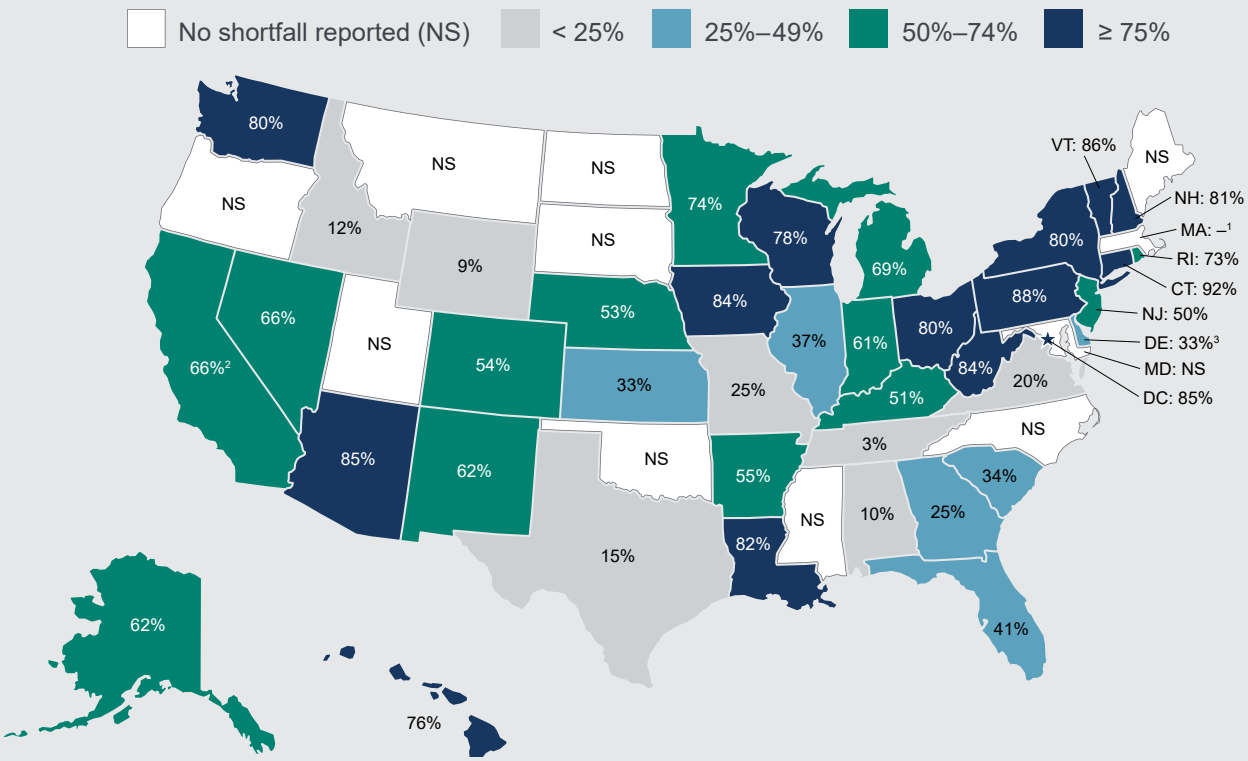
Notes: FY is fiscal year.

Source: MACPAC, 2023, analysis of FY 2020 Medicare cost reports.

Medicaid shortfall as a share of total uncompensated care for DSH hospitals varies widely across states (Figure 4-4). In SPRY 2018, 9 states reported no Medicaid shortfall for DSH hospitals and 27 states reported shortfall that exceeded 50 percent of DSH hospitals' total uncompensated care costs. There is also wide variation in Medicaid payment-to-cost ratios for DSH hospitals. Before DSH payments, Medicaid payments to DSH hospitals ranged from 64 percent of costs in Pennsylvania to 123 percent of costs in Utah in SPRY 2018.

Aggregate data on Medicaid shortfall for DSH hospitals may not reflect the experience of all hospitals

FIGURE 4-4. Medicaid Shortfall as a Share of Total Uncompensated Care Costs by State, SPRY 2018



Notes: SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. NS means no shortfall was reported in SPRY 2018. A total of 2,355 disproportionate share hospitals (DSH) hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2020 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. The analysis also excludes some hospitals in California, which have demonstration waivers under Section 1115 of the Social Security Act that allow them to distribute DSH funding to hospitals through safety-net care pools.

— Dash indicates zero.

[1] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act (the Act) allows it to use all of its DSH funding for the state's safety-net care pool instead.

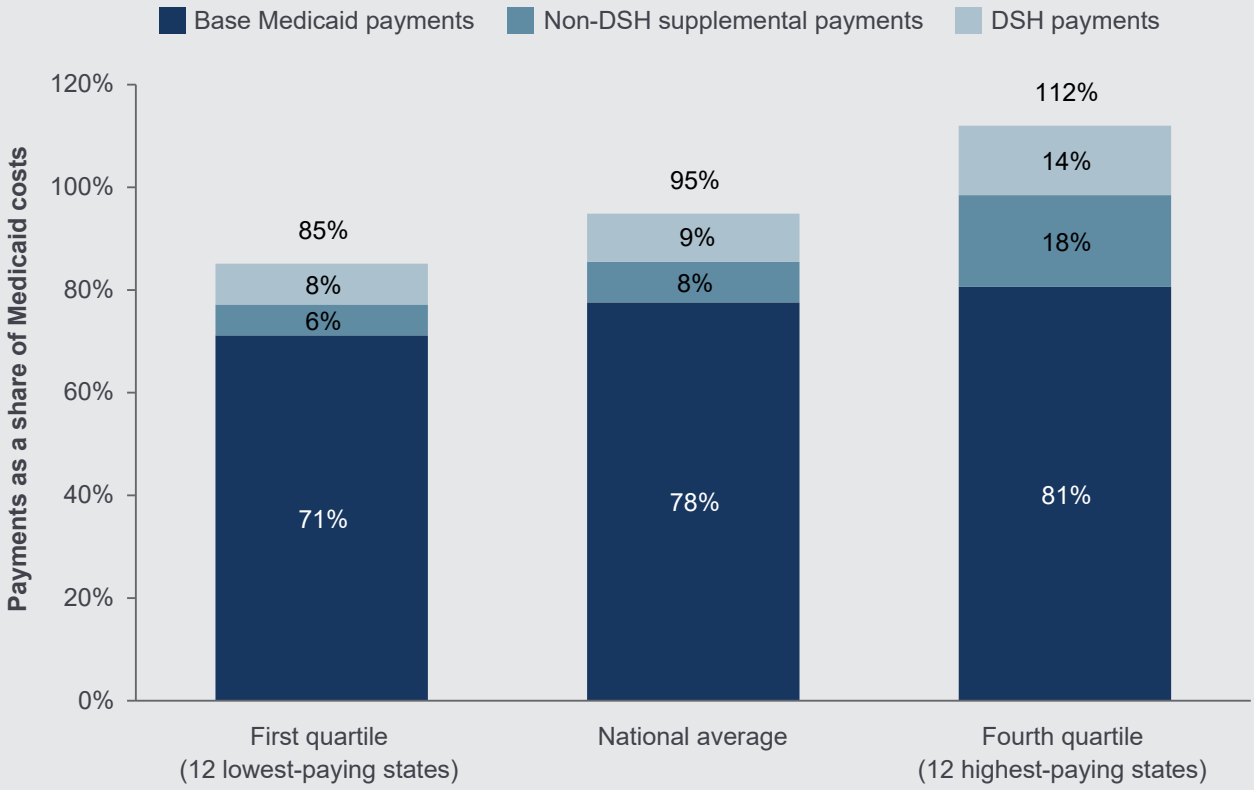
[2] DSH payments in California do not include DSH-financed spending under the state's Global Payment Program, which is authorized under the state's demonstration waiver under Section 1115 of the Act.

[3] Delaware has not submitted a SPRY 2018 as-filed DSH audit. This analysis uses SPRY 2017 Delaware DSH audit data.

Source: MACPAC, 2023, analysis of SPRY 2017–2018 as-filed Medicaid DSH audits.

in a state because Medicaid payment rates vary by hospital and because the net payment that a hospital receives may be lower than the total payment reported on DSH audits. For example, in the aggregate, DSH hospitals in Mississippi did not report a Medicaid shortfall in SPRY 2018, but 28 of the 59 hospitals that received DSH payments reported Medicaid shortfall in that year.[30] Moreover, Mississippi finances DSH payments with provider taxes, and stakeholders report that net Medicaid payments to hospitals in the state are below costs after adding the costs of these taxes (MACPAC 2019).

FIGURE 4-5. Medicaid Payments to DSH Hospitals as a Percentage of Medicaid Costs by National Average and Selected Quartiles, SPRY 2018



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. A total of 2,355 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2020 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. DSH payments can cover Medicaid and uninsured costs, but this figure calculates DSH and other Medicaid payments as a percentage of Medicaid costs. Quartiles were calculated based on each state's Medicaid payment to Medicaid cost ratio. Base Medicaid payments include fee for service as well as managed care payments for services. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on Medicaid DSH audits). States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a managed care base payment or as a supplemental payment. Payments shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers may not sum due to rounding.

Source: MACPAC, 2023, analysis of SPRY 2017–2018 as-filed Medicaid DSH audits.

We can also use Medicaid DSH audits to see how base payments and all supplemental payments compare with Medicaid costs at DSH hospitals. We find that overall Medicaid base payments pay 78 percent of costs, non-DSH supplemental payments pay 8 percent of costs, and DSH payments pay 9 percent of costs, though these averages mask significant state variation (Figure 4-5).[31]

In SPRY 2018, DSH hospitals in the 12 states with the lowest Medicaid payment to cost ratios received total Medicaid payments that covered 85 percent of the costs of care for Medicaid enrolled patients in the aggregate, and DSH hospitals in the 12 states with the highest Medicaid payment to cost ratios received payments that covered 112 percent of Medicaid costs in the aggregate.[32] Similar to DSH payments, these supplemental payments are intended to support a variety of goals and may not be intended to offset Medicaid shortfall (state level tables on base and supplemental payments for DSH hospitals are available in Appendix 4A).

Hospital margins

Changes in hospital uncompensated care costs may affect hospital margins. For example, deemed DSH hospitals report higher uncompensated care costs and lower operating and total margins than other hospital types in the aggregate. MACPAC estimates both total and operating margins using a combination of Medicaid DSH audit and Medicare cost report data. Operating margin primarily includes only revenues and costs related to patient care, while total margin also includes revenue not directly related to patient care, such as the hospital's investment income or state and local subsidies. MACPAC analyzes both types of margins to have a fuller understanding of the financial health of safety-net hospitals.

COVID-19 effects on hospital margins. COVID-19 has had a large effect on hospital margins. Hospitals noted greater expenses due to the costs of treating complex COVID-19 hospitalizations and the costs associated with implementing new infection control practices to protect patients and staff, both of which increased hospital uncompensated care costs to the extent that they were not paid for by other sources (AHA 2021b). Hospitals also experienced declines in non-COVID-19 service use as a result of postponed non-emergent and elective surgeries, which may reduce the amount of overall care (including reduced uncompensated care but also reduced revenue) relative to prior years (AHA 2021b; Gallagher et al. 2021; Birkmeyer et al. 2020; Mehrotra et al. 2020a, 2020b, 2020c).

To address pandemic-related financial challenges, Congress provided dedicated relief funding for hospitals through a variety of mechanisms. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), the Consolidated Appropriations Act, 2021, and ARPA made available $186.5 billion in provider relief funding to hospitals and other providers to offset lost revenue or expenses during the pandemic; a portion of this funding was also used to pay for care for uninsured individuals with COVID-19. The CARES Act also temporarily increased Medicare payments to hospitals for COVID-19 hospitalizations and established the Paycheck Protection Program for businesses with fewer than 500 employees.[33]

At the time of the initial distribution of funds, MACPAC expressed concern that provider relief funding was not appropriately targeting safety-net providers (MACPAC 2020a, 2020b). Since initial disbursements were based on and then updated to be based on all-payer net patient revenue, funding was less targeted toward hospitals that serve a large percentage of the Medicaid population and instead was mostly distributed to hospitals with high patient revenue (Buxbaum and Rak 2021). HHS eventually made additional provider relief funding available to hospitals with a high number of COVID-19 admissions, rural hospitals, children's hospitals, tribal hospitals, and safety-net hospitals (GAO 2021b).[34]

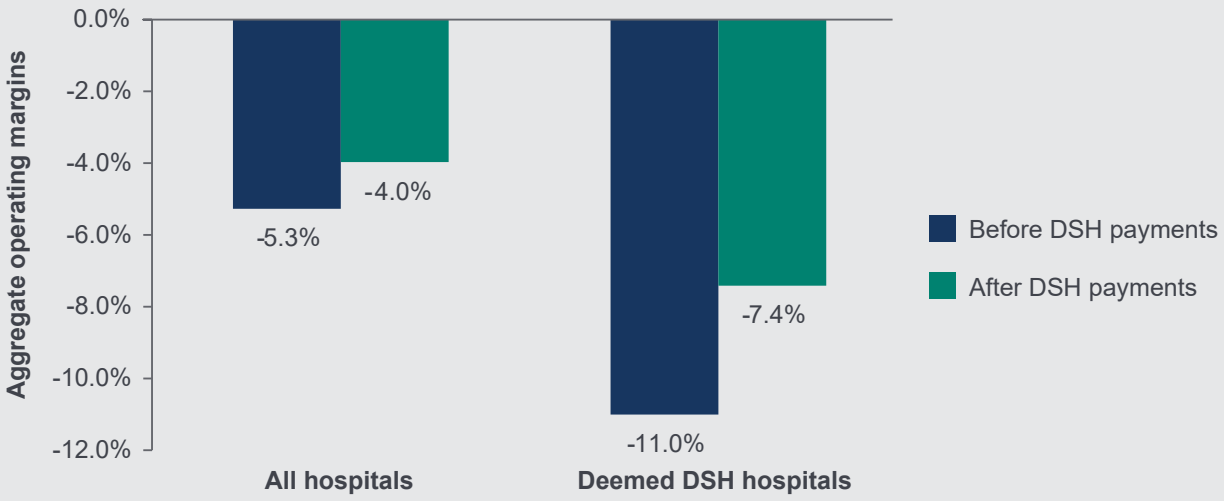
These funding allocations raised questions regarding how to define a safety-net hospital. In 2017, the Commission analyzed other criteria that could be used to identify hospitals that should receive DSH payments (MACPAC 2017). However, because DSH hospitals vary so much in terms of patient mix, mission, and market characteristics, it is difficult to identify a single, use-based standard that is applicable

to all hospitals and would be a clear improvement on current law. Academics, government agencies, and hospital associations have attempted to develop a common definition of a safety-net hospital. While the specific identification methods tend to vary, most use common factors such as patient mix (e.g., payer, patient demographics), geography, and measurements of hospital finances (e.g., amount of uncompensated care or total margin) (AHA 2022b, Dickson et al. 2022, MedPAC 2022). The Commission plans to monitor the extent to which DSH hospitals overlap with these definitions and other ways of evaluating the extent to which a hospital is part of the safety net.

Total and operating margins. In FY 2020, the aggregate operating margin was negative across all hospitals after counting DSH payments (-4.0 percent) and were 4.2 percentage points lower than in FY 2019.[35] Declines in operating margin were particularly acute for deemed DSH hospitals (Figure 4-6). Deemed DSH hospitals reported a negative aggregate operating margin both before and after counting DSH payments (-11.0 percent and -7.4 percent, respectively).

