

# Report to Congress on Medicaid and CHIP

**JUNE 2023**



**MACPAC**

Medicaid and CHIP Payment  
and Access Commission

## 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.

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and Access Commission



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**June 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 June 2023 *Report to Congress on Medicaid and CHIP*. This report includes four chapters that address modifying payment policy for safety net hospitals, integrating care for people who are dually eligible for Medicaid and Medicare, accessing Medicaid coverage and care for adults who leave incarceration, and identifying barriers to Medicaid home- and community-based services (HCBS).

In Chapter 1, the Commission makes recommendations to create automatic adjustments to disproportionate share hospital (DSH) payments, which are jointly financed between the federal and state governments and are statutorily required to offset hospitals' uncompensated care costs and support the financial stability of the nation's safety-net hospitals. The share of federal funding is determined by the federal medical assistance percentage (FMAP) and set on a federal funding basis.

The Commission makes four recommendations on providing automatic adjustments to DSH allotments when there are changes in the FMAP to do the following: (1) improve the relationship between total DSH funding and measures of need for DSH payments, (2) change the basis of DSH allotments from federal funding to total funding, (3) include DSH allotments in a countercyclical financing mechanism for Medicaid to preserve DSH funding when there is an economic recession, and (4) remove the requirement for the Centers for Medicare & Medicaid Services to compare DSH allotments to Medicaid spending so that allotments can be finalized in a timelier manner.

Chapter 2 continues the Commission's work on strategies to make integrated care the standard for the 12.2 million people eligible for both Medicaid and Medicare. Dually eligible beneficiaries often experience fragmented care and poor health outcomes due to a lack of coordination of services between Medicaid and Medicare. For dually eligible beneficiaries, integrating coverage could improve their care experience and reduce federal and state spending. To support states in developing an integrated care strategy, as recommended by the Commission in June 2022, the chapter describes the delivery system mechanisms available for integrating care and also looks at the changing landscape of integrated care. The chapter concludes with next steps in our ongoing work to advance integrated care for dually eligible beneficiaries.

Chapter 3 focuses on providing care to adults in the criminal justice system, who tend to have substantial behavioral and physical health needs. Although Medicaid's role is limited during incarceration, it is an important source of coverage for individuals released into the community. Congress and states have shown interest in improving health care transitions for this population as they leave incarceration. The chapter summarizes the demographic characteristics, health-related social needs, and health status of justice-involved adults as well as their ability to access Medicaid coverage and health care services before, during, and after incarceration. It also describes state efforts to provide timely Medicaid coverage and access to care for adults leaving state prisons and local jails. We then examine key considerations for implementing prerelease Medicaid services as well as future guidance and federal activities to support states in these efforts.

The final chapter of the June report continues the Commission's work on increasing access to Medicaid HCBS, which are designed to allow people who need long-term services and supports to live in their home or a homelike setting in the community. Although HCBS is not a mandatory benefit, all Medicaid programs currently provide some HCBS benefits. The chapter provides an overview of Medicaid coverage of HCBS, including eligibility, benefits, and spending, as well as the range of federal HCBS authorities. The chapter also describes findings from MACPAC's research on access to HCBS in two areas: barriers for beneficiaries and state challenges in administering these programs. Our findings highlight areas for further work and next steps aimed at increasing access to HCBS and addressing state challenges.

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 June 15.

Sincerely,



Melanie Bella, MBA  
Chair



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## Acknowledgments

The Commission would like to thank the following individuals who shared their time, expertise, and insight as MACPAC prepared the June 2023 *Report to Congress on Medicaid and CHIP*:

Amir Bassiri, Joseph Caldwell, Henry Claypool, Anne Marie Costello, Rich Cuno, Teresa DeCaro, Camille Dobson, Kristin Edwards, Tim Engelhardt, Katie Evans, Ben Finder, Stuart Goldstein, Lindsey Hammerslag, Leslie Hoffmann, Nancy Kirchner, Julie Kozminski, Erin Weir Lakhmani, Molly Collins Offner, Michael Ogborn, Erin O'Malley, Allison Rizer, Eric Rollins, David Ryan, Paul Saucier, Angela Sparrow, Sarah Spector, Jodie Sumeracki, Jeffery Talbert, Josh Trent, Vikki Wachino, Alice Weiss, and Elisabeth Wynn.

We are grateful for Lori Michelle Ryan for her thorough copyediting of this report.

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# Executive Summary: June 2023 Report to Congress on Medicaid and CHIP

MACPAC's June 2023 *Report to Congress on Medicaid and CHIP* contains four chapters of interest to Congress: (1) modifying payment policy for safety net hospitals, (2) integrating care for people who are dually eligible for Medicaid and Medicare, (3) accessing Medicaid coverage and care for adults who leave incarceration, and (4) identifying barriers to Medicaid home- and community-based services (HCBS).

## CHAPTER 1: Automatic Adjustments to Medicaid Disproportionate Share Hospital Allotments

In Chapter 1, the Commission makes recommendations to create automatic adjustments to disproportionate share hospital (DSH) payments, which are jointly financed between the federal and state governments and statutorily required to offset hospitals' uncompensated care costs and support the financial stability of the nation's safety-net hospitals. The share of federal funding is determined by the federal medical assistance percentage (FMAP) and set on a federal funding basis.

Unlike other Medicaid payments, DSH payments are capped at the state level by federal allotments. Because DSH allotments are set on a federal funding basis, total available state and federal DSH funding decreases when the FMAP increases.

During periods of normal economic growth, total DSH funding for states with declining per capita incomes is lower relative to other states. When Congress increases the FMAP during economic recessions, total available DSH funding for all states is reduced, although the need for DSH payments is greater. Calculating DSH allotments on a total funding basis would ensure total DSH funding is not affected by changes in the FMAP.

In this chapter, we make the following recommendations:

- 1.1 In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.
- 1.2 Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital funding is not affected by changes in the federal medical assistance percentage.
- 1.3 Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:
  - an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
  - an upper bound of 100 percent on adjusted matching rates;
  - an increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and
  - an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group).

- 1.4 To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare & Medicaid Services compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

## CHAPTER 2: Integrating Care for Dually Eligible Beneficiaries: Different Delivery Mechanisms Provide Varying Levels of Integration

Chapter 2 continues the Commission's work on strategies to make integrated care available for the 12.2 million people who are eligible for both Medicaid and Medicare. Dually eligible beneficiaries often experience fragmented care and poor health outcomes due to a lack of coordination of services between Medicaid and Medicare. For dually eligible beneficiaries, integrating coverage could improve their care experience and better target federal and state spending. About 21 percent of dually eligible beneficiaries were enrolled in integrated products in 2022.

In the June 2022 report to Congress, the Commission recommended that all states be required to develop a strategy to integrate care with federal support. Building on our recommendation, this chapter reviews the different delivery mechanisms that states use to provide Medicaid coverage to dually eligible beneficiaries and opportunities for integration. Our examination includes Medicaid fee for service, Medicare Advantage dual eligible special needs plans (D-SNPs), and the Medicare-Medicaid plans (MMPs) under the Financial Alignment Initiative demonstration.

In 2022, the Centers for Medicare & Medicaid Services (CMS) made regulatory changes that will sunset the MMPs, a long-standing capitated demonstration model that was seen as an example of full integration but had a limited reach. CMS is encouraging states to transition their MMP enrollees to integrated D-SNPs.

This change effectively makes D-SNPs the primary vehicle for states to integrate care, which may expand enrollment in these products.

States have access to different system design options to increase integration. MACPAC recognizes that fully integrated coverage is available only to a limited number of dually eligible beneficiaries and that state circumstances vary widely. The Commission will continue to identify options for states across delivery mechanisms as part of its ongoing work to advance integrated care for dually eligible beneficiaries.

## CHAPTER 3: Access to Medicaid Coverage and Care for Adults Leaving Incarceration

Chapter 3 focuses on providing care to adults in the criminal justice system. Federal law prohibits the use of federal Medicaid funds for health care services provided to Medicaid enrollees while they are inmates of public institutions (e.g., state prisons and local jails), except in cases of inpatient care lasting 24 hours or more. Although Medicaid's role is limited during incarceration, it is an important source of coverage for individuals released into the community. Congress and states have shown interest in improving health care transitions for this population as they leave incarceration.