Due to federal provider relief funding, FY 2020 total margin for hospitals appeared healthier than operating margins. Total margin accounts for all types of income (e.g., investment income) and funding that hospitals received from federal and state governments during the PHE. The aggregate total margin for all hospitals after DSH payments was 7.1 percent in FY 2020, which was

FIGURE 4-6. Aggregate Hospital Operating Margin before and after DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2020



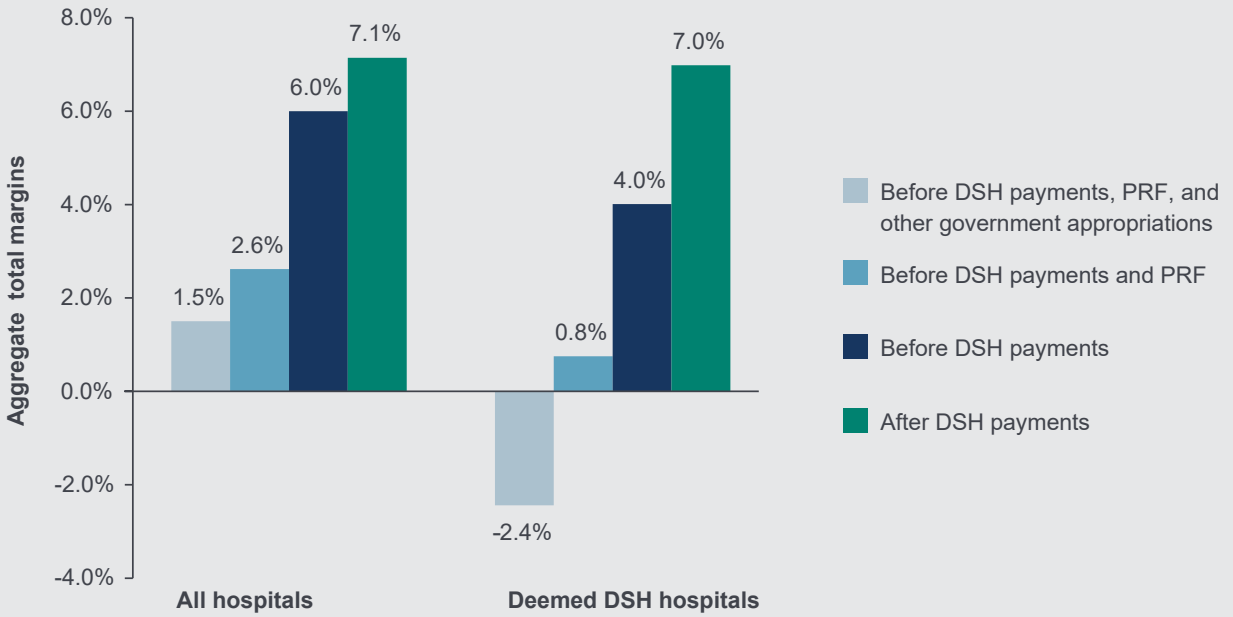
Notes: DSH is disproportionate share hospital. FY is fiscal year. Operating margins measure income from patient care divided by net patient revenue. Operating margin before DSH payments in FY 2020 was estimated using state plan rate year (SPRY) 2018 DSH audit data. The analysis excluded outlier hospitals reporting an operating margin greater than 1.5 times the interquartile range from the first and third quartiles. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. This analysis includes hospitals in California and Massachusetts that appear to meet the eligibility criteria for deemed DSH hospitals but did not receive DSH payments because these states instead distributed DSH funding through safety-net care pools authorized under waiver expenditure authority of Section 1115 of the Social Security Act. For further discussion of this methodology and limitations, see Appendix 4B.

Sources: MACPAC, 2023, analysis of FYs 2019–2020 Medicare cost reports and SPRY 2017–2018 as-filed Medicaid DSH audits.

0.2 percentage points higher than in FY 2019 (Figure 4-7). Before counting DSH payments, PHE related federal spending, and other government appropriations, deemed DSH hospitals reported an aggregate total margin of -2.4 percent in FY 2020. After counting these payments and appropriations, deemed DSH hospitals reported a positive aggregate total margin (7.0 percent), which was comparable to the aggregate total margin reported for all hospitals (7.1 percent).

MACPAC will continue to analyze hospital margins as more data on the economic disruptions caused by COVID-19 become available. Federal support for hospitals was smaller in FY 2021 than in FY 2020, and hospitals remain concerned that workforce shortages are contributing to increased labor costs, potentially straining their finances (Swanson 2022, Russell 2021). At the same time, research has found that provider relief funding was greater than COVID-19-related costs, which helped contribute to higher all-payer margins in 2021 among all hospitals compared with the 2017–2020 reporting years (MedPAC 2022b). We expect these effects to be reflected in our analyses of operating and total margins in future reports.

FIGURE 4-7. Aggregate Hospital Total Margin before and after DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2020



Notes: DSH is disproportionate share hospital. FY is fiscal year. PRF is provider relief funding and Paycheck Protection Program forgiven loans that were disbursed during the COVID-19 public health emergency and are reported on worksheet G3 of the Medicare cost reports. Total margin includes revenue not directly related to patient care, such as investment income, parking receipts, and non-DSH state and local subsidies to hospitals. Total margin before DSH payments in FY 2020 were estimated using state plan rate year (SPRY) 2018 DSH audit data. Other government appropriations include state or local subsidies to hospitals that are not Medicaid payments. Analysis excluded outlier hospitals reporting a total margin greater than 1.5 times the interquartile range from the first and third quartiles. COVID-19 PRF relates to funding that was authorized under the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139). Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. This analysis includes hospitals in California and Massachusetts that appear to meet the eligibility criteria for deemed DSH hospitals but did not receive DSH payments because these states instead distributed DSH funding through safety-net care pools authorized under waiver expenditure authority of Section 1115 of the Social Security Act. For further discussion of this methodology and limitations, see Appendix 4B.

Sources: MACPAC, 2023, analysis of FY 2019–2020 Medicare cost reports and SPRY 2017–2018 as-filed Medicaid DSH audits.

Hospitals with High Levels of Uncompensated Care That Also Provide Essential Community Services

MACPAC is required to provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services. Given that the concept of essential community services is not defined elsewhere in Medicaid statute or regulation, MACPAC has developed a definition based on the types of services suggested in the statutory provision calling for MACPAC's study and the limits of available data (Box 4-4).

Using data from 2020 Medicare cost reports and the 2020 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2018, almost all (93 percent) provided at least one of the services included in MACPAC's definition of essential community services, 70 percent provided two of these services, and 56 percent provided three or more of these services. By contrast, among non-deemed DSH hospitals, 38 percent provided three or more of these services.

BOX 4-4. Identifying Hospitals with High Levels of Uncompensated Care That Provide Essential Community Services for Low-Income, Uninsured, and Other Vulnerable Populations

MACPAC's authorizing statute requires that MACPAC provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services (§ 1900 of the Social Security Act). Based on the types of services suggested in the statute and the limits of available data, we included the following services in our definition of essential community services in this report:

- burn services;
- dental services;
- graduate medical education;
- HIV/AIDS care;
- inpatient psychiatric services (through a psychiatric subunit or stand-alone psychiatric hospital);
- neonatal intensive care units;
- obstetrics and gynecology services;
- primary care services;
- substance use disorder services; and
- trauma services.

We also included deemed DSH hospitals that were designated as critical access hospitals because they may be the only hospital in their geographic areas. See Appendix 4B for further discussion of our methodology and its limitations.

DSH Allotment Reductions

In December 2020, Congress delayed implementation of the FY 2021 DSH reductions until FY 2024 and extended DSH allotment reductions until FY 2027. As such, DSH allotments are scheduled to be reduced by the following annual amounts beginning October 1, 2023:

- $8 billion in FY 2024;
- $8 billion in FY 2025;
- $8 billion in FY 2026; and
- $8 billion in FY 2027.

DSH allotment reductions are applied against unreduced DSH allotments—that is, the amounts that states would have received without DSH allotment reductions.

DSH funding remains an important source of revenue for many safety-net hospitals. The Commission is concerned that the magnitude of cuts in DSH funding under current law may disrupt the financial viability of some safety-net hospitals and the services that they provide. The Commission previously recommended that should DSH allotment reductions go into effect, they should be phased in gradually to help mitigate disruptions for DSH hospitals by providing more time

BOX 4-5. Factors Used in Disproportionate Share Hospital Health Reform Reduction Methodology

The Disproportionate Share Hospital (DSH) Health Reform Reduction Methodology (DHRM), finalized in September 2019, is used by the Centers for Medicare & Medicaid Services to calculate how DSH allotment reductions will be distributed across states. As required by statute, the DHRM applies five factors when calculating state DSH allotment reductions:

Low-DSH factor. Allocates a smaller proportion of the total DSH allotment reductions to low-DSH states based on the size of these states' DSH expenditures relative to their total Medicaid expenditures. Low-DSH states are defined in statute as states with FY 2000 DSH expenditures that were less than 3 percent of total state Medicaid medical assistance expenditures for FY 2000. There are 17 low-DSH states, a number that includes Hawaii, whose eligibility is based on a special statutory exception (§§ 1923(f)(5) and 1923(f)(6) of the Social Security Act).

Uninsured percentage factor. Imposes larger DSH allotment reductions on states with lower uninsured rates relative to other states. One-half of DSH reductions are based on this factor.

High volume of Medicaid inpatients factor. Imposes larger DSH allotment reductions on states that do not target DSH payments to hospitals with high Medicaid volume. The proportion of a state's DSH payments made to hospitals with Medicaid inpatient utilization that is one standard deviation above the mean (the same criteria used to determine deemed DSH hospitals) is compared among states. One-quarter of DSH reductions are based on this factor.

High level of uncompensated care factor. Imposes larger reductions on states that do not target DSH payments to hospitals with high levels of uncompensated care. The proportion of a state's DSH payments made to hospitals with above-average uncompensated care as a proportion of total hospital costs is compared among states. This factor is calculated using DSH audit data, which define uncompensated care costs as the sum of Medicaid shortfall and unpaid costs of care for uninsured individuals. One-quarter of DSH reductions are based on this factor.

Budget neutrality factor. An adjustment to the high Medicaid and high uncompensated care factors that accounts for DSH allotments that were used as part of the budget neutrality calculations for coverage expansions under waivers under Section 1115 of the Social Security Act as of July 2009. Specifically, DSH funding used for coverage expansions is excluded from the calculation of whether DSH payments were targeted to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care.

to plan for potential changes before the full amount of reductions takes effect. Phasing in reductions will give states time to adjust to other types of Medicaid hospital payment policies to account for DSH funding changes. Under current law, DSH allotment reductions will amount to more than half of unreduced DSH allotment amounts in FY 2024 (54 percent), while scheduled reductions under previous legislation were applied more gradually (CRS 2021). Unreduced DSH allotments continue to increase each year based on inflation, so FY 2027 DSH allotment reductions will be a slightly smaller share of states' unreduced allotments (52.8 percent).[36] In FY 2028 and beyond, there are no DSH allotment reductions scheduled. Thus, under current law, state DSH allotments will return to their higher, unreduced DSH allotment amounts in FY 2028.

DSH allotment reductions will be applied using the DSH Health Reform Reduction Methodology (DHRM). This methodology uses specific statutorily defined criteria, such as applying greater DSH reductions to states with lower uninsured rates and states that do not target their DSH payments to high-need hospitals (Box 4-5).

Reduced versus unreduced DSH allotments

To determine the effects of DSH allotment reductions on state finances and DSH funding, we compared states' reduced DSH allotments to their unreduced amounts. For FY 2024, we estimated DSH allotment reduction factors using the most reliable and latest available data.

BOX 4-6. COVID-19 Public Health Emergency Unwinding and DSH Allotments

The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) increases federal disproportionate share hospital (DSH) allotments during the public health emergency (PHE) so that total available state and federal DSH funding is the same as it would have been without the application of the increased federal medical assistance percentage (FMAP) applied during the PHE. Without this adjustment, total available state and federal DSH funding would decrease when the FMAP increases.

Between FY 2020 and FY 2023, ARPA increased federal DSH allotments to correspond with the 6.2 percentage point increase in the FMAP added by the Families First and Coronavirus Response Act of 2020 (FFCRA) (P.L. 116-127). In FY 2023, this adjustment amounted to a $1.5 billion increase in federal DSH allotments above what they would be without ARPA. This change kept total DSH funding the same. Without the ARPA adjustment and with the enhanced FMAP under the FFCRA, total state and federal DSH funding would have been $2.5 billion lower than it would have been without ARPA.

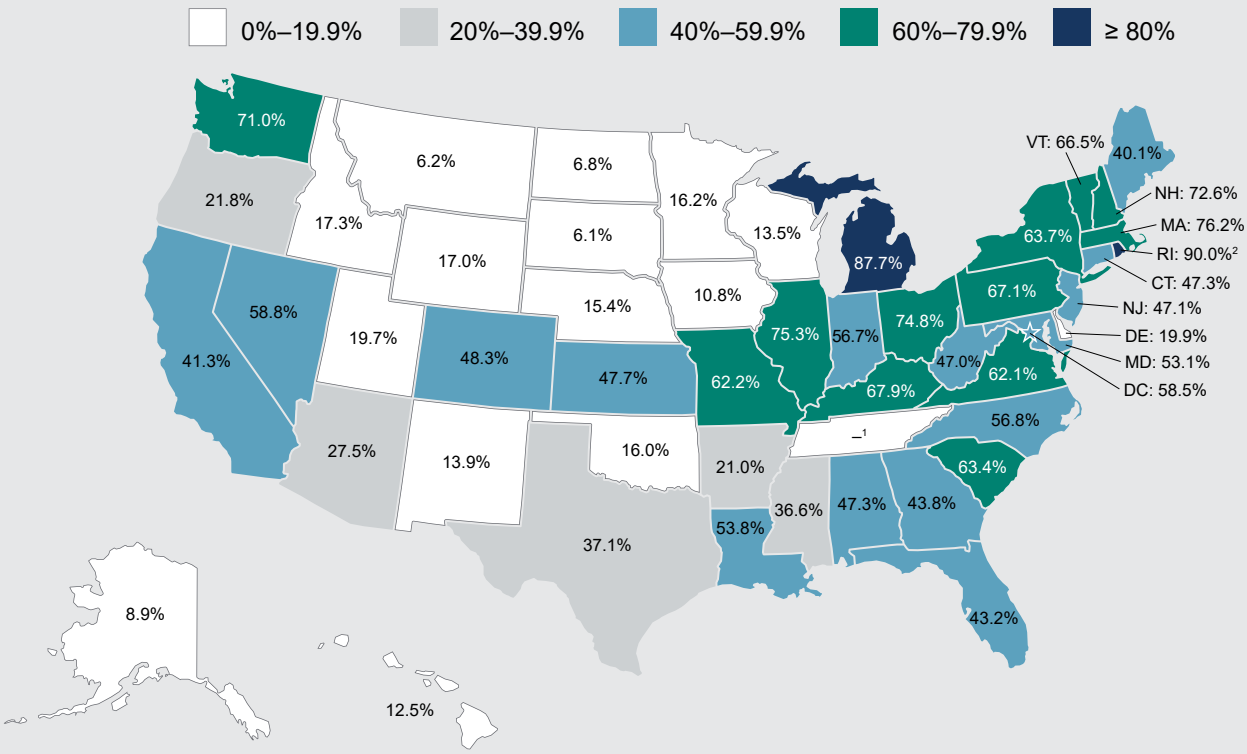
The Consolidated Appropriations Act, 2023 (P.L. 117-328), phases out the increased FMAP between April 1 and December 31, 2023. Specifically, from April to June 2023, the FMAP increase will be reduced from 6.2 percentage points to 5 percentage points; from July to September 2023, the FMAP increase will be reduced to 2.5 percentage points; from October to December 2023, the FMAP increase will be reduced to 1.5 percentage points; and after December 31, 2023, there will be no increased FMAP.

The Centers for Medicare & Medicaid Services have not yet issued guidance about how these changes to the increased FMAP will affect federal DSH allotments for FY 2023 and FY 2024. Because states have the flexibility to claim DSH payments at any point within a fiscal year, the changes in the FMAP for FY 2023 are not expected to affect FY 2023 DSH allotments. However, the Biden administration stated that the PHE will end May 11. If this were to occur, then states would not receive an ARPA adjustment to their DSH allotments for FY 2024. However, since the FMAP is increased by 1.5 percentage points at the start of FY 2024, then states will have less total DSH funding for DSH payments claimed between October and December 2023.

We used data from the 2021 American Community Survey and SPRY 2018 Medicaid DSH audits to estimate the reduction factors for each state and projected the DSH allotments in FY 2024 (Dobson and DaVanzo 2016). Because of the lack of available data, we did not attribute any reductions based on the budget neutrality factor. In each of FYs 2024–2027, DSH allotments will be reduced by $8 billion. The distribution of DSH allotment reductions among states is expected to be largely the same between FY 2024 and FY 2027, assuming states do not change their DSH targeting policies and there are no changes in uninsured rates across states.

This analysis compares reduced allotments to unreduced allotments in FY 2024. DSH allotments have been increased during the PHE. When the PHE ends, states will face additional reductions in federal DSH allotments. In FY 2023 DSH allotments were increased by $1.5 billion due to ARPA, but this increase will phase out by FY 2024 (Box 4-6).

FIGURE 4-8. Decrease in State DSH Allotments as a Percentage of Unreduced Allotments by State, FY 2024



Notes: DSH is disproportionate share hospital. FY is fiscal year. This analysis compares reduced allotments with unreduced allotments. This analysis assumes that the public health emergency ends in FY 2023. When the public health emergency ends, the enhanced federal DSH funding authorized under the American Rescue Plan Act of 2021 (P.L. 117-2) will expire.

— Dash indicates a 0 percent reduction in state DSH allotments.

[1] Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act).

[2] DSH allotment reductions are capped at 90 percent of unreduced allotments with the remaining allotment reductions being distributed to other states. This cap only affects DSH allotment reductions in Rhode Island.

Sources: MACPAC, 2023, analysis of preliminary unreduced and reduced allotment amounts using data provided by the Centers for Medicare & Medicaid Services as of October 11, 2022, and projected for FY 2024.

Reductions will affect states differently, with estimated reductions ranging from 6.1 percent to 90 percent of unreduced allotment amounts (Figure 4-8). Smaller reductions are applied to states with historically low DSH allotments (low-DSH states). Because of the low-DSH factor, the projected percentage reduction in DSH allotments for the 17 low-DSH states (15.2 percent in the aggregate) is much smaller than that of the other states (55.8 percent in the aggregate). Among states that do not meet the low-DSH criteria, the projected percentage reduction in DSH allotments is larger for states that expanded Medicaid as of January 1, 2022 (59.3 percent in the aggregate), than for states that did not expand Medicaid (47.3 percent in the aggregate). (Complete state-by-state information on DSH allotment reductions and other factors are included in Appendix 4A.)

DSH allotment reductions will result in a corresponding decline in spending only in states that spend their full DSH allotment. For example, 11 states are projected to have FY 2024 DSH allotment reductions that are smaller than the state's unspent DSH funding in FY 2020. This means that these states could make DSH payments from their reduced FY 2024 allotment equal to the payments that they made from their FY 2020 allotment.[37]

We do not know how states will respond to these reductions. As noted previously, some states distribute DSH funding proportionally among all eligible hospitals, while other states target payments to a small number of hospitals. States may also take different approaches to reductions, with some states applying them to all DSH hospitals and others reducing DSH payments only at specific hospitals. Because the DHRM applies larger reductions to states that do not target DSH funds to hospitals with high Medicaid volume or high levels of uncompensated care, states might change their DSH targeting policies to minimize their DSH allotment reductions in future years.[38] However, the DSH audit data used to calculate the DSH targeting factors in the DHRM have a substantial data lag of four to five years. States may be able to offset some of the effects of DSH allotment reductions by increasing other types of Medicaid payments to providers; however, each type of Medicaid payment is subject to its own unique rules and limitations. For example, DSH payments can be used to pay for unpaid costs of care for the uninsured, while other types of supplemental payments pay only for Medicaid costs and cannot exceed a reasonable estimate of what Medicare would have paid for the same service.[39]

Relationship of DSH Allotments to the Statutorily Required Factors

As in our past reports, we find little meaningful relationship between FY 2023 DSH allotments and the factors that Congress asked MACPAC to consider.[40] In summary, we found the following:

- **Changes in number of uninsured individuals.** FY 2023 DSH allotments range from less than $100 per uninsured individual in four states to more than $1,000 per uninsured individual in 11 states and the District of Columbia. Nationally, the average FY 2023 DSH allotment per uninsured individual is $568.
- **Amount and sources of hospital uncompensated care costs.** As a share of hospital charity care and bad debt costs reported on 2020 Medicare cost reports, FY 2023 federal DSH allotments range from less than 10 percent in five states to more than 80 percent in eight states and the District of Columbia. Nationally, these allotments are equal to 38.6 percent of hospital charity care and bad debt costs. At the state level, total FY 2023 DSH funding (including state and federal funds combined) exceeds total reported hospital charity care and bad debt costs in 12 states and the District of Columbia. Because DSH payments to hospitals may not exceed total uncompensated care costs for Medicaid and uninsured patients, states with DSH allotments larger than the amount of charity care and bad debt in their state will not be able to spend their full DSH allotment.[41]
- **Number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.** Finally, there continues to be no meaningful relationship between state DSH allotments and the number of deemed DSH hospitals in the state that provided at least one of the services included in MACPAC's definition of essential community services.

Endnotes

[1] This chapter includes findings for fiscal year (FY) 2020, which includes the period from October 1, 2019, through September 30, 2020, and FY 2021, which covers October 1, 2020, through September 30, 2021. The first determination of a nationwide public health emergency due to the novel coronavirus (COVID-19) was on January 31, 2020, midway through FY 2020. Thus, any FY 2020 findings include periods both before and during the public health emergency. We have noted any specific policy changes or data reporting differences related to the public health emergency as appropriate in the chapter.

[2] The changes to the DSH definition of Medicaid shortfall made by the Consolidated Appropriations Act, 2021 (P.L. 116-260), were effective beginning October 1, 2021. The law excludes enrollees who receive principal coverage through a third party (private insurance or Medicare) from calculations of Medicaid shortfall. The law also exempts the top 3 percent of hospitals that treat a high number and share of patients who are eligible for Medicare and receive Supplemental Security Income from this change. Additional background information about the history of DSH payment policy is included in Chapter 1 and Appendix A of MACPAC's first DSH report (MACPAC 2016).

[3] In addition to supplemental payments, some hospitals may also partially finance the non-federal share of DSH through provider taxes and other contributions. Assessing DSH payment within the context of these other financing and payment arrangements would assist the Commission in determining the extent to which DSH fulfills its statutory intent of funding hospitals that serve a high proportion of Medicaid beneficiaries and uninsured individuals. Additional information on all types of Medicaid payments to hospitals is provided in MACPAC's issue brief *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2021c). Additional information on how provider taxes are used to finance the non-federal share within Medicaid is provided in MACPAC's issue brief *Health Care-Related Taxes in Medicaid* (MACPAC 2021a).

[4] Aggregate fee-for-service base and supplemental payments, excluding DSH payments, cannot exceed what is known as the "upper payment limit." The limit is a reasonable estimate of what Medicare fee for service would have paid for the same service. States must demonstrate that they are complying with the upper payment limit by submitting hospital-level supplemental payment data annually to the Centers for Medicare & Medicaid Services (CMS). CMS is developing a data source that will start collecting this information for all supplemental payments after October 1, 2021; however, MACPAC is not yet aware of any publicly available analyses of this data (CMS 2021a).

[5] In February 2016, the Commission recommended that the Secretary of HHS collect and report complete information on Medicaid payments to hospitals to help inform analyses about the targeting of DSH payments. The Consolidated Appropriations Act, 2021 (P.L. 116-260), requires HHS to collect and report data on non-DSH supplemental payments beginning October 1, 2021. The Consolidated Appropriations Act, 2021, does not require states to collect and report data on the sources of non-federal share necessary to determine net payments at the provider level, which was also a component of MACPAC's prior recommendation. Subsequent guidance has clarified that all supplemental payments under Section 1115 demonstration waiver authority, such as Delivery System Reform Incentive Payments and uncompensated care pool payments, will be included in the new reporting requirements. However, supplemental payments made through managed care (also known as directed payments) will not be included in this new supplemental payment database. Though CMS is supposed to report this information for all supplemental payments after October 1, 2021, MACPAC is not aware of any publicly available analyses of this data (CMS 2021b).

[6] Medicare also makes DSH payments. Hospitals are generally eligible for Medicare DSH payments based on their Medicaid share of total inpatient days and Medicare Supplemental Security Income share of total Medicare days. Historically, the amount of Medicare DSH percentage add-on that a hospital was eligible to receive was based solely on a hospital's Medicaid and Supplemental Security Income patient use, but since 2014, the ACA has required that most Medicare DSH funds be converted to uncompensated care payments, distributed to hospitals based on each hospital's uncompensated care relative to other Medicare DSH hospitals. In addition, the ACA linked the total amount of funding for Medicare uncompensated care payments to the uninsured rate.

[7] The Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) created and expanded the Boren Amendment, which removed the requirement for Medicaid to pay nursing facilities and hospitals according to Medicare cost principles. P.L. 97-35 also required states to consider the situation of hospitals that serve a disproportionate share of low-income patients with special needs when setting Medicaid provider

payment rates for inpatient services. These payments are now known as "DSH payments." For more on the history of DSH payments, please refer to Chapter 1: Overview of Medicaid Policy on Disproportionate Share Hospital Payments in MACPAC's *March 2016 Report to Congress on Medicaid and CHIP* (MACPAC 2016).

[8] Medicaid DSH payments are not subject to this upper payment limit, but Medicaid DSH payments to an individual hospital are limited to that hospital's uncompensated care costs for Medicaid-enrolled and uninsured patients.

[9] The most recent marginal change to allotments was a temporary increase to DSH allotments for the remainder of the COVID-19 PHE. The increased DSH allotments did not change the total amount of DSH funding available (state and federal combined amounts) for the PHE but did increase the federal share of available funding by 6.2 percentage points.

[10] This amount is inclusive of the ARPA increase to DSH allotments, which were made retroactive to FY 2020.

[11] DSH spending in FY 2021 includes spending funded from prior year allotments. Total DSH spending includes an estimate of the portion of California's spending under its demonstration waiver authorized under Section 1115 of the Act, which is based on the state's DSH allotment.

[12] States are required to submit claims for federal Medicaid funding within two years after the payment is made. However, states can sometimes claim federal match for adjusted DSH payments that are made after the initial two-year window (*Virginia Department of Medical Assistance Services*, DAB No. 1838 (2002), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2002/dab1838.html).

[13] Analysis excludes unspent federal DSH funding that is reported for California and Massachusetts ($1.5 billion in FY 2020) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

[14] Uncompensated care is calculated differently on DSH audits and Medicare cost reports. Medicare cost reports define uncompensated care as charity care and bad debt for non-Medicare beneficiaries, including uncompensated care for individuals with insurance, which is not part of the Medicaid DSH definition of uncompensated care. Medicare cost reports do not include reliable information on Medicaid shortfall, which is part of the Medicaid DSH definition.

[15] During the COVID-19 pandemic, the process for finalizing DSH allotments was delayed longer than usual, and FY 2018 DSH allotments were not finalized until March 2022 (CMS 2022a).

[16] Though CMS provides states with draft preliminary and draft final allotments before publication on the *Federal Register*, it is unclear if states receive them with enough advance notice to appropriately plan their spenddown.

[17] States report hospital-specific DSH data on a SPRY basis, which often corresponds with the state fiscal year and may not align with the federal fiscal year.

[18] At the time of drafting this report, Delaware had not submitted its SPRY 2018 as-filed DSH audit to CMS. Therefore, we are relying on data from Delaware's SPRY 2017 as-filed DSH audit in this report.

[19] The 1997 Balanced Budget Act (P.L. 105-33) created the critical access hospital (CAH) certification to ensure that hospital care is accessible to beneficiaries in rural communities. To be CAH designated, a hospital must meet two location requirements: (1) it must be 35 miles from another hospital (including a CAH) or (2) be located more than a 15-mile drive from another hospital in areas of mountainous terrain or areas with only one-lane state highways or other local roads. However, a 2013 report found that 64 percent of CAHs do not meet these location requirements (GAO 2013).

[20] California made DSH payments to 6 percent of hospitals as reported on the as-filed Medicaid DSH audits for state FY 2018. However, this analysis does not include additional payments that the state made through its Section 1115 demonstration waiver that are financed with DSH funds.

[21] Analysis excludes California and Massachusetts because both states have hospitals that receive funding from safety-net care pools authorized under Section 1115 demonstration waivers that are financed with DSH funds. Analysis excludes New York and Alabama, which has no majority financing source for DSH payments. Analysis excludes Montana because it did not participate in GAO's survey collecting information on how states finance the non-federal share of DSH payments.

[22] This statistic includes only states that expanded Medicaid before January 1, 2021. Therefore, it does not include Missouri (expanded in October 2021) and Oklahoma (expanded in July 2021) (KFF 2022b).

[23] Missouri expanded Medicaid in October 2021 but also reported issues processing applications for its expansion population (CMS 2022b, KFF 2022b). CMS put Missouri on a mitigation plan to help improve the state's enrollment application wait times (CMS 2022c).

[24] Medicare cost reports define bad debt as debt for non-Medicare beneficiaries that also is not reimbursable by Medicare through other means (e.g., Medicare DSH payments).

[25] It should be noted that while uncompensated care increases every year, it has not increased as a percentage of operating expenses since 2015.

[26] Providers were allowed to use provider relief funding only for uncompensated care costs related to COVID-19, such as reimbursement for testing and treatment. Reimbursing uncompensated care unrelated to COVID-19 was not an allowable use of provider relief funds (HRSA 2022). This is further discussed later in the chapter.

[27] In previous years, MACPAC compared Medicare cost reports with Medicaid DSH audits to compare reporting of uncompensated care costs for the uninsured. While there is a large degree of correlation, the two datasets provide different figures. For example, average reported uncompensated care costs on Medicaid DSH audits were 28 percent lower than reported charity care and bad debt on the Medicare cost reports in FY 2017. This can partially be attributed to the different definitions of uncompensated care on cost reports when compared with Medicaid DSH audits. Medicaid DSH defines uncompensated care as unpaid costs of care for the uninsured and Medicaid shortfall, while cost report data on charity care includes both insured and uninsured individuals.