People of color, low-income individuals, and men are disproportionately represented among adults in the criminal justice system. Disproportionate rates of incarceration among certain racial and ethnic groups are the product of decades-long inequities, stemming from structural racism and explicit and implicit biases that disadvantage communities of color. Justice-involved adults tend to have considerable physical health, behavioral health, and health-related social needs as well as an elevated risk of death after incarceration. Medicaid-eligible adults leaving incarceration often experience delays in getting Medicaid coverage upon release. Limited data sharing between carceral and community-based providers contributes to discontinuity of care and poor health outcomes for this population.

In April 2023, CMS issued guidance on a reentry Section 1115 demonstration opportunity through which states meeting certain conditions can receive federal financial participation for prerelease Medicaid services provided to eligible individuals leaving incarceration. California was the first state to receive CMS approval for such a demonstration, and more than a dozen other states have similar pending applications.

The experience of states providing prerelease services to facilitate care transitions for incarcerated individuals returning to the community will illuminate future policy considerations for Medicaid's role in serving this population. The Commission will monitor these state demonstrations, including any reporting on implementation and outcomes, and provide future guidance.

## CHAPTER 4: Access to Home- and Community-Based Services

The final chapter continues the Commission's work on increasing access to Medicaid HCBS, which are designed to allow people who need long-term services and supports (LTSS) to live in their homes or a homelike setting in the community. This benefit encompasses a wide range of services that include personal care services provided in a community setting, supported employment, non-medical transportation, and home-delivered meals.

HCBS are optional services for states, but all states cover some HCBS benefits. There is variation in how these benefits are delivered, the types of services covered, the populations served, and the criteria used to determine eligibility. Over the past decade, more than half of all spending on LTSS has been on HCBS compared to institutional care.

The chapter describes findings from MACPAC's research on access to HCBS in two areas: barriers for beneficiaries and state challenges in administering these programs. Some of the key challenges include limited provider availability, state budgetary constraints, waiver waiting lists, and gaps

in beneficiary knowledge about the services that are available. Differences in access to HCBS may exist across a range of factors, including by LTSS subpopulation, by race and ethnicity, by geographic location, and by age. However, more data are necessary, particularly related to race and ethnicity, to describe these differences in greater detail.

Our findings highlight areas for future work as well as next steps aimed at increasing access to HCBS and addressing state challenges. The Commission will work to identify policies that drive toward a more streamlined HCBS delivery system that increases access for beneficiaries and reduces the administrative burden for states.





Chapter 1:

# Countercyclical Medicaid Disproportionate Share Hospital Allotments

# Countercyclical Medicaid Disproportionate Share Hospital Allotments

## Recommendations

- 1.1** In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.
- 1.2** Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital funding is not affected by changes in the federal medical assistance percentage.
- 1.3** Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:
  - an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
  - an upper bound of 100 percent on adjusted matching rates;
  - an increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and
  - an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group)
- 1.4** To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare & Medicaid Services compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

## Key Points

- Unlike other Medicaid payments, DSH payments are capped at the state level by federal allotments.
- Because DSH allotments are set on a federal funding basis, total available state and federal DSH funding decreases when the FMAP increases.
- Periods of normal economic growth result in less total DSH funding for states with declining per capita incomes relative to other states.
- When Congress increases the FMAP during economic recessions, the total available DSH funding for all states is reduced, although the need for DSH payments is greater.
- Calculating DSH allotments on a total funding basis would ensure total DSH funding is not affected by changes in the FMAP, similar to how other limits on Medicaid spending are set.

# CHAPTER 1:

## Countercyclical Medicaid Disproportionate Share Hospital Allotments

Medicaid disproportionate share hospital (DSH) payments are statutorily required payments intended to offset hospitals' uncompensated care costs and support the financial stability of safety-net hospitals. Similar to other Medicaid payments, DSH payments are jointly financed by states and the federal government, and the share of federal funding is determined by the federal medical assistance percentage (FMAP). However, unlike other Medicaid payments, the federal share of DSH funding available in each state is capped by federal allotments.

Because DSH allotments are set on a federal funding basis, total available state and federal DSH funding decreases when a state's FMAP increases. During periods of normal economic growth, this policy results in less total DSH funding for states with declining per capita incomes relative to other states. When Congress increases the FMAP during economic recessions or other disruptive events, this policy results in less total DSH funding for all states.

In the Commission's view, DSH allotments should be calculated on a total funding basis so that DSH funding is not affected by changes in the FMAP. This policy is similar to how other limits on Medicaid spending are set, and it would ensure that states are not adversely affected by declines in their per capita income relative to other states. Congress enacted a similar policy during the COVID-19 public health emergency (PHE), which ended May 11, 2023. During interviews with states and providers, we found that most stakeholders preferred this approach to other policies to adjust DSH allotments because it preserves funding for providers, supports states, and is relatively easy for states to implement.

A change in the calculation of DSH allotments does not address the Commission's long-standing concern that DSH allotments have little meaningful relationship to measures of need for DSH payments, such as levels

of uncompensated care and the number of Medicaid-enrolled or uninsured individuals. Current allotments are largely based on states' historical DSH spending before federal limits were established in 1992, and they vary widely by state. In March 2019, the Commission made a series of recommendations to improve the relationship between DSH allotments and measures of need for DSH payments by changing the formula for distributing pending DSH allotment reductions, which have not yet been enacted by Congress.

Under current law, federal DSH allotments are scheduled to be reduced by \$8 billion in FY 2024 (54 percent of unreduced amounts), and the wide variation in state DSH allotments is projected to continue after reductions take effect. Chapter 4 of MACPAC's March 2023 report to Congress examines the potential state and hospital effects of these pending reductions, which were initially included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) but have been delayed several times.

Although the Commission is concerned that the magnitude of DSH reductions may affect the financial viability of some safety-net providers, the Commission's prior analyses focused on budget-neutral ways to restructure funding under current law. Specifically, the Commission recommended that Congress minimize the effects of reductions on hospitals that currently rely on DSH funding by phasing in reductions more gradually and applying reductions to unspent DSH funding first. To align reduced DSH allotments with measures of need, the Commission recommended that Congress change the formula for distributing reductions to gradually improve the relationship between DSH allotments and the number of non-elderly low-income individuals in each state (MACPAC 2019).

In this chapter, the Commission reaffirms its prior DSH allotment recommendations while also recommending that Congress permanently change the calculation of DSH allotments from a federal funding basis to a total funding basis. In addition, the Commission reaffirms its March 2021 recommendation that Congress implement a countercyclical adjustment to the FMAP during economic recessions. The Commission also recommends that Congress make a technical change to allow the Centers for Medicare & Medicaid Services (CMS) to finalize DSH allotments sooner so that states can make DSH payments on a timelier basis to

support providers. In sum, the Commission makes four recommendations:

- In order to reduce the wide variation in state DSH allotments based on historical 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 (HHS) to develop a methodology to distribute reductions in a way that gradually improves the relationship between total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.
- Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal DSH funding is not affected by changes in the FMAP.
- Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office (GAO) as the basis. The Commission recommends this policy change should also include:
  - an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
  - an upper bound of 100 percent on adjusted matching rates;
  - an increase in federal DSH allotments so that total available DSH funding does not change as a result of changes to the FMAP; and
  - an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group).
- To provide states and hospitals with greater certainty about available DSH allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that CMS compare DSH allotments

to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

This chapter summarizes the Commission's analyses, which informed the development of these recommendations. The chapter begins by reviewing current DSH and FMAP policies and the effects of previous adjustments to DSH allotments during economic recessions. Then, it reviews the state-by-state effects of calculating DSH allotments on a total funding basis during periods of normal economic growth. The chapter concludes with more information about the rationale and implications for each of the Commission's recommendations.

## Background

Unlike other Medicaid payments, state DSH spending is limited by allotments that are set on a federal funding basis. As a result, when the FMAP increases, total available state and federal DSH funding decreases. This section provides an overview of current DSH policy, the FMAP calculation, and how these policies interact.

### DSH policy

State Medicaid programs are statutorily required to make DSH payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients.<sup>1</sup> The total amount of such payments a state can make is limited by annual DSH allotments. States can distribute DSH payments to any qualifying hospital in their state, but DSH payments to a hospital cannot exceed the total amount of uncompensated care that the hospital provides.<sup>2</sup> 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.

**DSH allotments.** DSH allotments vary widely among states, reflecting the evolution of federal policy over time. States were first authorized to make Medicaid DSH payments in 1981, when Medicaid hospital

payment methods and amounts were uncoupled from Medicare payment standards.<sup>3</sup> Initially, states were slow to make these payments, but after Congress clarified that DSH payments were not subject to Medicaid hospital upper payment limits, total state and federal DSH spending grew rapidly in the early 1990s—from \$1.3 billion in 1990 to \$17.7 billion in 1992 (Matherlee 2002, Klemm 2000, Holahan et al. 1998).<sup>4</sup>

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.” Allotments were initially established in 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.