[28] Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 2020 Medicare cost report data used in this chapter have not been audited, so bad debt and charity care costs may not be reported consistently for all hospitals. CMS began to audit charity care and bad debt costs reported on Medicare cost reports in fall 2018 (CMS 2018).

[29] The AHA annual survey also differs from DSH audit data in its definition of Medicaid shortfall. Most notably, the AHA survey includes the costs of provider taxes, which are not included on DSH audits (Nelb et al. 2016).

[30] Forty-five percent of hospitals in Mississippi are not included on the state's SPRY 2018 DSH audit because these hospitals did not receive DSH payments.

[31] Medicaid DSH audits include data on base payment amounts within fee for service and managed care. States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a base payment within managed care or as a supplemental payment.

[32] Analysis of Medicaid payment-to-cost ratios is limited to DSH hospitals with complete DSH audit data. This analysis excludes institutions for mental disease and hospitals that are outside of the state that the Medicaid program operates in.

[33] In addition, the Families First and Coronavirus Response Act of 2020 (P.L. 116-127) provided an option for states to provide Medicaid coverage for diagnostic testing to uninsured individuals with COVID-19.

[34] For the purposes of distributing provider relief funding, the Health Resources and Services Administration defined safety net providers as acute care facilities with a disproportionate patient percentage (a measure used for calculation of Medicare DSH payments) of more than 20.2 percent, annual uncompensated care of more than $25,000 per bed, and a profit margin of 3 percent or less. Children's hospitals were also included if more than 20.2 percent of their inpatients were Medicaid patients (HRSA 2021).

[35] FY 2020 cost report data includes fiscal quarters before the pandemic started (CDC 2022).

[36] Unreduced allotments increase each year based on the Consumer Price Index for All Urban Consumers, and these inflation-based increases will apply even in years when DSH allotment reductions take effect.

[37] For states to spend the same amount of DSH funding in FY 2024 as they spent in FY 2020, DSH payments to individual hospitals may not exceed those hospitals' uncompensated care costs.

[38] Additional analyses of potential strategic state responses to the DSH allotment reduction methodology proposed by CMS are provided in Chapter 2 of MACPAC's 2016 DSH report (MACPAC 2016).

[39] Additional information on all types of Medicaid payments to hospitals is provided in MACPAC's issue brief *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2021c).

[40] All estimates of FY 2023 DSH allotments and the different measures of need are using the ARPA-enhanced allotments, which applied an enhanced FMAP of 6.2 percentage points to total DSH funding (state and federal amounts). To see our FY 2023 DSH allotment estimates with and without ARPA's enhanced allotments, please refer to Appendix 4A.

[41] For Medicaid DSH purposes, uncompensated care includes Medicaid shortfall, which is not included in the Medicare cost report definition of uncompensated care. As a result, the total amount of uncompensated care reported on Medicare cost reports may differ from the amount of uncompensated care costs that states can pay for with Medicaid DSH funds.

References

American Hospital Association (AHA). 2022a. *Underpayment by Medicare and Medicaid fact sheet*. Washington, DC: AHA. https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf.

American Hospital Association (AHA). 2022b. *Exploring metropolitan anchor hospitals and the communities they serve*. Washington, DC: AHA. https://www.aha.org/guidesreports/2022-10-21-exploring-metropolitan-anchor-hospitals-and-communities-they-serve.

American Hospital Association (AHA). 2021a. *Fact sheet: Underpayment by Medicare and Medicaid*. Washington, DC: AHA. https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid.

American Hospital Association (AHA). 2021b. *Financial effects of COVID-19: Hospital outlook for the remainder of 2021*. Washington, DC: AHA. https://www.aha.org/guidesreports/2021-09-21-financial-effects-covid-19-hospital-outlook-remainder-2021.

American Hospital Association (AHA). 2020. *Underpayment by Medicare and Medicaid fact sheet, January 2020*. Washington, DC: AHA. https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf.

American Hospital Association (AHA). 2015. *Underpayment by Medicare and Medicaid fact sheet*. Washington, DC: AHA. https://www.aha.org/system/files/2018-02/2015-medicaremedicaidunderpmt.pdf.

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2022. *Unwinding the Medicaid continuous enrollment provision: projected enrollment effects and policy approaches*. Washington, DC: ASPE. https://aspe.hhs.gov/reports/unwinding-medicaid-continuous-enrollment-provision.

Birkmeyer, J., A. Barnato, N. Birkmeyer, et al. 2020. The impact of the COVID-19 pandemic on hospital admissions in the United States. Health Affairs 39, no. 11: 2010–2017. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00980.

Buxbaum, J.D., and S. Rak. 2021. Equity and the uneven distribution of federal COVID-19 relief funds to US hospitals. *Health Affairs* 40, no. 9: 1473–1482. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02018.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2022. COVID data tracker. Accessed October 31, 2022. Atlanta, GA: CDC. https://covid.cdc.gov/covid-data-tracker/#hospitalizations.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. Medicaid program; final FY 2018, final FY 2019, preliminary FY 2020, and preliminary FY 2021 disproportionate share hospital allotments, and final FY 2018, final FY 2019, preliminary FY 2020, and preliminary FY 2021 institutions for mental diseases disproportionate share hospital limits. Notice. *Federal Register* 87, (March 16): 14858–14888. https://www.federalregister.gov/documents/2022/03/16/2022-05459/medicaid-program-final-fy-2018-final-fy-2019-preliminary-fy-2020-and-preliminary-fy-2021.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. *MAGI application processing time snapshot report: January–March 2022*. Baltimore, MD: CMS. https://www.medicaid.gov/state-overviews/downloads/magi-app-process-time-snapshot-rpt-jan-mar-2022.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. *Missouri eligibility and enrollment mitigation plan—July 11, 2022*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/eligibility/downloads/missouri-mitigation-plan.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. E-mail to MACPAC, January 4.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. Letter from Daniel Tsai to state Medicaid directors regarding "New supplemental payment reporting and Medicaid disproportionate share hospital requirements under the Consolidated Appropriations Act, 2021." December 10, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/smd21006.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and policy changes and fiscal year 2019 rates; quality reporting requirements for specific providers; Medicare and Medicaid electronic health record (EHR) incentive programs (promoting interoperability programs) requirements for eligible hospitals, critical access hospitals, and eligible professionals; Medicare cost reporting requirements; and physician certification and recertification of claims. Final rule. *Federal Register* 83, no. 160 (August 17): 41144–41784. https://www.federalregister.gov/d/2018-16766.

Congressional Budget Office (CBO). 2022. *The budget and economic outlook: 2022 to 2032*. Washington, DC: CBO. https://www.cbo.gov/system/files/2022-05/51118-2022-05-Budget-Projections.xlsx.

Congressional Research Service (CRS). 2021. *Medicaid disproportionate share hospital (DSH) reductions*. Washington, DC: CRS. https://crsreports.congress.gov/product/pdf/IF/IF10422.

Congressional Research Service (CRS). 2020. *Medicaid disproportionate share hospital payments*. Washington, DC: CRS. https://crsreports.congress.gov/product/pdf/R/R42865.

Dickson, E., S. Purves, and C. Shields. 2022. To protect America's safety-net hospitals, establish a new federal designation. *Health Affairs Forefront*, October 3. https://www.healthaffairs.org/content/forefront/protect-america-s-safety-net-hospitals-establish-new-federal-designation.

Dobson, A., and J.E. DaVanzo. 2016. *DSH allotment reduction projections*. Washington, DC: Medicaid and CHIP Payment and Access Commission.

Gallagher, K., J. Gerhart, K. Amin, et al. 2021. *Early 2021 data show no rebound in health care utilization*. Washington, DC: Kaiser Family Foundation. August 2021. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/.

Health care cost institute (HCCI). 2022. 2020 *Health care cost and utilization report*. Washington, DC: HCCI. https://healthcostinstitute.org/images//pdfs/HCCI_2020_Health_Care_Cost_and_Utilization_Report.pdf.

Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services. 2022. Terms and conditions. https://www.hrsa.gov/provider-relief/compliance/terms-conditions.

Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services. 2021. PRB provider relief fund general information FAQ. https://www.hrsa.gov/provider-relief/faq/general?field_faq_category_tid=All&combine=.

Holahan, J., B.K. Bruen, and D. Liska. 1998. *The decline in Medicaid spending growth in 1996: Why did it happen?* Washington, DC: Urban Institute. http://webarchive.urban.org/UploadedPDF/410365.pdf.

Kaiser Family Foundation (KFF). 2022a. *2022 Employer health benefits survey*. San Francisco, CA: KFF. https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/.

Kaiser Family Foundation (KFF). 2022b. *Status of state Medicaid expansion decisions: Interactive map*. Washington, DC: KFF. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

Kaiser Family Foundation (KFF). 2021. *Employer health benefits: 2021 annual survey*. San Francisco, CA: KFF. https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.

Keisler-Starkey, K., and L.N. Bunch. 2022. *Health insurance coverage in the United States: 2021*. Washington, DC: U.S. Census Bureau. https://www.census.gov/library/publications/2022/demo/p60-278.html.

Klem, J.D. 2000. Medicaid spending: A brief history. *Health Care Financing Review* 22, no. 1: 105–112. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00fallpg105.pdf.

Matherlee, K. 2002. *The federal-state struggle over Medicaid matching funds: An update*. Washington, DC: National Health Policy Forum. https://hsrc.himmelfarb.gwu.edu/sphhs_centers_nhpf/99/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. Chapter 3: Annual analysis of disproportionate share hospital allotments to states. In *Report to Congress on Medicaid and CHIP*. March 2022. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-3-Annual-Analysis-of-Disproportionate-Share-Hospital-Allotments-to-States.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. *Health care-related taxes in Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/publication/health-care-related-taxes-in-medicaid/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021c. *Medicaid base and supplemental payments to hospitals*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021d. *COVID relief funding for Medicaid providers*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/02/COVID-Relief-Funding-for-Medicaid-Providers.pdf.

Medicaid and CHIP Payments and Access Commission (MACPAC). 2020a. Letter from Melanie Bella to Alex Azar regarding "The decision to extend the public health emergency." August 25, 2020. https://www.macpac.gov/wp-content/uploads/2020/08/Letter-to-the-HHS-Secretary-Regarding-Notice-to-States-on-Unwinding-the-COVID-19-Public-Health-Emergency.pdf.

Medicaid and CHIP Payments and Access Commission (MACPAC). 2020b. Letter from Melanie Bella to Seema Verma regarding "The decision to distribute the first wave of funding to health care providers under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) based on institutions' Medicare fee-for-service revenues." April 10, 2020. https://www.macpac.gov/wp-content/uploads/2020/04/Letter-to-the-CMS-Administrator-on-CARES-Act-Fund-Distribution.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. Chapter 3: Annual analysis of disproportionate share hospital allotments to states. In *Report to Congress on Medicaid and CHIP*. March 2019. Washington, DC: MACPAC. https://www.macpac.gov/publication/march-2019-analysis-of-disproportionate-share-hospital-allotments-to-states/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. Chapter 3: Improving the targeting of disproportionate share hospital payments to providers. In *Report to Congress on Medicaid and CHIP*. March 2017. Washington, DC: MACPAC. https://www.macpac.gov/publication/improving-the-targeting-of-disproportionate-share-hospital-payments-to-providers/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. *Report to Congress on Medicaid disproportionate share hospital payments*. February 2016. Washington, DC: MACPAC. https://www.macpac.gov/publication/report-to-congress-on-medicaid-disproportionate-share-hospital-payments/.

Medicare Payment Advisory Commission (MedPAC). 2022. Chapter 3: Supporting safety-net providers. In *Report to Congress: Medicare and the health care delivery system*. June 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch3_MedPAC_Report_to_Congress_SEC.pdf.

Medicare Payment Advisory Commission (MedPAC). 2022b. Assessing payment adequacy and updating payments: hospital inpatient and outpatient services; and supporting Medicare safety-net hospitals. December 2022. https://www.medpac.gov/wp-content/uploads/2021/10/Tab-C-Hospital-Updates-8-Dec-2022.pdf

Mehrotra, A., M. Chernew, D. Linetsky, et al. 2020a. *The impact of the COVID-19 pandemic on outpatient visits: Visits return to pre-pandemic levels, but not for all providers and patients*. New York, NY: Commonwealth Fund. https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels.

Mehrotra, A., M. Chernew, D. Linetsky, et al. 2020b. *The impact of the COVID-19 pandemic on outpatient visits: Changing patterns of care in the newest COVID-19 hot spots*. New York, NY: Commonwealth Fund. https://www.commonwealthfund.org/publications/2020/aug/impact-covid-19-pandemic-outpatient-visits-changing-patterns-care-newest.

Mehrotra, A., M. Chernew, D. Linetsky, et al. 2020c. *The impact of the COVID-19 pandemic on outpatient visits: A rebound emerges*. New York, NY: Commonwealth Fund. https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits.

Nelb, R., J. Teisl, A. Dobson, et al. 2016. For disproportionate-share hospitals, taxes and fees curtail Medicaid payments. *Health Affairs* 35, no. 12: 2277–2281. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0602.

Russell, J. 2021. Hospitals spend millions in race to hire traveling nurses. *Indianapolis Business Journal*, October 8. https://www.ibj.com/articles/hospitals-race-to-hire-traveling-nurses.

Swanson, E. 2022. *National hospital flash report summary: December 2021*. Chicago, IL: KaufmanHall. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-summary-december-2021.

U.S. Government Accountability Office (GAO). 2021a. Questionnaire data on states' methods for financing Medicaid payments in 2018, a supplement to GAO-21-98. E-mail to MACPAC, February 23.

U.S. Government Accountability Office (GAO). 2021b. *COVID-19: Sustained federal action is crucial as pandemic enters its second year*. March 2021. Washington, DC: GAO. https://www.gao.gov/products/gao-21-387.

U.S. Government Accountability Office (GAO). 2014. *Medicaid financing: States' increased reliance on funds from health care providers and local governments warrants improved CMS data collection*. Washington, DC: GAO. https://www.gao.gov/assets/670/665077.pdf.

U.S. Government Accountability Office (GAO). 2013. *Most critical access hospitals would not meet the location requirements if required to re-enroll in Medicare*. Washington, DC: GAO. https://oig.hhs.gov/oei/reports/oei-05-12-00080.pdf.