Under current law, federal DSH allotments increase each year based on the change in the consumer price index for all urban consumers. However, because Medicaid spending has grown faster than DSH allotments, DSH spending as a share of overall Medicaid spending has declined from 15.2 percent in FY 1992 to 3.6 percent in FY 2016 (CRS 2016).

States are not required to spend their entire allotment, but the allotment sets an upper bound on federal funding. States do not receive federal matched funds for DSH payments that exceed the allotment. States typically have up to two years to spend their DSH allotments after the end of the fiscal year.<sup>5</sup> As of the end of FY 2022, \$1.9 billion (15 percent) of FY 2020 DSH allotments were unspent.<sup>6</sup>

**DSH payments.** In FY 2021, DSH payments to hospitals totaled \$14.1 billion, which was approximately 7 percent of all Medicaid payments to hospitals (MACPAC 2023a).<sup>7</sup> States set their own DSH payment policy and can send DSH payments to any hospital that has a Medicaid inpatient utilization rate of at least 1 percent. States are also required to make DSH payments to deemed DSH hospitals, which serve a high share of Medicaid and low-income patients and account for about 13 percent of all hospitals nationwide (MACPAC 2023b).<sup>8</sup>

DSH funding is an important source of revenue for many deemed DSH hospitals. For example, in FY 2020, DSH payments accounted for 3.6 percent

of operating revenue for deemed DSH hospitals, compared to 1.3 percent of operating revenue for all hospitals. Even after DSH payments, deemed DSH hospitals report lower operating and total margins than other hospitals in the aggregate (MACPAC 2023b).

Total state and federal DSH payments to an individual hospital cannot exceed the hospital’s uncompensated care costs, which are defined as Medicaid shortfall plus unpaid costs of care for uninsured individuals. Although states can address Medicaid shortfall by increasing other types of Medicaid payments to hospitals, DSH is the only type of Medicaid payment in statute that can explicitly pay for unpaid costs of care for uninsured individuals.<sup>9</sup>

**DSH financing.** Similar to other Medicaid payments, states can finance the non-federal share of DSH payments through a variety of sources, including state general revenue, provider taxes, and intergovernmental transfers (IGTs) or certified public expenditures from state and local government sources, such as publicly owned hospitals. Compared to other Medicaid payments, states are more likely to finance DSH payments with provider taxes or funds from local governments. For example, in state FY 2018, 34 percent of DSH payments were financed by state funds, compared to 68 percent of all Medicaid payments (MACPAC 2023a).<sup>10</sup>

The methods states use to finance the non-federal share of DSH payments may affect how they choose to distribute DSH payments. For example, among the 10 states that primarily financed DSH payments through funds from local governments in state FY 2018, 72 percent of DSH payments were targeted to publicly owned hospitals, which is a larger share compared to states that fund DSH payments through general revenue or a provider tax (43 percent and 34 percent, respectively) (MACPAC 2023b). 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).<sup>11</sup> Because provider taxes are required to be broad based, broadly distributing DSH payments can help ensure that most hospitals are able to offset the costs of the provider tax (MACPAC 2021a). More



information about state DSH payment policies is included in Chapter 3 of MACPAC's March 2017 report to Congress (MACPAC 2017).

DSH payments that are financed through a provider tax or an IGT from publicly owned hospitals effectively lower the payment that a provider receives, after accounting for the provider contribution to the non-federal share. For example, in state plan rate year 2011, provider taxes reduced net payments to DSH hospitals by 4 percent, and IGTs from publicly owned hospitals reduced net payments by an additional 7 percent (Nelb et al. 2016).

## FMAP calculation

The FMAP determines the federal share of Medicaid expenditures and is based on a rolling three-year average of each state's per capita income relative to the national average. States with lower per capita incomes have a higher FMAP (up to the statutory maximum of 83 percent), and states with higher per capita incomes have a lower FMAP (with a statutory minimum of 50 percent). This policy is intended to reflect states' differing abilities to fund Medicaid from their own revenues. The District of Columbia is an exception to this policy, and its FMAP is fixed in statute at 70 percent. In addition, the statute provides different FMAPs for some services and populations (MACPAC 2023c).

Under current law, FMAPs are not adjusted automatically when there is an economic recession. Congress must act to modify FMAPs outside of annual updates. In general, Congress has temporarily increased the FMAP to provide fiscal relief and stimulus to states during economic recessions or other disruptive events, such as natural disasters. For example, during the COVID-19 PHE, Congress increased the FMAP by 6.2 percentage points.

Countercyclical increases in federal funding for Medicaid help offset increasing Medicaid enrollment and declining state revenue during economic recessions (Holahan 2011). Medicaid enrollment and spending increase when a downturn in the economic cycle leads to rising unemployment, which in turn contributes to both increases in the low-income population and the number of people losing employer-sponsored insurance (KFF 2008). States also differ in

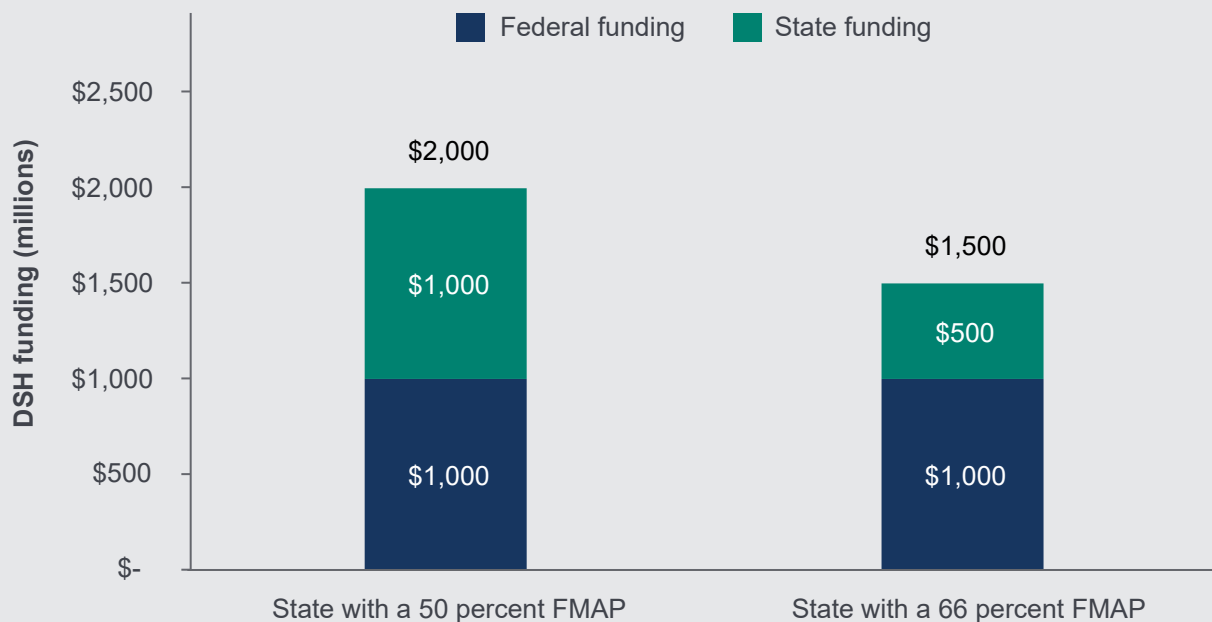
their ability to generate revenue to finance the state share of increased Medicaid spending because of differences in local economic conditions. During an economic downturn, state revenue often declines due to reduced sales tax and income tax collections. After the recession in 2008, each 1 percentage point rise in unemployment led to a 3–4 percent decrease in state general fund revenues (Dorn et al. 2008).

In 2021, the Commission recommended that Congress implement an automatic countercyclical FMAP using a prototype developed by the GAO as the basis (MACPAC 2021b). If Congress were to implement the Commission's recommendation, the model would increase a state's FMAP commensurate to changes in the state's employment rate when a national recession is triggered.<sup>12</sup> For example, the increases in unemployment at the start of the COVID-19 PHE would have triggered an increased FMAP under the GAO model, ranging from 1.34 to 9.11 percentage points in July through September 2020 (MACPAC 2021b).