APPENDIX 4A: State-Level Data

TABLE 4A-1. State DSH allotments, FYs 2023–2024 (millions)

State	FY 2023 without ARPA adjustment		FY 2023 with ARPA adjustment		FY 2024 without ARPA adjustment	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$25,401.9**	**$14,466.6**	**$25,401.9**	**$16,041.5**	**$11,904.3**	**$6,824.2**
Alabama	**560.1**	405.7	**560.1**	440.4	**302.3**	219.0
Alaska	**53.7**	26.9	**53.7**	30.2	**50.2**	25.1
Arizona	**192.0**	133.6	**192.0**	145.5	**142.6**	99.2
Arkansas	**79.8**	56.9	**79.8**	61.9	**64.6**	46.0
California	**2,892.5**	1,446.3	**2,892.5**	1,625.6	**1,740.5**	870.2
Colorado	**244.1**	122.0	**244.1**	137.2	**129.3**	64.7
Connecticut	**527.7**	263.9	**527.7**	296.6	**284.8**	142.4
Delaware	**20.4**	11.9	**20.4**	13.2	**16.8**	9.8
District of Columbia	**115.4**	80.8	**115.4**	88.0	**49.1**	34.4
Florida	**439.4**	263.9	**439.4**	291.1	**255.8**	153.6
Georgia	**537.0**	354.6	**537.0**	387.9	**309.5**	204.3
Hawaii	**22.9**	12.9	**22.9**	14.3	**20.6**	11.5
Idaho	**30.9**	21.7	**30.9**	23.6	**26.2**	18.4
Illinois	**567.3**	283.6	**567.3**	318.8	**143.5**	71.8
Indiana	**429.5**	282.0	**429.5**	308.6	**190.6**	125.1
Iowa	**82.3**	52.0	**82.3**	57.1	**75.3**	47.5
Kansas	**91.1**	54.4	**91.1**	60.1	**48.8**	29.2
Kentucky	**265.1**	191.3	**265.1**	207.7	**87.2**	63.0
Louisiana	**1,344.5**	904.6	**1,344.5**	987.9	**637.2**	428.7
Maine	**218.9**	138.5	**218.9**	152.1	**134.3**	85.0
Maryland	**201.2**	100.6	**201.2**	113.1	**96.8**	48.4
Massachusetts	**804.8**	402.4	**804.8**	452.3	**196.1**	98.0
Michigan	**540.3**	349.6	**540.3**	383.1	**68.0**	44.0
Minnesota	**194.0**	98.5	**194.0**	110.6	**166.7**	84.7
Mississippi	**258.4**	201.2	**258.4**	217.2	**167.8**	130.6
Missouri	**949.7**	625.0	**949.7**	683.9	**368.0**	242.2
Montana	**23.4**	15.0	**23.4**	16.4	**22.5**	14.4
Nebraska	**64.5**	37.3	**64.5**	41.3	**55.9**	32.4

TABLE 4A-1. (continued)

State	FY 2023 without ARPA adjustment		FY 2023 with ARPA adjustment		FY 2024 without ARPA adjustment	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$25,401.9**	**$14,466.6**	**$25,401.9**	**$16,041.5**	**$11,904.3**	**$6,824.2**
Nevada	**97.4**	61.0	**97.4**	67.1	**41.1**	25.7
New Hampshire	**422.4**	211.2	**422.4**	237.4	**118.7**	59.4
New Jersey	**1,698.6**	849.3	**1,698.6**	954.6	**921.7**	460.9
New Mexico	**36.7**	26.9	**36.7**	29.1	**32.4**	23.7
New York	**4,238.2**	2,119.1	**4,238.2**	2,381.9	**1,578.0**	789.0
North Carolina	**574.8**	389.2	**574.8**	424.8	**254.7**	172.5
North Dakota	**24.4**	12.6	**24.4**	14.1	**23.3**	12.0
Ohio	**843.0**	536.0	**843.0**	588.2	**217.9**	138.5
Oklahoma	**70.9**	47.8	**70.9**	52.2	**61.1**	41.1
Oregon	**99.0**	59.7	**99.0**	65.9	**79.3**	47.8
Pennsylvania	**1,423.9**	740.5	**1,423.9**	828.7	**480.6**	249.9
Rhode Island	**158.9**	85.8	**158.9**	95.6	**16.3**	8.8
South Carolina	**612.2**	432.1	**612.2**	470.0	**229.7**	162.1
South Dakota	**25.7**	14.6	**25.7**	16.2	**24.7**	14.0
Tennessee[1]	**80.3**	53.1	**80.3**	58.1	**80.3**	53.1
Texas	**2,107.2**	1,261.6	**2,107.2**	1,392.2	**1,359.4**	813.9
Utah	**39.3**	25.9	**39.3**	28.3	**32.3**	21.3
Vermont	**53.2**	29.7	**53.2**	33.0	**18.2**	10.2
Virginia	**228.2**	115.6	**228.2**	129.7	**88.6**	44.9
Washington	**488.1**	244.1	**488.1**	274.3	**145.3**	72.6
West Virginia	**120.3**	89.1	**120.3**	96.5	**65.3**	48.3
Wisconsin	**207.5**	124.7	**207.5**	137.6	**184.0**	110.6
Wyoming	**0.6**	0.3	**0.6**	0.3	**0.5**	0.3

Notes: DSH is disproportionate share hospital. FY is fiscal year. ARPA is the American Rescue Plan Act of 2021 (P.L. 117-2), which provided increased DSH allotments to states during the COVID-19 public health emergency. This table assumes no ARPA increased DSH allotments for FY 2024. State and federal totals are different from data reported on the Centers for Medicare & Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES) because MBES estimates apply a traditional federal medical assistance percentage (FMAP) to the ARPA-increased federal allotment.

[1] Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act).

Sources: MACPAC, 2023, analysis of CMS MBES and CBO 2022.

TABLE 4A-2. FY 2024 DSH Allotment Reductions by State (millions)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Reductions as a percent of unreduced allotments
Total	**$26,030.2**	**$14,824.2**	**$14,125.9**	**$8,000.0**	**54.0%**
Alabama	**574.0**	415.7	**271.7**	196.8	47.3
Alaska	**55.1**	27.5	**4.9**	2.4	8.9
Arizona	**196.8**	136.9	**54.2**	37.7	27.5
Arkansas	**81.8**	58.3	**17.2**	12.3	21.0
California	**2,964.3**	1,482.2	**1,223.8**	611.9	41.3
Colorado	**250.1**	125.1	**120.8**	60.4	48.3
Connecticut	**540.8**	270.4	**256.1**	128.0	47.3
Delaware	**20.9**	12.2	**4.2**	2.4	19.9
District of Columbia	**118.3**	82.8	**69.2**	48.4	58.5
Florida	**450.3**	270.4	**194.5**	116.8	43.2
Georgia	**550.4**	363.4	**240.9**	159.1	43.8
Hawaii	**23.5**	13.2	**2.9**	1.6	12.5
Idaho	**31.7**	22.2	**5.5**	3.8	17.3
Illinois	**581.4**	290.7	**437.8**	218.9	75.3
Indiana	**440.1**	289.0	**249.5**	163.9	56.7
Iowa	**84.3**	53.2	**9.1**	5.7	10.8
Kansas	**93.3**	55.8	**44.5**	26.6	47.7
Kentucky	**271.6**	196.0	**184.4**	133.1	67.9
Louisiana	**1,377.9**	927.0	**740.7**	498.3	53.8
Maine	**224.3**	142.0	**90.0**	57.0	40.1
Maryland	**206.2**	103.1	**109.4**	54.7	53.1
Massachusetts	**824.7**	412.4	**628.6**	314.3	76.2
Michigan	**553.7**	358.3	**485.7**	314.3	87.7
Minnesota	**198.8**	101.0	**32.1**	16.3	16.2
Mississippi	**264.8**	206.2	**97.0**	75.6	36.6
Missouri	**973.3**	640.5	**605.3**	398.4	62.2
Montana	**23.9**	15.3	**1.5**	0.9	6.2
Nebraska	**66.1**	38.3	**10.2**	5.9	15.4
Nevada	**99.8**	62.5	**58.7**	36.8	58.8
New Hampshire	**432.9**	216.5	**314.2**	157.1	72.6

TABLE 4A-2. (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Reductions as a percent of unreduced allotments
Total	**$26,030.2**	**$14,824.2**	**$14,125.9**	**$8,000.0**	**54.0%**
New Jersey	**1,740.7**	870.4	**819.0**	409.5	47.1
New Mexico	**37.6**	27.5	**5.2**	3.8	13.9
New York	**4,343.4**	2,171.7	**2,765.3**	1,382.7	63.7
North Carolina	**589.1**	398.8	**334.3**	226.4	56.8
North Dakota	**25.1**	12.9	**1.7**	0.9	6.8
Ohio	**863.9**	549.3	**646.0**	410.7	74.8
Oklahoma	**72.7**	49.0	**11.6**	7.8	16.0
Oregon	**101.5**	61.2	**22.2**	13.4	21.8
Pennsylvania	**1,459.3**	758.8	**978.7**	508.9	67.1
Rhode Island	**162.9**	87.9	**146.6**	79.1	90.0
South Carolina	**627.4**	442.8	**397.7**	280.7	63.4
South Dakota	**26.3**	14.9	**1.6**	0.9	6.1
Tennessee[1]	**80.3**	53.1	**—**	—	—
Texas	**2,159.5**	1,292.9	**800.1**	479.0	37.1
Utah	**40.2**	26.5	**7.9**	5.2	19.7
Vermont	**54.5**	30.4	**36.3**	20.2	66.5
Virginia	**233.9**	118.4	**145.2**	73.6	62.1
Washington	**500.2**	250.1	**355.0**	177.5	71.0
West Virginia	**123.3**	91.3	**58.0**	42.9	47.0
Wisconsin	**212.7**	127.8	**28.6**	17.2	13.5
Wyoming	**0.6**	0.3	**0.1**	0.1	17.0

Notes: FY is fiscal year. DSH is disproportionate share hospital. Under current law, federal DSH allotments will be reduced by $8 billion in FY 2024. This table assumes that FY 2024 DSH allotments are not increased based on the adjustment included in the American Rescue Plan Act of 2021 (P.L. 117-2) that applies during the public health emergency. MACPAC lacks the data to estimate the budget neutrality factor, and therefore, that factor is not used in our estimates. For further discussion of methodology and limitations, see Appendix 4B.

— Dash indicates zero.

[1] Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act).

Sources: MACPAC, 2023, analysis of CBO 2022, Census 2022, SPRY 2017-2018 as-filed Medicaid DSH Audits, and Dobson and DaVanzo 2016.

TABLE 4A-3. Number of Uninsured Individuals and Uninsured Rate by State, 2019–2021

State	2019		2021		Difference in uninsured (2019–2021)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population
Total	**29,639**	**9.2%**	**28,227**	**8.6%**	**-1,412**	**-0.5%**
Alabama	469	9.7	489	9.9	20	0.1
Alaska	86	12.2	80	11.4	-6	-0.8
Arizona	809	11.3	766	10.7	-43	-0.6
Arkansas	271	9.1	273	9.2	2	0.0
California	3,002	7.7	2,713	7.0	-289	-0.7
Colorado	453	8.0	455	8.0	2	0.0
Connecticut	207	5.9	184	5.2	-23	-0.7
Delaware	63	6.6	57	5.7	-6	-0.8
District of Columbia	25	3.5	24	3.7	-1	0.2
Florida	2,784	13.2	2,598	12.1	-186	-1.1
Georgia	1,398	13.4	1,339	12.6	-59	-0.8
Hawaii	56	4.2	54	3.9	-2	-0.2
Idaho	191	10.8	166	8.8	-25	-2.0
Illinois	923	7.4	875	7.0	-48	-0.4
Indiana	578	8.7	504	7.5	-74	-1.2
Iowa	156	5.0	151	4.8	-5	-0.2
Kansas	262	9.2	264	9.2	2	0.0
Kentucky	283	6.4	251	5.7	-32	-0.8
Louisiana	404	8.9	345	7.6	-59	-1.3
Maine	107	8.0	78	5.7	-29	-2.3
Maryland	357	6.0	369	6.1	12	0.1
Massachusetts	204	3.0	173	2.5	-31	-0.5
Michigan	571	5.8	495	5.0	-76	-0.8
Minnesota	273	4.9	252	4.5	-21	-0.4
Mississippi	377	13.0	343	11.9	-34	-1.1
Missouri	604	10.0	571	9.4	-33	-0.6
Montana	87	8.3	89	8.2	2	-0.1
Nebraska	158	8.3	138	7.1	-20	-1.2
Nevada	348	11.4	362	11.6	14	0.2

TABLE 4A-3. (continued)

State	2019		2021		Difference in uninsured (2019–2021)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population
Total	**29,639**	**9.2%**	**28,227**	**8.6%**	**-1,412**	**-0.5%**
New Hampshire	84	6.3	71	5.1	-13	-1.1
New Jersey	692	7.9	657	7.2	-35	-0.7
New Mexico	205	10.0	207	10.0	2	0.0
New York	1,007	5.2	1,019	5.2	12	0.0
North Carolina	1,157	11.3	1,078	10.4	-79	-0.8
North Dakota	51	6.9	59	7.9	8	1.0
Ohio	758	6.6	758	6.5	0	-0.1
Oklahoma	553	14.3	538	13.8	-15	-0.5
Oregon	299	7.2	255	6.1	-44	-1.1
Pennsylvania	726	5.8	702	5.5	-24	-0.3
Rhode Island	43	4.1	47	4.3	4	0.3
South Carolina	548	10.8	512	10.0	-36	-0.8
South Dakota	88	10.2	83	9.5	-5	-0.7
Tennessee	682	10.1	686	10.0	4	-0.2
Texas	5,234	18.4	5,224	18.0	-10	-0.4
Utah	307	9.7	299	9.0	-8	-0.6
Vermont	28	4.5	23	3.7	-5	-0.8
Virginia	658	7.9	574	6.8	-84	-1.1
Washington	496	6.6	488	6.4	-8	-0.2
West Virginia	118	6.7	107	6.1	-11	-0.6
Wisconsin	329	5.7	312	5.4	-17	-0.4
Wyoming	70	12.3	69	12.2	-1	-0.2

Notes: 0.0 indicates an amount between -5,000 and 5,000 that rounds to zero; 0.0 percent indicates an amount between 0.05 percent and 0.05 percent that rounds to zero. Data are taken from the U.S. Census Bureau's American Community Survey. The American Community Survey released synthetic data for calendar year 2020, which means that they are estimates of state-level uninsured rates using multiple sources. Therefore, we are showing changes in the uninsured rate between 2019 and 2021.

Sources: MACPAC, 2023, analysis of Census 2022 and Keisler-Starkey and Bunch 2022.