## Interaction between DSH allotments and the FMAP

For most Medicaid spending that is not subject to federal allotments, a higher FMAP will result in more total funding for the same level of state contribution, compared to a lower FMAP. For example, a state that spends \$2 billion on medical assistance and has a 50 percent FMAP would need to contribute \$1 billion in state share. However, a state that spends \$2 billion on medical assistance and has a 66.7 percent FMAP would need to contribute only \$666 million in state share.

The opposite is true for DSH funding, which is limited on a federal funding basis. Under current law, the total amount of state and federal DSH funding available to a state is determined by dividing the federal DSH allotment by the FMAP. A higher FMAP will result in less total DSH funding for a given allotment compared to a lower FMAP. For example, a state with a \$1 billion federal allotment and a 50 percent FMAP could make a total of \$2 billion in DSH payments. However, a state with a \$1 billion allotment and a 66.7 percent FMAP could make only a total of \$1.5 billion in total DSH payments (Figure 1-1). In both circumstances, a state's ability to claim all available DSH funding is dependent on states providing the state share for these expenditures.

**FIGURE 1-1.** State and Federal DSH Funding for a Hypothetical State under Two FMAP Scenarios

**Notes:** DSH is disproportionate share hospital. FMAP is federal medical assistance percentage.

**Source:** MACPAC analysis

**FMAP exceptions for DSH.** Because a higher FMAP decreases total DSH funding, Congress has excluded DSH payments from some FMAP increases in the past. For example, Congress excluded DSH payments from FMAP increases during the 2007–2009 financial crisis. However, Congress applied an increased FMAP to DSH payments for states that had a large influx of refugees due to Hurricane Katrina in 2005, resulting in less total available DSH funding for affected states (Deficit Reduction Act of 2005, P.L. 109-171).

**Comparison to other Medicaid funding limits.** As a point of comparison, many other limits on Medicaid spending are established on a total funding basis and are not affected by changes in the FMAP. For example, budget neutrality limits for Section 1115 demonstrations and upper payment limits (UPL) on fee-for-service payment rates are based on total state and federal spending (MACPAC 2023a, 2021c). For the UPL, states must annually demonstrate that total fee-for-service payments to hospitals and other institutional providers do not exceed a reasonable estimate of what Medicare would have paid for

the same service in the aggregate for a class of providers. In UPL demonstrations, CMS collects data only on total state and federal spending. In Section 1115 demonstrations, federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration (MACPAC 2021d). However, CMS calculates this federal limit using projections of total state and federal spending and multiplying this amount by the FMAP.<sup>13</sup>

## Analyses of Previous Countercyclical DSH Policies

During the past two economic recessions, Congress made temporary changes to DSH allotment policy. This section reviews the federal, state, and hospital effects of these policies, based on MACPAC's quantitative analyses and interviews with state officials, hospital associations, and CMS.

Specifically, the Commission examined the following policy changes made during the 2007–2009 financial crisis and the COVID-19 pandemic:

- Increased federal allotment without FMAP change:** The American Rescue and Recovery Act (ARRA, P.L. 111-5) increased DSH allotments by a fixed amount (2.5 percent) but did not change the FMAP for DSH payments. All Medicaid payments except for DSH received an enhanced FMAP of 6.2 percent. ARRA was the first time that Congress created a countercyclical increase for DSH payments.
- Increased FMAP without federal allotment change:** The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) increased the FMAP for all Medicaid expenditures, including DSH, by 6.2 percentage points, but it did not change federal DSH allotments, and total DSH funding decreased.
- Increased FMAP and allotment based on total funding:** The American Rescue Plan Act (ARPA, P.L. 117-2) increased federal DSH allotments to ensure that total DSH funding would remain the same as it would have been without the application of the 6.2 percent enhanced FMAP.
- Without a countercyclical adjustment to the FMAP or DSH allotments, a total of \$22.8 billion in state and federal DSH funding would have been available (\$13 billion in federal allotments and \$9.8 billion in state matching funds).
- If federal allotments were increased 2.5 percent without a change in the FMAP, as they were under ARRA, then total available funding would have also increased 2.5 percent, to \$23.4 billion. However, for states to spend all available funding, they would have had to increase the amount of state matching funds that they provided from \$9.8 billion to \$10.0 billion.
- If the FMAP was increased without a change in federal allotments, as was done under FFCRA, the required state share of DSH funding would decline from \$9.8 billion to \$7.5 billion, but total available DSH funding would also decline accordingly, from \$22.8 billion to \$20.5 billion.
- The ARPA policy of basing DSH funding on a total funding while also increasing the FMAP keeps total DSH funding at the same amount as it would have been without a countercyclical adjustment (\$22.8 billion), but it also provides state fiscal relief by reducing the required state share from \$9.8 billion to \$8.4 billion. However, the federal spending under this approach is higher (\$14.4 billion) than the other countercyclical policies.

Changes to DSH policies during the COVID-19 pandemic occurred alongside other policy changes that also affected hospital finances. For example, at the start of the COVID-19 PHE, Congress also created a \$178 billion provider relief fund to help offset provider losses during the pandemic, much of which has been allocated to hospitals (MACPAC 2022a). This new funding source was an unprecedented action, and as such, provider relief funding may not be available for future economic downturns.

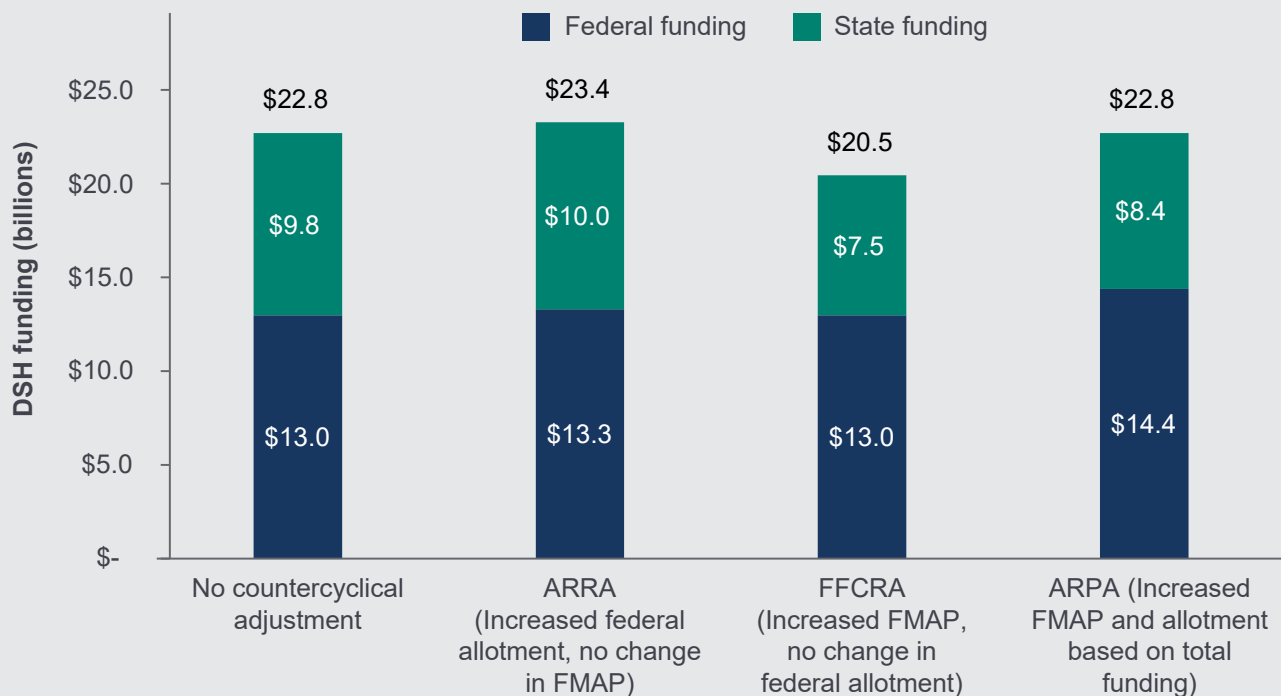
## Effects on state and federal DSH funding

To understand the potential effects of these policies on available state and federal DSH funding, we examined what their effects would have been on FY 2021 DSH allotments (Figure 1-2).

## Potential hospital effects

The effects of these policies on individual hospitals depend on how states respond to changes in their DSH allotments. During economic recessions, hospitals may be eligible for more DSH funding because of increases in hospital uncompensated care costs, but states may not always choose to spend their full DSH allotments or may respond by changing other types of Medicaid payments to hospitals. In addition, changes in the FMAP may affect hospitals differently, depending on how DSH payments are financed.



**FIGURE 1-2. DSH Allotments under Different Countercyclical Policy Scenarios, FY 2021 (billions)**

**Notes:** DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. ARRA is American Recovery and Reinvestment Act of 2009 (P.L. 111-5). FFCRA is Families First Coronavirus Response Act (P.L. 116-127). ARPA is American Rescue Plan Act (P.L. 117-2). No countercyclical adjustment assumes no changes to DSH allotments or the FMAP from before the COVID-19 pandemic. ARRA increased DSH allotments by 2.5 percent. FFCRA increased the FMAP for Medicaid payments by 6.2 percentage points. ARPA changed the basis of DSH allotments from federal funding to total funding. Totals may not sum due to rounding.

**Source:** MACPAC, 2023, analysis of Medicaid Budget and Expenditure System.

### Changes in hospital uncompensated care.

Economic recessions are associated with higher levels of unemployment and declines in employer-sponsored coverage, which can result in increased Medicaid enrollment and an increased number of uninsured individuals (MACPAC 2021b). These coverage changes can result in increased hospital uncompensated care for Medicaid and uninsured individuals, thus increasing hospitals' need for DSH payments to offset these costs (Garthwaite et al. 2015). Furthermore, economic recessions may affect states differently, either in the duration or severity of the downturn. Increases in uncompensated care may be more considerable in states with larger increases in unemployment.

**Unspent DSH allotments.** Even if hospitals report enough uncompensated care to exhaust available DSH funding, some states do not spend their full DSH allotment because of challenges in financing the non-federal share of DSH payments. These challenges may become more pronounced during an economic recession, since some states may have declines in revenue due to rising unemployment. In these states, hospitals may not benefit from higher federal allotments without a corresponding increase in the FMAP, as was done under ARRA, because states would need to generate additional state matching funds to make more DSH payments.

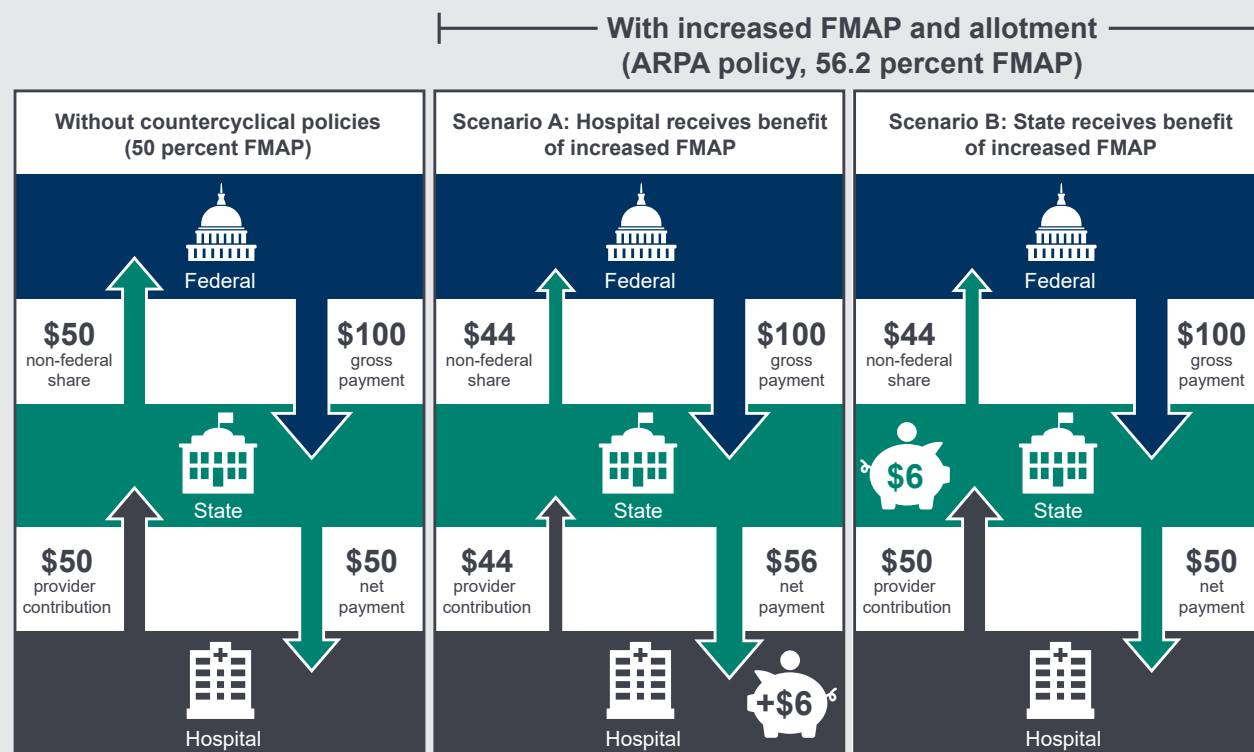
**Effects of state financing methods.** States may react to legislative changes in their DSH allotment differently based on how they finance the non-federal share of DSH payments. DSH allotment adjustments may not automatically result in providers receiving additional federal funds if states do not provide state matching funds.

Conversely, if a provider finances the non-federal share of DSH payments using provider taxes or IGTs, and the amount that the provider contributes to the non-federal share declines when the FMAP increases, then the net payments that the provider receives would increase. For example, in a state with a 50 percent FMAP that finances DSH payments from providers,

a 6.2 percent increase in the FMAP would result in a 12.4 percent increase in the net payments the provider receives if the state decides to pass on the benefits of the increased FMAP to the hospital in the form of either tax relief or a smaller IGT transfer from publicly owned hospitals.<sup>14</sup> However, a state could also choose to keep the provider contribution the same, retain the 6.2 percent increase in the FMAP, and use additional federal contribution to address state fiscal challenges during a downturn (Figure 1-3).

**Changes to other Medicaid hospital payments to cover uncompensated care.** Although DSH is the only statutory Medicaid payment that is intended to pay for unpaid costs of care for uninsured individuals,

**FIGURE 1-3.** Scenarios for Net Payments to Hospitals that Finance the State Share of DSH Payments



**Notes:** DSH is disproportionate share hospital. FMAP is federal medical assistance percentage. ARPA is American Rescue Plan Act (P.L. 117-2). ARPA temporarily transitioned allotments from a federal funding basis to a total funding basis. Under ARPA all Medicaid payments, including DSH, have an FMAP increased by 6.2 percentage points during the COVID-19 public health emergency. Provider contributions can be in the form of a provider tax, intergovernmental transfer, or certified public expenditure. The piggy bank illustrates whether the state or the hospital receives the benefit of the increased FMAP.

**Source:** MACPAC analysis

states can increase Medicaid base payment rates or make other supplemental payments to pay for the costs of care for Medicaid-enrolled patients. These other types of Medicaid payments also require states to finance the non-federal share of Medicaid payments. In general, it is more difficult for states to target non-DSH Medicaid payments to hospitals for unpaid costs associated with uninsured individuals because these payments are typically based on Medicaid use (MACPAC 2021b, MACPAC 2019).<sup>15</sup>

## Stakeholder perspectives

State Medicaid officials and hospital associations in five states with different methods of financing and targeting DSH payments offered perspectives on how prior countercyclical DSH policies affected DSH payments to hospitals, particularly during the PHE.<sup>16</sup>

**DSH has been an important source of funding that offsets uncompensated care during an economic recession.** All stakeholders noted the importance of DSH funding in offsetting uncompensated care during economic recessions. Compared to other types of Medicaid payments, states appreciated the flexibility to target DSH funding to safety-net hospitals. For example, one state used existing flexibility to accelerate DSH payments to providers at the start of the pandemic to ensure safety-net providers had enough cash flow to manage the initial disruptions in care (NM HSD 2020). Many also made other types of non-DSH supplemental payments to hospitals but noted it would be administratively difficult to try to offset declines in DSH funding with these other types of Medicaid payments.

Hospital associations highlighted the challenges that hospitals typically face during economic recessions. They also noted that the COVID-19 pandemic was different from prior recessions because of the Medicaid continuous coverage requirement, which prevented a large increase in the number of uninsured individuals, and federal provider relief funding, which helped to offset hospital losses during the early stage of the pandemic (Karpman and Zuckerman 2021, MACPAC 2020). Given that these additional sources of support may not be available in future recessions, stakeholders noted the continued need for stable and predictable DSH funding.