TABLE 4A-4. State Levels of Uncompensated Care, FYs 2019–2020

State	Total hospital uncompensated care costs, 2019		Total hospital uncompensated care costs, 2020		Difference in total hospital uncompensated care costs, 2020-2019	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Total	**$40,524**	**4.0%**	**$41,901**	**4.1%**	**$1,376**	**0.0%**
Alabama	**748**	6.5	**814**	6.7	**66**	0.2
Alaska	**53**	2.7	**51**	2.6	**-1**	-0.1
Arizona	**451**	2.7	**486**	2.8	**35**	0.1
Arkansas	**232**	3.3	**268**	3.7	**37**	0.5
California	**2,498**	2.0	**2,570**	2.3	**72**	0.3
Colorado	**409**	2.6	**446**	2.7	**37**	0.1
Connecticut	**239**	1.9	**264**	1.9	**26**	0.0
Delaware	**83**	2.5	**91**	2.7	**9**	0.1
District of Columbia	**64**	1.6	**65**	1.7	**1**	0.0
Florida	**3,891**	7.4	**4,111**	7.6	**220**	0.1
Georgia	**2,369**	8.7	**2,586**	9.2	**218**	0.5
Hawaii	**52**	1.5	**58**	1.7	**6**	0.2
Idaho	**203**	3.6	**182**	3.1	**-21**	-0.5
Illinois	**1,591**	3.9	**1,680**	4.0	**89**	0.1
Indiana	**862**	3.5	**805**	3.2	**-57**	-0.3
Iowa	**218**	2.2	**208**	2.0	**-9**	-0.2
Kansas	**403**	4.1	**416**	4.1	**13**	0.0
Kentucky	**342**	2.3	**332**	2.2	**-10**	-0.2
Louisiana	**406**	2.8	**414**	2.7	**8**	-0.1
Maine	**184**	3.0	**204**	3.2	**20**	0.2
Maryland	**550**	3.3	**625**	3.7	**76**	0.3
Massachusetts	**479**	1.7	**548**	1.8	**69**	0.2
Michigan	**619**	1.8	**619**	1.8	**-1**	0.0
Minnesota	**349**	1.7	**336**	1.6	**-13**	-0.1
Mississippi	**571**	7.0	**595**	7.1	**24**	0.2
Missouri	**1,267**	5.9	**1,336**	6.1	**68**	0.2
Montana	**88**	2.0	**92**	2.0	**4**	0.0
Nebraska	**310**	4.6	**297**	4.2	**-12**	-0.4

TABLE 4A-4. (continued)

State	Total hospital uncompensated care costs, 2019		Total hospital uncompensated care costs, 2020		Difference in total hospital uncompensated care costs, 2020-2019	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Total	**$40,524**	**4.0%**	**$41,901**	**4.1%**	**$1,376**	**0.0%**
Nevada	**274**	4.3	**296**	4.5	**22**	0.2
New Hampshire	**160**	3.0	**158**	2.9	**-2**	-0.1
New Jersey	**1,089**	4.3	**1,186**	4.4	**97**	0.1
New Mexico	**154**	2.6	**158**	2.6	**4**	0.0
New York	**2,299**	2.8	**2,300**	2.7	**0**	-0.2
North Carolina	**1,841**	6.2	**1,982**	6.4	**141**	0.3
North Dakota	**92**	2.2	**103**	2.4	**11**	0.3
Ohio	**1,153**	2.9	**1,165**	2.8	**13**	0.0
Oklahoma	**765**	6.9	**772**	6.7	**8**	-0.2
Oregon	**368**	2.7	**381**	2.8	**13**	0.1
Pennsylvania	**866**	1.9	**838**	1.8	**-28**	-0.2
Rhode Island	**67**	1.7	**73**	1.9	**6**	0.2
South Carolina	**920**	6.6	**918**	6.1	**-2**	-0.5
South Dakota	**134**	3.0	**132**	2.7	**-2**	-0.3
Tennessee	**1,167**	5.8	**1,131**	5.4	**-36**	-0.4
Texas	**6,899**	10.7	**7,298**	10.7	**399**	0.0
Utah	**366**	4.5	**336**	4.0	**-30**	-0.6
Vermont	**55**	2.0	**49**	1.7	**-6**	-0.3
Virginia	**1,097**	5.1	**839**	3.8	**-257**	-1.2
Washington	**519**	2.2	**534**	2.2	**15**	0.0
West Virginia	**197**	2.7	**237**	3.2	**40**	0.5
Wisconsin	**410**	1.8	**417**	1.8	**7**	0.0
Wyoming	**103**	5.7	**97**	5.2	**-6**	-0.5

Notes: FY is fiscal year. Uncompensated care is calculated using Medicare cost reports, which define uncompensated care as charity care and non-Medicare and non-reimbursable Medicare bad debt. 0.0 indicates an amount between -500,000 and 500,000 that rounds to zero; 0.0 percent indicates an amount between 0.05 percent and 0.05 percent that rounds to zero. Because of changes in Medicare cost report definitions that changed uncompensated care reporting for 2015 and subsequent years, these data are not comparable with data for prior years.

Source: MACPAC, 2023, analysis of Medicare cost reports for FYs 2019–2020.

TABLE 4A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria by State, FY 2018

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,957**	**2,507**	**42%**	**749**	**13%**	**695**	**12%**
Alabama	114	78	68	7	6	7	6
Alaska	24	3	13	1	4	1	4
Arizona	114	41	36	39	34	34	30
Arkansas	104	7	7	1	1	1	1
California[1]	408	26	6	23	6	15	4
Colorado	104	35	34	12	12	12	12
Connecticut	39	7	18	3	8	3	8
Delaware[2]	15	3	20	3	20	3	20
District of Columbia	12	7	58	5	42	4	33
Florida	251	72	29	33	13	32	13
Georgia	164	121	74	20	12	18	11
Hawaii	26	12	46	2	8	2	8
Idaho	51	25	49	7	14	6	12
Illinois	203	8	4	8	4	8	4
Indiana	165	55	33	11	7	10	6
Iowa	123	10	8	9	7	9	7
Kansas	149	63	42	18	12	18	12
Kentucky	116	98	84	43	37	38	33
Louisiana	205	61	30	39	19	36	18
Maine	38	1	3	1	3	1	3
Maryland	58	10	17	7	12	7	12
Massachusetts[3]	97	–	–	–	–	–	–
Michigan	161	106	66	9	6	9	6
Minnesota	140	30	21	10	7	10	7

TABLE 4A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,957**	**2,507**	**42%**	**749**	**13%**	**695**	**12%**
Mississippi	108	59	55	18	17	18	17
Missouri	136	102	75	23	17	22	16
Montana	66	7	11	4	6	4	6
Nebraska	98	26	27	9	9	9	9
Nevada	57	20	35	4	7	4	7
New Hampshire	30	26	87	4	13	4	13
New Jersey	97	76	78	25	26	25	26
New Mexico	55	8	15	5	9	4	7
New York	196	185	94	44	22	44	22
North Carolina	128	82	64	22	17	21	16
North Dakota	50	2	4	1	2	1	2
Ohio	229	155	68	15	7	15	7
Oklahoma	145	57	39	12	8	11	8
Oregon	63	21	33	10	16	10	16
Pennsylvania	223	166	74	34	15	28	13
Rhode Island	14	10	71	2	14	2	14
South Carolina	84	60	71	16	19	14	17
South Dakota	61	21	34	10	16	10	16
Tennessee	139	70	50	24	17	16	12
Texas	575	177	31	93	16	92	16
Utah	58	38	66	6	10	5	9
Vermont	16	13	81	1	6	1	6
Virginia	109	37	34	7	6	6	6
Washington	105	60	57	15	14	12	11

TABLE 4A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,957**	**2,507**	**42%**	**749**	**13%**	**695**	**12%**
West Virginia	62	43	69	14	23	13	21
Wisconsin	143	93	65	16	11	16	11
Wyoming	29	14	48	4	14	4	14

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 80 DSH hospitals that did not submit an FY 2020 Medicare cost report. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our definition of essential community services includes the following services that we could identify based on the limits of available data: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, primary care services, substance use disorder services, and trauma services.

— Dash indicates zero.

[1] Analysis excludes 17 hospitals that received funding under the state's Global Payment Program as authorized under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[2] Delaware did not submit a state plan rate year (SPRY) 2018 DSH audit, and this analysis uses its SPRY 2017 DSH audit.

[3] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Act allows it to use all of its DSH funding for the state's safety-net care pool. However, at least eight hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

Sources: MACPAC, 2023, analysis of AHA 2022, Medicare cost reports for FY 2020, and SPRY 2017–2018 as-filed Medicaid DSH audits.

TABLE 4A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals by State, SPRY 2018

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**772,886**	**441,276**	**57%**	**148,203**	**19%**	**43,091**	**26,920**	**62%**	**12,447**	**29%**
Alabama	14,661	13,006	89	842	6	697	633	91	105	15
Alaska	1,410	593	42	80	6	104	54	52	3	2
Arizona	15,249	7,434	49	7,233	47	996	669	67	658	66
Arkansas	9,354	978	10	127	1	374	32	8	2	0
California[1]	72,651	4,765	7	3,268	4	4,958	437	9	294	6
Colorado	10,757	4,753	44	1,990	19	673	365	54	195	29
Connecticut	7,672	1,174	15	553	7	493	66	13	47	10
Delaware[2]	2,632	473	18	473	18	147	35	24	35	24
District of Columbia	2,970	2,176	73	1,076	36	238	184	77	98	41
Florida	56,029	23,309	42	12,740	23	2,805	1,638	58	1,166	42
Georgia	22,138	18,337	83	5,202	23	1,227	1,092	89	473	39
Hawaii	2,651	2,267	86	261	10	183	171	93	48	26
Idaho	3,180	2,451	77	1,046	33	132	114	87	56	43
Illinois	30,205	1,865	6	1,865	6	1,682	118	7	118	7
Indiana	16,998	7,986	47	3,810	22	913	543	59	358	39
Iowa	7,344	2,580	35	2,534	35	337	216	64	213	63
Kansas	8,379	4,779	57	3,256	39	266	201	76	183	69
Kentucky	14,217	13,230	93	4,815	34	895	841	94	369	41
Louisiana	16,449	8,564	52	3,408	21	801	411	51	210	26
Maine	2,985	51	2	51	2	135	1	0	1	0
Maryland	12,544	2,449	20	1,721	14	819	115	14	45	5
Massachusetts[3]	18,733	–	–	–	–	1,456	–	–	–	–
Michigan	23,953	17,610	74	2,080	9	1,354	936	69	194	14
Minnesota	11,284	6,175	55	1,975	17	623	467	75	202	32
Mississippi	10,090	5,562	55	2,260	22	420	251	60	150	36
Missouri	18,194	13,994	77	2,523	14	933	595	64	164	18

TABLE 4A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**772,886**	**441,276**	**57%**	**148,203**	**19%**	**43,091**	**26,920**	**62%**	**12,447**	**29%**
Montana	2,927	351	12	231	8	108	17	16	12	11
Nebraska	5,571	3,758	67	1,409	25	184	174	95	103	56
Nevada	7,403	4,447	60	1,459	20	538	415	77	205	38
New Hampshire	2,787	2,561	92	859	31	122	118	97	73	60
New Jersey	21,380	19,816	93	6,472	30	1,081	1,034	96	464	43
New Mexico	4,297	1,018	24	217	5	339	87	26	13	4
New York	45,210	44,291	98	9,326	21	3,553	3,487	98	991	28
North Carolina	22,126	19,241	87	7,321	33	1,211	1,136	94	517	43
North Dakota	2,587	132	5	25	1	87	2	3	0	0
Ohio	32,142	26,922	84	5,432	17	1,790	1,525	85	581	32
Oklahoma	11,107	6,833	62	769	7	480	318	66	28	6
Oregon	6,940	3,921	56	1,704	25	444	309	70	175	39
Pennsylvania	35,818	32,266	90	6,614	18	1,825	1,744	96	606	33
Rhode Island	2,849	2,129	75	869	31	168	148	88	99	59
South Carolina	12,234	10,927	89	3,410	28	592	572	97	291	49
South Dakota	2,739	1,909	70	1,549	57	90	87	96	81	90
Tennessee	18,602	14,159	76	5,618	30	952	825	87	469	49
Texas	68,275	39,084	57	19,878	29	3,074	2,429	79	1,571	51
Utah	5,460	4,475	82	968	18	224	209	93	75	34
Vermont	1,135	972	86	415	37	52	52	100	30	58
Virginia	16,409	9,842	60	2,406	15	736	554	75	209	28
Washington	11,978	9,120	76	1,439	12	860	663	77	133	15
West Virginia	5,834	5,145	88	1,703	29	324	309	95	150	46
Wisconsin	12,986	10,639	82	2,679	21	573	513	90	180	31
Wyoming	1,364	758	56	245	18	22	11	50	4	19

TABLE 4A-6. (continued)

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Excludes 80 DSH hospitals that did not submit a fiscal year (FY) 2020 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. For further discussion of the methodology and limitations, see Appendix 4B.

— Dash indicates zero; 0 indicates an amount less than 500 that rounds to zero; 0 percent indicates an amount less than 0.5 percent that rounds to zero.

[1] Analysis excludes 17 hospitals that received funding under California's Global Payment Program demonstration waiver under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[2] Delaware did not submit a SPRY 2018 DSH audit, and this analysis uses its SPRY 2017 DSH audit.

[3] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Act allows it to use all of its DSH funding for the state's safety-net care pool. However, at least eight hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

Sources: MACPAC, 2023, analysis of SPRY 2017–2018 as-filed Medicaid DSH audits and Medicare cost reports for FYs 2018–2020.

TABLE 4A-7. Medicaid Payments to DSH Hospitals as a Share of Costs by State, SPRY 2018

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**40%**	**78%**	**8%**	**9%**	**95%**	**69%**	**7%**	**8%**	**85%**
Alabama	68	72	25	20	**117**	58	21	16	**95**
Alaska	8	96	–	1	**97**	94	–	1	**95**
Arizona	35	64	10	4	**77**	61	9	4	**74**
Arkansas[1]	6	69	23	25	**118**	65	22	24	**111**
California[2]	6	86	6	13	**105**	84	5	13	**102**
Colorado	34	68	24	9	**101**	64	23	8	**95**
Connecticut	10	79	8	3	**90**	78	8	3	**89**
Delaware[3]	13	94	–	18	**112**	84	–	16	**100**
District of Columbia	25	67	4	15	**86**	64	4	14	**82**
Florida	27	74	12	3	**89**	61	10	3	**74**
Georgia	73	83	7	9	**99**	64	5	7	**76**
Hawaii	46	79	14	2	**96**	78	14	2	**94**
Idaho	49	97	2	4	**102**	85	1	3	**90**
Illinois	2	71	0	36	**107**	47	0	24	**71**
Indiana	33	89	1	10	**99**	83	1	10	**93**
Iowa	8	80	3	11	**94**	78	3	10	**91**
Kansas	40	85	5	8	**98**	70	4	7	**81**
Kentucky	78	96	0	5	**102**	94	0	5	**99**
Louisiana	28	67	1	36	**104**	62	1	34	**97**
Maryland	10	106	–	4	**110**	96	–	3	**99**
Michigan	62	90	4	5	**99**	88	4	5	**97**
Minnesota	18	86	5	1	**92**	83	5	1	**89**
Mississippi	55	86	19	15	**121**	71	16	13	**99**
Missouri	68	94	–	16	**110**	79	–	13	**93**

TABLE 4A-7. (continued)

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**40%**	**78%**	**8%**	**9%**	**95%**	**69%**	**7%**	**8%**	**85%**
Montana[1]	11	76	35	1	**112**	73	33	1	**106**
Nebraska	24	77	2	5	**84**	65	2	4	**71**
Nevada	35	71	13	6	**90**	66	12	5	**83**
New Hampshire	83	69	0	27	**95**	64	0	25	**89**
New Jersey	67	80	4	8	**93**	69	4	7	**80**
New Mexico	15	92	3	7	**101**	89	3	6	**98**
New York	84	74	3	12	**89**	70	3	12	**85**
North Carolina	59	71	34	6	**110**	57	27	5	**89**
North Dakota[1]	2	100	6	3	**109**	92	6	3	**100**
Ohio	66	78	4	7	**89**	74	4	6	**85**
Oklahoma	37	76	31	3	**110**	62	25	2	**89**
Oregon[1]	30	97	6	3	**105**	94	5	3	**103**
Pennsylvania	72	54	9	6	**70**	52	9	6	**67**
Rhode Island	71	87	2	12	**101**	83	2	12	**97**
South Carolina	63	84	4	16	**104**	69	3	13	**85**
South Dakota	33	98	2	1	**101**	88	2	1	**91**
Tennessee	47	82	18	2	**101**	70	15	2	**87**
Texas	29	79	14	17	**110**	57	10	12	**80**
Utah[1]	64	102	20	3	**126**	84	16	3	**103**
Vermont	81	77	–	6	**84**	74	–	6	**81**
Virginia	34	80	14	5	**99**	65	11	4	**79**
Washington	55	83	2	6	**91**	80	2	6	**88**
West Virginia	65	67	15	3	**86**	65	15	3	**83**
Wisconsin	63	82	1	2	**85**	79	1	2	**82**
Wyoming	48	79	18	1	**97**	58	13	0	**72**

TABLE 4A-7. (continued)

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. A total of 2,355 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2020 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. The analysis also excludes Massachusetts, which does not make DSH payments to hospitals because it has a demonstration waiver under Section 1115 of the Social Security Act that allows the commonwealth to distribute DSH funding to hospitals through safety-net care pools. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on Medicaid DSH audits). States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a managed care payment or as a supplemental payment. Payments shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers may not sum due to rounding.

— Dash indicates zero; 0 percent indicates an amount less than 0.5 percent that rounds to zero.

[1] These states had DSH payments more than 100 percent of Medicaid costs and unpaid costs of care for the uninsured, according to as-filed DSH audits. Because DSH payments cannot exceed a hospital's Medicaid costs and unpaid costs of care for the uninsured, the Centers for Medicare & Medicaid Services (CMS) will recoup these funds. Final DSH payment amounts may change after CMS finalizes its review of DSH audits.

[2] DSH payments in California do not include DSH-financed spending under the state's Global Payment Program, which is authorized under the state's demonstration waiver under Section 1115 of the Act. California also has a special exception to DSH payments, and some hospitals can be paid up to 175% of uncompensated care costs.

[3] Delaware has not submitted a SPRY 2018 as-filed DSH audit. This analysis uses SPRY 2017 Delaware DSH audit data.

Source: MACPAC, 2023, analysis of SPRY 2017–2018 as-filed Medicaid DSH audits.

TABLE 4A-8. FY 2023 DSH Allotment per Uninsured Individual and Non-Elderly Low-Income Individual by State

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per uninsured individual (thousands)		FY 2023 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$25,401.9**	**$16,041.5**	**$899.9**	**$568.3**	**$326.4**	**$206.1**
Alabama	**560.1**	440.4	**1,146.4**	901.4	**388.4**	305.4
Alaska	**53.7**	30.2	**671.1**	377.2	**353.1**	198.4
Arizona	**192.0**	145.5	**250.7**	189.9	**107.7**	81.6
Arkansas	**79.8**	61.9	**292.3**	226.6	**85.5**	66.3
California	**2,892.5**	1,625.6	**1,066.4**	599.3	**319.9**	179.8
Colorado	**244.1**	137.2	**536.0**	301.2	**223.7**	125.7
Connecticut	**527.7**	296.6	**2,875.4**	1,615.9	**828.6**	465.6
Delaware	**20.4**	13.2	**360.0**	232.9	**99.0**	64.0
District of Columbia	**115.4**	88.0	**4,764.9**	3,630.8	**822.0**	626.4
Florida	**439.4**	291.1	**169.1**	112.0	**82.5**	54.7
Georgia	**537.0**	387.9	**401.1**	289.7	**190.8**	137.8
Hawaii	**22.9**	14.3	**421.1**	262.2	**86.4**	53.8
Idaho	**30.9**	23.6	**186.4**	142.3	**65.2**	49.7
Illinois	**567.3**	318.8	**648.3**	364.3	**203.4**	114.3
Indiana	**429.5**	308.6	**851.5**	611.9	**263.6**	189.4
Iowa	**82.3**	57.1	**544.0**	377.2	**121.9**	84.5
Kansas	**91.1**	60.1	**345.3**	227.8	**133.7**	88.2
Kentucky	**265.1**	207.7	**1,056.9**	828.3	**204.0**	159.9
Louisiana	**1,344.5**	987.9	**3,891.5**	2,859.5	**918.9**	675.2
Maine	**218.9**	152.1	**2,819.1**	1,959.0	**829.4**	576.3
Maryland	**201.2**	113.1	**544.8**	306.2	**183.2**	102.9
Massachusetts	**804.8**	452.3	**4,661.1**	2,619.6	**702.7**	394.9
Michigan	**540.3**	383.1	**1,090.6**	773.3	**222.7**	157.9
Minnesota	**194.0**	110.6	**770.4**	439.1	**189.6**	108.1
Mississippi	**258.4**	217.2	**753.4**	633.3	**270.6**	227.5
Missouri	**949.7**	683.9	**1,663.6**	1,197.9	**641.7**	462.1
Montana	**23.4**	16.4	**261.1**	183.6	**89.3**	62.8
Nebraska	**64.5**	41.3	**468.8**	300.4	**155.2**	99.4
Nevada	**97.4**	67.1	**269.3**	185.4	**115.9**	79.8
New Hampshire	**422.4**	237.4	**5,991.0**	3,367.0	**2,324.8**	1,306.5
New Jersey	**1,698.6**	954.6	**2,586.4**	1,453.6	**1,024.3**	575.6

TABLE 4A-8. (continued)

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per uninsured individual (thousands)		FY 2023 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$25,401.9**	**$16,041.5**	**$899.9**	**$568.3**	**$326.4**	**$206.1**
New Mexico	**36.7**	29.1	**177.1**	140.7	**54.5**	43.3
New York	**4,238.2**	2,381.9	**4,158.0**	2,336.8	**947.4**	532.4
North Carolina	**574.8**	424.8	**533.1**	394.0	**214.1**	158.2
North Dakota	**24.4**	14.1	**411.6**	237.7	**149.4**	86.3
Ohio	**843.0**	588.2	**1,112.5**	776.3	**302.4**	211.0
Oklahoma	**70.9**	52.2	**131.9**	97.0	**59.2**	43.5
Oregon	**99.0**	65.9	**387.6**	257.8	**101.8**	67.7
Pennsylvania	**1,423.9**	828.7	**2,029.7**	1,181.3	**531.6**	309.4
Rhode Island	**158.9**	95.6	**3,385.3**	2,036.6	**720.2**	433.2
South Carolina	**612.2**	470.0	**1,195.8**	918.1	**447.8**	343.8
South Dakota	**25.7**	16.2	**308.2**	194.0	**132.3**	83.2
Tennessee	**80.3**	58.1	**117.1**	84.7	**43.4**	31.4
Texas	**2,107.2**	1,392.2	**403.4**	266.5	**256.6**	169.6
Utah	**39.3**	28.3	**131.4**	94.8	**55.7**	40.2
Vermont	**53.2**	33.0	**2,275.0**	1,411.0	**465.9**	289.0
Virginia	**228.2**	129.7	**397.4**	225.9	**139.5**	79.3
Washington	**488.1**	274.3	**1,000.2**	562.1	**335.8**	188.7
West Virginia	**120.3**	96.5	**1,126.3**	903.5	**230.3**	184.8
Wisconsin	**207.5**	137.6	**664.7**	440.7	**175.0**	116.1
Wyoming	**0.6**	0.3	**8.6**	4.8	**4.6**	2.6

Notes: DSH is disproportionate share hospital. FY is fiscal year. Non-elderly low-income individuals are defined as individuals younger than age 65 with family incomes less than 200 percent of the federal poverty level. Totals show FY 2023 federal allotments that were increased by the American Rescue Plan Act of 2021 (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 4B.

Sources: MACPAC, 2023, analysis of Census 2022, Keisler-Starkey and Bunch 2022, SPRY 2017–2018 Medicaid as-filed DSH audits, and the CMS MBES.

TABLE 4A-9. FY 2023 DSH Allotment as a Percentage of Hospital Uncompensated Care Costs by State, FY 2020

State	FY 2023 federal DSH allotment (millions)	FY 2023 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2020	FY 2023 DSH funding (state and federal, millions)	FY 2023 total DSH funding as a percentage of hospital uncompensated care in the state, FY 2020
Total	**$16,041.5**	**38.6%**	**$25,401.9**	**61.1%**
Alabama	440.4	54.1	560.1	68.8
Alaska	30.2	59.2	53.7	105.3
Arizona	145.5	29.9	192.0	39.5
Arkansas	61.9	23.0	79.8	29.7
California	1,625.6	64.0	2,892.5	113.8
Colorado	137.2	30.8	244.1	54.8
Connecticut	296.6	112.2	527.7	199.6
Delaware	13.2	14.5	20.4	22.4
District of Columbia	88.0	135.1	115.4	177.3
Florida	291.1	7.1	439.4	10.7
Georgia	387.9	15.1	537.0	21.0
Hawaii	14.3	24.5	22.9	39.4
Idaho	23.6	13.2	30.9	17.3
Illinois	318.8	19.1	567.3	33.9
Indiana	308.6	38.3	429.5	53.3
Iowa	57.1	27.4	82.3	39.5
Kansas	60.1	14.4	91.1	21.9
Kentucky	207.7	63.8	265.1	81.5
Louisiana	987.9	240.2	1,344.5	326.9
Maine	152.1	74.5	218.9	107.2
Maryland	113.1	18.1	201.2	32.2
Massachusetts	452.3	82.6	804.8	147.0
Michigan	383.1	62.0	540.3	87.5
Minnesota	110.6	33.0	194.0	57.8
Mississippi	217.2	36.6	258.4	43.6
Missouri	683.9	51.2	949.7	71.1
Montana	16.4	17.9	23.4	25.4
Nebraska	41.3	13.9	64.5	21.7
Nevada	67.1	22.7	97.4	32.9
New Hampshire	237.4	149.8	422.4	266.6
New Jersey	954.6	81.0	1,698.6	144.1
New Mexico	29.1	18.6	36.7	23.4

TABLE 4A-9. (continued)

State	FY 2023 federal DSH allotment (millions)	FY 2023 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2020	FY 2023 DSH funding (state and federal, millions)	FY 2023 total DSH funding as a percentage of hospital uncompensated care in the state, FY 2020
Total	**$16,041.5**	**38.6%**	**$25,401.9**	**61.1%**
New York	2,381.9	103.8	4,238.2	184.8
North Carolina	424.8	21.4	574.8	29.0
North Dakota	14.1	13.6	24.4	23.6
Ohio	588.2	50.8	843.0	72.7
Oklahoma	52.2	6.8	70.9	9.2
Oregon	65.9	17.3	99.0	26.0
Pennsylvania	828.7	100.0	1,423.9	171.8
Rhode Island	95.6	130.8	158.9	217.4
South Carolina	470.0	51.4	612.2	67.0
South Dakota	16.2	12.3	25.7	19.5
Tennessee	58.1	5.3	80.3	7.3
Texas	1,392.2	19.5	2,107.2	29.6
Utah	28.3	8.4	39.3	11.7
Vermont	33.0	67.3	53.2	108.5
Virginia	129.7	15.5	228.2	27.2
Washington	274.3	52.7	488.1	93.7
West Virginia	96.5	41.2	120.3	51.4
Wisconsin	137.6	33.0	207.5	49.8
Wyoming	0.3	0.4	0.6	0.6

Notes: DSH is disproportionate share hospital. FY is fiscal year. Uncompensated care is calculated using 2019 Medicare cost reports, which define uncompensated care as charity care and bad debt. Because of recent changes in Medicare cost report definitions that changed uncompensated care reporting for 2015 and subsequent years, these data are not comparable with data for prior years. Totals show FY 2023 federal allotments that were increased by the American Rescue Plan Act of 2021 (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 4B.

Sources: MACPAC, 2023, analysis of AHA 2022, the CMS MBES, and SPRY 2018 as-filed Medicaid DSH audits.

TABLE 4A-10. FY 2023 DSH Allotment per Deemed DSH Hospital Providing at Least One Essential Community Service by State

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per deemed DSH hospital (millions)		FY 2023 DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$25,401.9**	**$16,041.5**	**$33.9**	**$21.4**	**$36.5**	**$23.1**
Alabama	**560.1**	440.4	**80.0**	62.9	**80.0**	62.9
Alaska	**53.7**	30.2	**53.7**	30.2	**53.7**	30.2
Arizona	**192.0**	145.5	**4.9**	3.7	**5.6**	4.3
Arkansas	**79.8**	61.9	**79.8**	61.9	**79.8**	61.9
California[1]	**2,892.5**	1,625.6	**125.8**	70.7	**192.8**	108.4
Colorado	**244.1**	137.2	**20.3**	11.4	**20.3**	11.4
Connecticut	**527.7**	296.6	**175.9**	98.9	**175.9**	98.9
Delaware	**20.4**	13.2	**6.8**	4.4	**6.8**	4.4
District of Columbia	**115.4**	88.0	**23.1**	17.6	**28.9**	22.0
Florida	**439.4**	291.1	**13.3**	8.8	**13.7**	9.1
Georgia	**537.0**	387.9	**26.9**	19.4	**29.8**	21.5
Hawaii	**22.9**	14.3	**11.5**	7.1	**11.5**	7.1
Idaho	**30.9**	23.6	**4.4**	3.4	**5.2**	3.9
Illinois	**567.3**	318.8	**70.9**	39.9	**70.9**	39.9
Indiana	**429.5**	308.6	**39.0**	28.1	**42.9**	30.9
Iowa	**82.3**	57.1	**9.1**	6.3	**9.1**	6.3
Kansas	**91.1**	60.1	**5.1**	3.3	**5.1**	3.3
Kentucky	**265.1**	207.7	**6.2**	4.8	**7.0**	5.5
Louisiana	**1,344.5**	987.9	**34.5**	25.3	**37.3**	27.4
Maine	**218.9**	152.1	**218.9**	152.1	**218.9**	152.1
Maryland	**201.2**	113.1	**28.7**	16.2	**28.7**	16.2
Massachusetts[2]	**804.8**	452.3	**–**	–	**–**	–
Michigan	**540.3**	383.1	**60.0**	42.6	**60.0**	42.6
Minnesota	**194.0**	110.6	**19.4**	11.1	**19.4**	11.1

TABLE 4A-10. (continued)

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per deemed DSH hospital (millions)		FY 2023 DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$25,401.9**	**$16,041.5**	**$33.9**	**$21.4**	**$36.5**	**$23.1**
Mississippi	**258.4**	217.2	**14.4**	12.1	**14.4**	12.1
Missouri	**949.7**	683.9	**41.3**	29.7	**43.2**	31.1
Montana	**23.4**	16.4	**5.8**	4.1	**5.8**	4.1
Nebraska	**64.5**	41.3	**7.2**	4.6	**7.2**	4.6
Nevada	**97.4**	67.1	**24.3**	16.8	**24.3**	16.8
New Hampshire	**422.4**	237.4	**105.6**	59.4	**105.6**	59.4
New Jersey	**1,698.6**	954.6	**67.9**	38.2	**67.9**	38.2
New Mexico	**36.7**	29.1	**7.3**	5.8	**9.2**	7.3
New York	**4,238.2**	2,381.9	**96.3**	54.1	**96.3**	54.1
North Carolina	**574.8**	424.8	**26.1**	19.3	**27.4**	20.2
North Dakota	**24.4**	14.1	**24.4**	14.1	**24.4**	14.1
Ohio	**843.0**	588.2	**56.2**	39.2	**56.2**	39.2
Oklahoma	**70.9**	52.2	**5.9**	4.3	**6.4**	4.7
Oregon	**99.0**	65.9	**9.9**	6.6	**9.9**	6.6
Pennsylvania	**1,423.9**	828.7	**41.9**	24.4	**50.9**	29.6
Rhode Island	**158.9**	95.6	**79.5**	47.8	**79.5**	47.8
South Carolina	**612.2**	470.0	**38.3**	29.4	**43.7**	33.6
South Dakota	**25.7**	16.2	**2.6**	1.6	**2.6**	1.6
Tennessee	**80.3**	58.1	**3.3**	2.4	**5.0**	3.6
Texas	**2,107.2**	1,392.2	**22.7**	15.0	**22.9**	15.1
Utah	**39.3**	28.3	**6.5**	4.7	**7.9**	5.7
Vermont	**53.2**	33.0	**53.2**	33.0	**53.2**	33.0
Virginia	**228.2**	129.7	**32.6**	18.5	**38.0**	21.6
Washington	**488.1**	274.3	**32.5**	18.3	**40.7**	22.9

TABLE 4A-10. (continued)

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per deemed DSH hospital (millions)		FY 2023 DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$25,401.9**	**$16,041.5**	**$33.9**	**$21.4**	**$36.5**	**$23.1**
West Virginia	**120.3**	96.5	**8.6**	6.9	**9.3**	7.4
Wisconsin	**207.5**	137.6	**13.0**	8.6	**13.0**	8.6
Wyoming	**0.6**	0.3	**0.1**	0.1	**0.1**	0.1

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 80 DSH hospitals that did not submit a Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our definition of community services includes the following services based on the limits of available data: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, primary care services, substance use disorder services, and trauma services. Totals show FY 2023 federal allotments that were increased by the American Rescue Plan Act of 2021 (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 4B.