**States and providers assessed available DSH funding on a total funding basis.** At the state level, state officials and hospital associations preferred to measure DSH funding on a total funding basis. As a result, these stakeholders viewed the FFCRA FMAP increase as a reduction in DSH funding even though the federal DSH allotment amounts were unchanged. Because of these concerns, some hospital associations joined a multistate coalition to advocate for the ARPA policy to transition allotments to a total funding basis, so that total DSH payments could remain the same as prepandemic levels.

Stakeholders were generally supportive of the ARPA policy of basing DSH allotments on total funding during the pandemic. Stakeholders noted that changing the basis for DSH allotments to total funding preserved DSH funding and supported states and was relatively administratively simple for states to implement. Preserving DSH funding also prevented the need for states to make state statutory or regulatory changes to their DSH payment policies or other Medicaid payments to offset the effects of any changes.

**Increased FMAP supported state and local government budgets.** States generally used the increased FMAP provided by FFCRA and ARPA to support state budgets rather than increase Medicaid payments to providers. Before ARPA was implemented, two states responded to FFCRA by increasing payments to DSH hospitals using unmatched state funds to preserve the same amount of funding that providers would have received before the pandemic. Once ARPA was implemented, these states retroactively adjusted their payments to claim federal matching funds to support their state budgets.

In two states that financed DSH payments with a provider tax, the tax rate remained the same after the increased FMAP took effect and the savings from reductions in the non-federal share for DSH payments accrued to the state rather than providers. One state has a mechanism in place to adjust provider taxes based on the size of the total DSH allotment, but even after the passage of FFCRA and ARPA, the state calculated the provider tax amount needed for the non-federal share based on the state's traditional FMAP. The state's savings from the increased FMAP during the PHE were directed to a

separate account that benefited the state's overall budget rather than benefiting providers directly.

In one of the states that financed DSH with IGTs from public hospitals, the benefits of the increased FMAP accrued to the public hospital and their affiliated local governments. After the FMAP increased, these hospitals contributed less of the state share for DSH and therefore received larger net DSH payments. The state officials and hospitals association in this state noted the benefits of increasing net payments to these hospitals because of the important role that these public hospitals play in providing care to Medicaid-enrolled and uninsured patients.

**States were concerned about their ability to finance increases to hospital payments during economic recessions.** State officials noted challenges with contributing more to the non-federal share of DSH or other Medicaid hospital payments during economic recessions, when state revenue is typically limited. Some hospital associations would have preferred a countercyclical policy that increased total state and federal DSH funding, similar to the ARRA policy that was implemented during the 2007–2009 economic recession. These associations were less concerned about the state's ability to finance DSH payments than stakeholders in other states because of state-specific policies requiring the state to spend all available DSH funding.

**Stakeholders preferred certainty to help plan for the future.** Although the ARPA policy addressed many concerns raised by stakeholders, states and hospitals expressed concern that Congress waited more than a year into the PHE to make this change. The ARPA policy was retroactively applied to the start of the PHE, but the delay in implementing ARPA still created uncertainty over how much DSH funding would be available to states and providers during the first year of the PHE.

In addition to concerns about delays by Congress, stakeholders also raised concerns about CMS's delay in finalizing DSH allotments. For example, FY 2020 and FY 2021 preliminary DSH allotments were not posted to the *Federal Register* until March 2022 (CMS 2022). Final DSH allotments take even longer for CMS to finalize, and some states noted that they often leave some DSH funding unspent until allotments are finalized. CMS officials noted that

the statutory requirement for them to compare DSH allotments to state spending was the primary reason for this delay, since spending amounts are typically not finalized until two years after the close of the fiscal year.

## DSH Allotments during Periods of Normal Economic Growth

Total DSH funding is affected by annual changes in the FMAP due to changes in a state's per capita income relative to other states. Although states with lower per capita incomes have a higher share of non-elderly low-income individuals in their states, states with declining per capita incomes have less total available DSH funding because their FMAP increases.

To examine this issue, this section describes how the FMAP affected total DSH funding during a period of normal economic growth (FYs 2014–2019) and analyzes the state effects of applying a different policy that would base allotments on total funding.

### Relationship between FMAP and measures of need for DSH payments

States with higher FMAPs are likely to have a greater need for DSH payments because their per capita income is lower than other states, on average. For example, in 2019, state per capita income was highly correlated with the share of non-elderly low-income individuals in each state, a measure that the Commission recommended that Congress use to rebase DSH allotments if DSH allotment reductions take effect (Figure 1-4). The Commission chose this measure because it is correlated with state levels of uncompensated care and is not affected by state choices to expand Medicaid under the ACA to adults younger than age 65 with incomes less than 138 percent of the federal poverty level (FPL) (MACPAC 2019). In 2019, states with low per capita income had a higher percentage of low-income individuals. Conversely, states with high per capita income had a lower percentage of low-income individuals, and many of these states have an FMAP at the statutory minimum (50 percent).

**FIGURE 1-4.** State Per Capita Income by the Percentage of Non-Elderly Population That Is Low Income and by Whether a State Has an FMAP at the Statutory Minimum of 50 Percent, 2019



**Notes:** FMAP is federal medical assistance percentage. Percentage of non-elderly population that is low income is the percentage of the population younger than age 65 that has a household income less than 200 percent of the federal poverty level. Per capita income is the state income divided by the state population. R is the Pearson correlation coefficient. States include all 50 states but not the District of Columbia, which has a statutorily set FMAP of 70 percent. Correlation is between the state per capita income and percentage of non-elderly population that is low income and is represented by the Pearson correlation coefficient. A coefficient of 0 represents no linear correlation, and a coefficient of -1 represents a perfect linear negative correlation.

**Source:** MACPAC, 2023, analysis of BLS 2023 and Census 2023.

## Current variation in DSH funding based on FMAP changes

The effects of the FMAP on total DSH funding can be observed by examining changes in total available DSH funding over time. Although federal DSH allotments

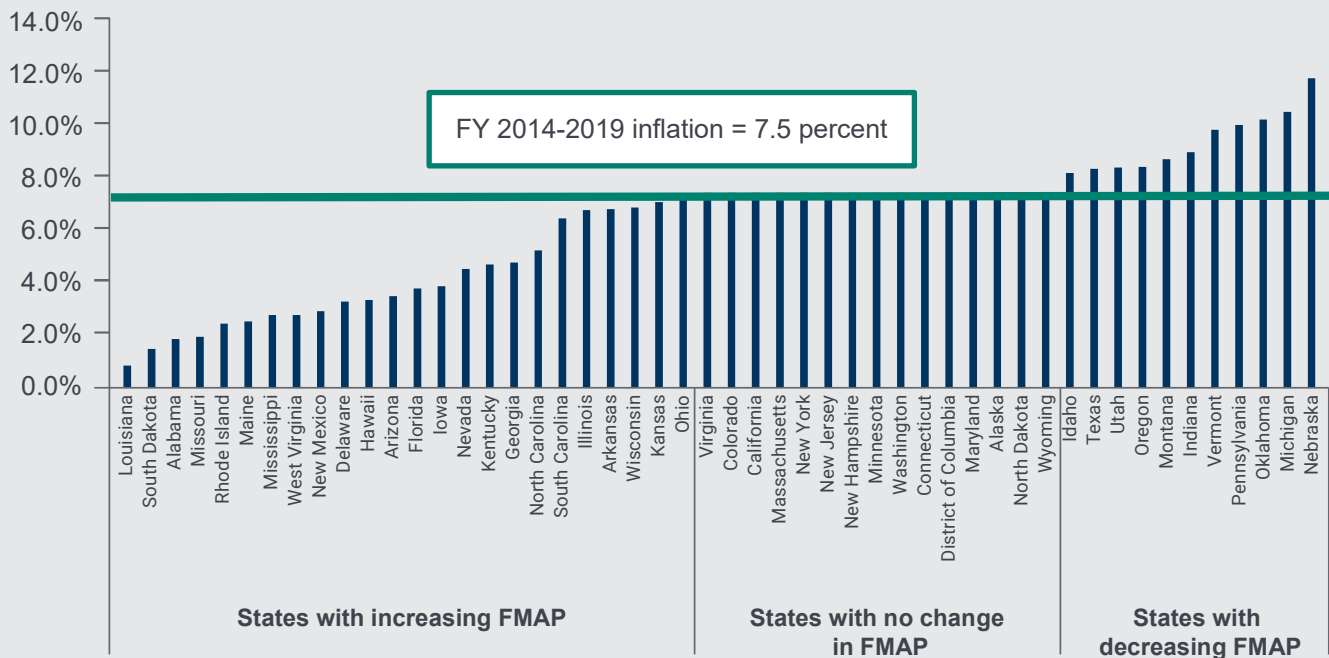
increase annually based on inflation in all states under current law, states with increasing FMAPs have total DSH funding that increases slower than inflation, and states with decreasing FMAPs have total DSH funding that increases faster than inflation.