— Dash indicates that the category is not applicable.

[1] Analysis excludes 17 hospitals that received funding under California's Global Payment Program demonstration waiver under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different mechanism.

[2] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Act allows it to use all of its DSH funding for the state's safety-net care pool instead; for this reason, no hospitals in the state can be categorized as DSH or deemed DSH hospitals.

Sources: MACPAC, 2023, analysis of AHA 2022, CMS MBES, and SPRY 2018 as-filed Medicaid DSH audits.

References

American Hospital Association (AHA). 2022. 2020 AHA annual survey data. Washington, DC: AHA. https://www.ahadata.com/aha-annual-survey-database.

Congressional Budget Office (CBO). 2022. *The budget and economic outlook: 2022 to 2032*. Washington, DC: CBO. https://www.cbo.gov/system/files/2022-05/51118-2022-05-Budget-Projections.xlsx.

Dobson, A., and J.E. DaVanzo. 2016. *DSH allotment reduction projections*. Washington, DC: Medicaid and CHIP Payment and Access Commission.

Keisler-Starkey, K., and L.N. Bunch. 2022. *Health insurance coverage in the United States: 2021*. Washington, DC: U.S. Census Bureau. https://www.census.gov/library/publications/2022/demo/p60-278.html.

U.S. Census Bureau (Census), U.S. Department of Commerce. 2022. American Community Survey. Washington, DC: Census. https://www.census.gov/programs-surveys/acs.

APPENDIX 4B: Methodology and Data Limitations

MACPAC used data from several different sources to analyze and describe Medicaid disproportionate share hospital (DSH) payments and their relationship to factors such as uninsured rates, uncompensated care, and DSH hospitals with high levels of uncompensated care that provide access to essential services. We also modeled DSH allotment reductions and simulated DSH payments under a variety of scenarios. In the following sections, we describe the data sources used in this analysis and the limitations associated with each one, and we review the modeling assumptions we made for our projections of DSH allotments and payments.

Primary Data Sources

DSH audit data

We used state plan rate year 2018 DSH audit reports, the most recent data available, to examine historic DSH spending and the distribution of DSH spending among a variety of hospital types. These data were provided by the Centers for Medicare & Medicaid Services (CMS) on an as-filed basis and are subject to change as CMS completes its internal review of state DSH audit reports.

Overall, 2,507 hospitals receiving DSH payments are represented in our analyses of DSH audit data. We did not include audit data provided by states for hospitals that did not receive DSH payments. (Sixty-one hospitals were excluded under this criterion.) Some hospitals received DSH payments from multiple states; we combined the data for duplicate hospitals so that each hospital would appear only once in the dataset.

Medicare cost reports

We used Medicare cost report data to examine uncompensated care for all hospitals in each state. A hospital that receives Medicare payments must file an annual Medicare cost report, which includes a range of financial and non-financial data about hospital performance and services provided. We excluded hospitals in U.S. territories, religious non-medical health care institutions, and hospitals participating in special Medicare demonstration projects. (Ninety-one hospitals were excluded under these criteria.) These facilities submit Medicare cost reports but do not receive Medicare DSH payments.

We linked DSH audit data and Medicare cost report data to create descriptive analyses of DSH hospitals and to identify deemed DSH hospitals. Hospitals were matched based on their CMS certification number. In total, 2,507 DSH hospitals were included in these analyses. We excluded 80 DSH hospitals without matching 2020 Medicare cost reports.

When using Medicare cost reports to analyze hospital uncompensated care, we excluded hospitals that reported uncompensated care costs that were greater than hospital operating expenses or had missing uncompensated care fields or the operating expenses. A total of 1,471 hospitals were excluded under this criterion.

When using Medicare cost reports to analyze hospital operating margins, we excluded hospitals with operating margins that were more than 1.5 times the interquartile range above the highest quartiles or below the lowest quartile. (Under this criterion, 386 hospitals were excluded from our analysis of fiscal year (FY) 2020 operating margins.) Operating margins were calculated by subtracting operating expenses (OE) from net patient revenue (NPR) and dividing the result by NPR: (NPR – OE) ÷ NPR. Total margins, in contrast, included additional types of hospital revenue, such as investment income, state or local subsidies, and revenue from other facets of hospital operations (e.g., parking lot receipts).

Definition of Essential Community Services

MACPAC's authorizing statute requires that our analysis include data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education and the continuum of primary through quaternary care, including the provision of trauma care and public health services (§ 1900 of the Social Security Act (the Act)).

In this report, we use the same definition to identify such hospitals that was used in MACPAC's 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*. This definition is based on a two-part test:

- Is the hospital a deemed DSH hospital?
- Does the hospital provide at least one essential service?

Deemed DSH hospital status

According to the Act, hospitals must meet one of two criteria to qualify as a deemed DSH hospital: (1) a Medicaid inpatient utilization rate greater than one standard deviation above the mean for hospitals in the state or (2) a low-income utilization rate greater than 25 percent (§ 1923(b)(1) of the Act). Because deemed DSH hospitals are statutorily required to receive DSH payments, we excluded from our analysis hospitals that did not receive DSH payments in 2018.

Calculation of the Medicaid inpatient utilization rate threshold for each state requires data from all hospitals in that state, and we relied on Medicare cost reports to make those calculations and to determine which hospitals exceeded this threshold. A major limitation of this approach is that Medicaid inpatient utilization reported on Medicare cost reports does not include services provided to Medicaid enrollees that were not paid for by Medicaid (e.g., Medicare-funded services for individuals who are dually eligible for Medicare and Medicaid). However, the Medicaid DSH definition of Medicaid inpatient utilization includes services provided to anyone who is eligible for Medicaid, even if Medicaid is not the primary payer. Thus, our identification of deemed DSH hospitals may omit some hospitals with high utilization by dually eligible beneficiaries and overstate the extent to which hospitals with low utilization by dually eligible beneficiaries (e.g., children's hospitals) exceed the threshold.

The low-income utilization rate threshold for deemed DSH hospitals is the same for all states (25 percent), so we were able to use Medicaid DSH audit data to determine whether hospitals met this criterion. However, about 17 percent of DSH hospitals did not provide data on the rate of low-income utilization on their DSH audits, and these omissions limited our ability to identify all deemed DSH hospitals.

Both California and Massachusetts distribute DSH funding through waivers authorized under Section 1115 of the Act. Consequently, Massachusetts does not have any hospitals that submit Medicaid DSH audits, while California has 17 public hospitals that do not submit Medicaid DSH audits. For these two states, MACPAC used Medicare cost report data to estimate deemed DSH status. Twenty-five additional hospitals were included from California and Massachusetts using this methodology.

Provision of essential community services

Because the term "essential community services" is not otherwise defined in statute or regulation, we identified a number of services that could be considered essential community services using available data from 2019 Medicare cost reports and the 2020 American Hospital Association annual survey (Table 4B-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the American Hospital Association annual survey.

TABLE 4B-1. Essential Community Services by Data Source

American Hospital Association annual survey	Burn services
	HIV/AIDS care
	Obstetrics and gynecology services
	Substance use disorder services
Medicare cost reports	Graduate medical education

For this report, for the sake of inclusiveness, any deemed DSH hospital providing at least one essential community service was included in our analysis. For deemed DSH hospitals, we also included certain hospital types if they were the only hospital in their geographic areas to provide certain types of services. These hospital types included critical access hospitals because they are often the only hospital within a 25-mile radius.

Projections of DSH Allotments

DSH allotment reductions from FY 2024 were calculated using data from Medicaid DSH audits, Medicare cost reports, and U.S. Census Bureau uninsured data using a methodology devised by Dobson DaVanzo & Associates, LLC (Dobson and DaVanzo 2016). DSH allotments for FY 2024 were calculated by determining what FY 2023 allotments would have been without the increase from the American Rescue Plan Act of 2021 (P.L. 117-2), increasing this amount by the Consumer Price Index projections for All Urban Consumers, and applying an $8 billion reduction, consistent with the current schedule of DSH allotment reductions in statute (CBO 2022).[42] MACPAC estimated the Medicaid inpatient factor and the uncompensated care factor using state plan rate year 2018 Medicaid DSH audits. MACPAC used 2021 American Community Survey data to estimate the uninsured percentage factor. We could not apply the budget neutrality factor adjustment in this report because budget neutrality information for FY 2024 was not available.

Unreduced allotments increase each year for all states except Tennessee, whose DSH allotment is specified in statute (Section 1923(f)(6)(A)(vi) of the Act). Per the final rule, DSH allotment reductions are limited to 90 percent of each state's unreduced DSH allotment (CMS 2019). This reduction cap limits the reductions for Rhode Island in FY 2024, and its excess reduction amounts are proportionately allocated among the remaining states that do not exceed the reduction cap.

Endnote

[42] The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) increased FYs 2020–2023 federal DSH allotments because of the COVID-19 pandemic for the remainder of the public health emergency. ARPA increased these allotments by estimating the total amount of DSH available to states (state share and federal allotment) for each year and calculated the federal share with an enhanced 6.2 percentage point federal medical assistance percentage (FMAP) for each state. MACPAC estimated FY 2023's non-ARPA enhanced allotment using a similar method and used these estimates to project FY 2024's DSH unreduced and reduced allotment amounts.

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Medicaid program; State disproportionate share hospital allotment reductions. Final rule. *Federal Register* 84, no. 186 (September 25): 50308–50332. https://www.federalregister.gov/d/2019-20731.

Congressional Budget Office (CBO). 2022. *The budget and economic outlook: 2022 to 2032*. Washington, DC: CBO. https://www.cbo.gov/system/files/2022-05/51118-2022-05-Budget-Projections.xlsx.

Dobson, A., and J.E. DaVanzo. 2016. *DSH allotment reduction projections*. Washington, DC: Medicaid and CHIP Payment and Access Commission.

Appendix

Authorizing Language (§ 1900 of the Social Security Act)

Medicaid and CHIP Payment and Access Commission

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as ''MACPAC'').

(b) DUTIES.—

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

(A) review policies of the Medicaid program established under this title (in this section referred to as ''Medicaid'') and the State Children's Health Insurance Program established under title XXI (in this section referred to as ''CHIP'') affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

(A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term ''appropriate committees of Congress'' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘‘MedPAC’’) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Melanie Bella, MBA, (Chair), is head of partnerships and policy at Cityblock Health, which facilitates health care delivery for low-income urban populations, particularly Medicaid beneficiaries and those dually eligible for Medicaid and Medicare. Previously, she served as the founding director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services (CMS), where she designed and launched payment and delivery system demonstrations to improve quality and reduce costs. Ms. Bella also was the director of the Indiana Medicaid program, where she oversaw Medicaid, the State Children's Health Insurance Program (CHIP), and the state's long-term care insurance program. Ms. Bella received her master of business administration from Harvard University.

Kisha Davis, MD, MPH, (Vice Chair), is the Montgomery County Health Officer, responsible for overseeing all public health services within Montgomery County and working with the Maryland Department of Health to coordinate disease control and collaborate on state health policies. Previously, she was vice president of health equity for Aledade. Prior to this, Dr. Davis was Maryland medical director for VaxCare Corporation; worked as a family physician at CHI Health Care in Rockville, Maryland; and served as program manager at CFAR in Philadelphia, Pennsylvania, where she supported projects for family physicians focused on payment reform and practice transformation to promote health system change. Dr. Davis has also served as the medical director and director of community health at CHI and as a family physician at a federally qualified health center (FQHC) in Maryland. As a White House Fellow at the U.S. Department of Agriculture, she established relationships among leaders of FQHCs and the Women, Infants, and Children nutrition program. Dr. Davis received her degree in medicine from the University of Connecticut and her master of public health from Johns Hopkins University.

Heidi L. Allen, PhD, MSW, is an associate professor at Columbia University School of Social Work, where she studies the impact of social policies on health and financial well-being. She is a former emergency department social worker and spent several years in state health policy, examining health system redesign and public health insurance expansions. In 2014 and 2015, she was an American Political Science Association Congressional Fellow in Health and Aging Policy. Dr. Allen is also a standing member of the National Institutes of Health's Health and Healthcare Disparities study section. Dr. Allen received her doctor of philosophy in social work and social research and a master of social work in community-based practice from Portland State University.

Sonja L. Bjork, JD, is the deputy chief executive officer of Partnership HealthPlan of California (PHC), a non-profit community-based Medicaid managed care plan. Before joining PHC, Ms. Bjork worked as a dependency attorney representing youth in the child welfare system. During her tenure at PHC, she has overseen multiple benefit implementations and expansion of the plan's service area. Ms. Bjork served on the executive team directing the plan's $280 million strategic investment of health plan reserves to address social determinants of health. These included medical respite, affordable housing, and substance use disorder treatment options. Ms. Bjork received her juris doctor from the UC Berkeley School of Law.

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Darin Gordon is president and CEO of Gordon & Associates in Nashville, Tennessee, where he provides health care–related consulting services to a wide range of public- and private-sector clients. Previously, he was director of Medicaid and CHIP in Tennessee for 10 years, where he oversaw various program improvements, including the implementation of a statewide value-based purchasing program. During this time, he served as president and vice president of the National Association of Medicaid Directors for four years. Before becoming director of Medicaid and CHIP, he was the chief financial officer and director of managed care programs. Mr. Gordon received his bachelor of science from Middle Tennessee State University.

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Kirstin Blom, MIPA, is a policy director and the contracting officer. Before joining MACPAC, Ms. Blom was an analyst in health care financing at the Congressional Research Service. Before that, Ms. Blom worked as a principal analyst at the Congressional Budget Office, where she estimated the cost of proposed legislation on the Medicaid program. Ms. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office (GAO). She holds a master of international public affairs from the University of Wisconsin, Madison, and a bachelor of arts in international studies and Spanish from the University of Wisconsin, Oshkosh.

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