For example, although inflation increased 7.5 percent between FY 2014 and FY 2019, increases in DSH funding ranged from 0.8 percent (Louisiana) to 11.9 percent (Nebraska) (Figure 1-5). Over the five-year period from 2014 to 2019, Louisiana had a 4.0 percentage point increase in its FMAP, and Nebraska had a 2.2 percentage point decline in its FMAP. Additional state-by-state data are available in Appendix 1A.

The changes in the two states with the largest and smallest increases in total DSH funding between FY 2014 and FY 2019 illustrate the current lack of alignment between annual DSH adjustments and measures of need. During this period, Louisiana had the lowest increase in total DSH funding of

any state (0.8 percent), but in 2019, Louisiana had the ninth lowest per capita income (\$47,668) and the fifth highest rate of low-income and non-elderly individuals in the country (38.1 percent). Conversely, Nebraska had the greatest increase in total DSH funding between 2014 and 2019 (11.9 percent), even though Nebraska's rate of low-income non-elderly individuals is more than 10 percentage points lower than Louisiana (27.1 percent). In future years, the specific states that are affected most by current law will change as state per capita incomes change, but in general, the current policy benefits states with a lower share of low-income individuals.

**FIGURE 1-5.** Percentage Change in DSH Funding Relative to Inflation, FYs 2014–2019



**Notes:** DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. DSH funding is the combined federal allotment and the state share. Chart shows state and federal combined DSH funding percentage growth between FY 2014 and FY 2019. Chart shows that states with increasing FMAPs between 2014 and 2019 had less DSH funding growth when compared to states with decreasing FMAPs. The green line shows the rate of inflation between FY 2014 and FY 2019. Figure excludes Tennessee, which did not have a DSH allotment in FY 2014 because its allotment is set in statute under Section 1923(f) of the Social Security Act.

**Source:** MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.



## State effects of setting DSH allotments based on total funding

If DSH allotments are set on a total funding basis instead of a federal funding basis, then total DSH funding would not be affected by changes in the FMAP. Instead of increasing federal allotments annually based on inflation, total DSH funding would increase by the same rate in all states under this policy. For example, between FY 2014 and FY 2019, all states would have received a 7.5 percentage point increase in total DSH funding under the total funding basis policy instead of the wide variation in total DSH funding growth under current law (Table 1-1).

States with increasing FMAPs would benefit the most from a total funding basis policy. For example, the 24 states that saw an increase in their FMAP between FY 2014 and FY 2019 would have had a larger increase in their federal DSH allotment on average (11.3 percent) under this policy than they had under current law (7.5 percent).

Conversely, states with declining FMAPs would not benefit from a total funding basis policy because they would receive less federal funding compared to current law. For example, the 11 states that saw a decrease in their FMAP between FY 2014 and FY 2019 would have had a smaller increase in their federal DSH allotment (5.8 percent) under a total funding basis policy than they had under current law (7.5 percent). However, these states would still have received an increase in total available DSH funding that kept pace with inflation.

The states with no change in their FMAPs would have had no change in their DSH allotments as a result of a total funding basis policy. These include all 14 states that had the statutory minimum 50 percent FMAP in 2019 and the District of Columbia, whose FMAP is fixed in statute (MACPAC 2022b). Overall, these states account for almost half of total DSH funding (47.5 percent in 2019). Because the FMAP in these states cannot decrease further, permanently basing DSH allotments on total funding would

**TABLE 1-1.** Changes in DSH Funding during Periods of Normal Economic Growth with a Federal vs. Total Funding Basis, FYs 2014–2019

Change in state FMAP	Number of states	Average percent change in federal DSH allotment		Average percent change in total available state and federal DSH funding	
		Allotment based on federal funding (Current law)	Allotment based on total funding (MACPAC recommendation)	Allotment based on federal funding (Current law)	Allotment based on total funding (MACPAC recommendation)
Increased FMAP	24	7.5%	11.3%	3.9%	7.5%
Decreased FMAP	11	7.5	5.8	9.3	7.5
No change to FMAP	15	7.5	7.5	7.5	7.5

**Notes:** DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. Under current law, DSH allotments are based on federal funding, and the federal allotment grows with inflation. MACPAC's recommendation would change the basis of allotments to state and federal funding, and the total funding allotment would grow with inflation. Under either policy, states must provide non-federal funding to spend all available state and federal DSH funds. Number of states includes the District of Columbia and excludes Tennessee, which did not have a DSH allotment in FY 2014 because its allotment is set in statute under Section 1923(f) of the Social Security Act.

**Source:** MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.

benefit these states only if their FMAP increased in the future. More detailed estimates of the state-by-state effects of setting limits on DSH spending at the combined state and federal amount between FY 2014 and FY 2019 and between FY 2018 and FY 2019 are available in Appendix 1A.

## Commission Recommendations

The Commission makes four recommendations on actions that Congress can take to improve federal policy for DSH allotments and the calculation of the FMAP.

### Recommendation 1.1

In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of 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 total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

#### Rationale

The Commission has long held that DSH allotments should better relate to current measures of need rather than historical spending. To the extent that Congress makes changes to calculate DSH allotments on a total funding basis, it should also ensure that efforts to rebase DSH allotments on measures of need are also based on total state and federal DSH funding.

In March 2019, the Commission made a similar recommendation to restructure pending DSH allotment reductions to improve the relationship between DSH allotments and measures of need. The Commission concluded that a new statutory formula was needed because the DSH allotment reduction methodology currently prescribed in statute is

projected to preserve much of the historical variation in DSH allotments.

As discussed further in the March 2019 report, the Commission considered a variety of measures of need for DSH payments that could be used in a new formula, including hospital uncompensated care costs, the number of uninsured individuals in a state, and the number of Medicaid-enrolled individuals. Ultimately, the Commission concluded that the number of non-elderly low-income individuals in a state is the best measure to use because this measure is correlated with state levels of uncompensated care and is not affected by state decisions about whether to expand Medicaid coverage under the ACA to adults younger than age 65 with incomes less than 138 percent of the FPL. The Commission also noted the importance of adjusting allotments to account for differences in hospital costs in different geographic areas.

In March 2019, the Commission also recommended that Congress phase in DSH allotment reductions gradually and that DSH allotment reductions be applied to unspent DSH funding first. The Commission reaffirms its support for these recommendations, but there is not a need for a conforming change to the text of these recommendations if the calculation of DSH allotments are changed to a total funding basis.

#### Implications

**Federal spending.** The Congressional Budget Office (CBO) did not estimate the effects of this recommendation as a stand-alone policy separate from the Commission's other DSH allotment recommendations in its March 2019 report (phasing in reductions more gradually and applying reductions to unspent DSH funding first). Overall, these policies were designed to be budget neutral for the federal government.

**States.** Compared to current law, this policy would result in larger total DSH funding reductions for states with above average DSH funding per non-elderly low-income individual and smaller reductions in DSH funding for states with below average DSH funding per non-elderly low-income individual. This policy does not change the total amount of reductions for



all states. Additional information about the state-by-state effects of this policy are provided in MACPAC's March 2019 report to Congress.

**Enrollees.** It is difficult to predict how this change may affect enrollees because access to hospital services is also affected by how states and hospitals respond to DSH allotment reductions. The proposed rebasing policy would not change the amount of reductions, but it alters which states are most affected.

**Plans.** This recommendation would likely have no direct effect on Medicaid managed care plans.

**Providers.** This policy would affect providers differently based on which states they are located in, but the federal amount of reductions in DSH funding is unchanged.

## Recommendation 1.2

Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital (DSH) funding is not affected by changes in the federal medical assistance percentage.

### Rationale

Because DSH allotments are currently set on a federal funding basis, increases in the FMAP decrease total available state and federal DSH funding. This outcome negatively affects states that have an increase in their FMAP because of declining per capita income relative to other states, and it also negatively affects all states when Congress increases the FMAP during an economic recession or other disruptive event.

During the COVID-19 PHE, Congress temporarily set DSH funding on a total funding basis so that the amount of DSH payments a state could make would not be affected by the increased FMAP. Stakeholders preferred this policy to other mechanisms to adjust DSH funding because it preserved funding for hospitals and supported states and was relatively easy for states to implement.

Compared to current law, calculating DSH allotments on a total funding basis would result in small reductions in federal DSH allotments for states that have increasing per capita income relative to other states. However, these states also have lower rates of low-income non-elderly individuals, a potential measure of need for DSH payments. Overall, this policy has no net effect on federal spending during periods of normal economic growth, and it is consistent with how other types of Medicaid spending are affected by changes in the FMAP.

### Design considerations

To implement this policy, CMS could choose to recalculate federal DSH allotments when the FMAP changes, or it could choose to publish limits only on total DSH spending by state and determine the federal share of DSH when states submit claims for federal matching funds. CMS currently publishes the federal share of DSH allotments annually, but publishing a limit on total spending by state would be more consistent with the process used for other Medicaid spending, and it may make it easier for CMS to respond to mid-year changes in the FMAP.

The annual changes in the FMAP are published two years before the start of the fiscal year, so CMS should have time to incorporate any changes in the FMAP into its calculation of federal DSH allotments. Current regulations require CMS to post federal DSH allotments by April of the fiscal year.

During economic recessions or other disruptive events, such as natural disasters, Congress may make changes to the FMAP that apply partway through the year, which would require CMS to recalculate federal DSH allotments when the FMAP changes. For example, the 6.2 percentage point increase in the FMAP during the COVID-19 PHE was applied in the second quarter of FY 2020. Under ARPA, FY 2020 DSH allotments were increased for the full year so that total DSH funding would be the same as it would have been if the 6.2 percentage point increase in the FMAP were not in effect.

The ARPA policy will expire in FY 2023, and a 1.5 percentage point FMAP increase is currently scheduled for the first quarter of FY 2024. Unlike

prior FMAP increases, this increase is contingent on state compliance with specific requirements for unwinding the continuous coverage provisions.<sup>17</sup> Because CMS will not know in advance whether a state's FMAP will be reduced because of this penalty, it could be challenging for CMS to determine the federal share of DSH funding in advance. Instead, if Congress implements the Commission's recommendation, it might be administratively easier for CMS to publish the limit on total DSH funding and calculate the federal share of DSH funding at the time when a state submits its claim for DSH payments. This would remove the need for CMS to update allotments on the *Federal Register* whenever there is a mid-year change in the FMAP, though CMS would need to update the data systems that record DSH payments to reflect this new policy.

### Implications

**Federal spending.** According to the CBO, this recommendation will not result in a change in federal spending during periods of normal economic growth. During an economic recession or other disruptive event, this recommendation would increase federal spending on DSH proportionate to any increased FMAP that Congress provides.

**States.** This policy would help ensure that total DSH funding is not affected by increases in the FMAP. Compared to current law, states with increasing FMAPs would have higher federal allotments, while states with declining FMAPs would have lower federal allotments. When Congress increases the FMAP during economic recessions or other disruptive events, this policy would uniformly increase federal DSH allotments for all states.

**Enrollees.** This policy would likely have no direct effect on enrollees, though this policy may indirectly affect patients served by DSH hospitals. In particular, by preventing reductions in DSH funding when Congress increases the FMAP during an economic recession, this policy could also help DSH hospitals maintain access to care for Medicaid enrollees and uninsured individuals.

**Plans.** This recommendation would likely have no direct effect on Medicaid managed care plans.

**Providers.** This policy would help prevent changes in DSH funding when a state's FMAP changes. States would not need to reduce payments to DSH hospitals when Congress provides statutory increases to the FMAP. During periods of normal economic growth, providers would see the same level of DSH payments since DSH funding would grow with inflation.

## Recommendation 1.3

Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on adjusted matching rates;
- a temporary increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and
- an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group).

### Rationale

Recessions are a common feature in the US economy. Since 1990, a recession occurred in 1990, 2001, 2007, and 2020. An automatic countercyclical financing mechanism based on the GAO prototype model would have been triggered in each of those recessions and helped states respond more quickly during an economic crisis.

As described in the MACPAC March 2021 report to Congress, the GAO countercyclical financing model is a helpful prototype that aligns with the Commission's goals. The GAO model uses objective and timely indicators of an economic downturn, ensuring that

federal assistance would flow to states several fiscal quarters before Congress acts. The model uses unemployment and employment data that is published monthly and therefore is a timely and comparable measure across states. The model's trigger also is sufficiently sensitive that it would have been triggered during each of the previous three recessions over the last 20 years but not sensitive enough to trigger an FMAP increase due to minor economic fluctuations.<sup>18</sup> The GAO model also targets federal support to states that need it most.<sup>19</sup>

Including DSH allotments in the countercyclical financing model would ensure that there is not a decline in DSH funding when the FMAP is automatically adjusted upward. Basing DSH allotments on total funding would ensure that once the model is triggered, the federal share of DSH payments would automatically increase without decreasing payment levels. This would provide more certainty for states and providers about the total amount of DSH funding available for uncompensated care. States and hospitals have expressed concerns about the length of time it took for Congress to establish a countercyclical DSH allotment policy during the PHE, which affected the timing of DSH payments and the ability for states to plan their spending of DSH funds.

## Implications

**Federal spending.** This recommendation would increase federal spending on Medicaid in the form of a fiscal stimulus to states when the countercyclical financing model is triggered. According to CBO, implementing this recommendation would cost \$10 billion in FY 2024 and about \$70 billion from FY 2023 to FY 2033. The DSH provision within this recommendation accounts for 1.1 percent (\$750 million) of the \$70 billion 10-year estimate.

In MACPAC's March 2021 report to Congress, CBO estimated that a similar countercyclical financing model would have cost \$1 billion in the first year and \$30 billion–\$40 billion over the next 10 years (MACPAC 2021a). CBO's higher estimate in this report is attributed to updated economic data that increases the likelihood of a recession in the coming year compared to the likelihood of a recession in 2021.

These estimates assume that Congress will not otherwise act to increase the FMAP in future downturns. If Congress does not adopt this recommendation, it could still decide to provide an FMAP increase in response to a future economic recession as it has done several times in the past, and such changes would increase federal spending. For example, in 2009, Congress authorized a 27-month increase in Medicaid FMAP that added \$32 billion in federal Medicaid outlays in FY 2009 and \$40 billion in FY 2010 (CBO 2009). These types of stimulus expenditures cannot be factored into routine budgeting processes and are not included in the Medicaid baseline once their authority expires.

**States.** This policy would provide fiscal stimulus to states for Medicaid when the countercyclical financing model is triggered. Increases in federal spending would offset reductions in state spending commensurate with the declines in the state-level unemployment and wage and salary data. Introducing DSH language into MACPAC's previous recommendation ensures that DSH payments receive the same fiscal relief as most other Medicaid payments.

**Enrollees.** The availability of additional federal funding and the maintenance of effort requirement will help ensure that states have the funds and the incentive to support increased Medicaid enrollment during an economic downturn. This policy may also indirectly benefit enrollees by preserving total available funds for DSH hospitals, which could help these hospitals maintain access to care for Medicaid enrollees and uninsured individuals.

**Plans.** This recommendation would likely have no direct effect on Medicaid managed care plans.

**Providers.** The availability of a predictable source of additional federal funding would help states more effectively determine how to allocate their budgets and may enable them to delay or prevent provider and plan rate cuts that would otherwise be made to meet a state balanced budget requirement. This policy would not reduce DSH funding when the financing model is triggered, when hospital uncompensated care costs are expected to increase. Publicly owned hospitals may benefit if states choose to reduce provider contributions to the non-federal share in response to

the countercyclical FMAP. Hospitals that fund DSH payments through a provider tax may also benefit if the state passes along the FMAP savings in the form of tax relief; however, tax relief may not be realized until subsequent fiscal years.

## Recommendation 1.4

To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare & Medicaid Services (CMS) compare DSH allotments to total state Medicaid medical assistance

expenditures in a given year before finalizing DSH allotments for that year.

### Rationale

MACPAC has found that some states did not spend their full DSH allotments in the year that they were intended because there is a substantial delay before CMS finalizes DSH allotments. For example, finalized FY 2018 DSH allotments were not posted until March 2022. Currently, CMS provides states only with preliminary estimates of the amount of DSH funding available, but the states were cautious about spending this full amount before allotments were finalized in case they may have to recoup funds from hospitals later.

**FIGURE 1-6.** National DSH Expenditures as a Share of Medical Expenditures, 1989–2016



**Notes:** DSH is disproportionate share hospital. DSH expenditures include both state and federal funds. Medical expenditures include state and federal medical spending, which does not typically include administrative spending.

**Source:** MACPAC, 2023, analysis of CMS Medicaid Budget and Expenditure System and CMS 2016.

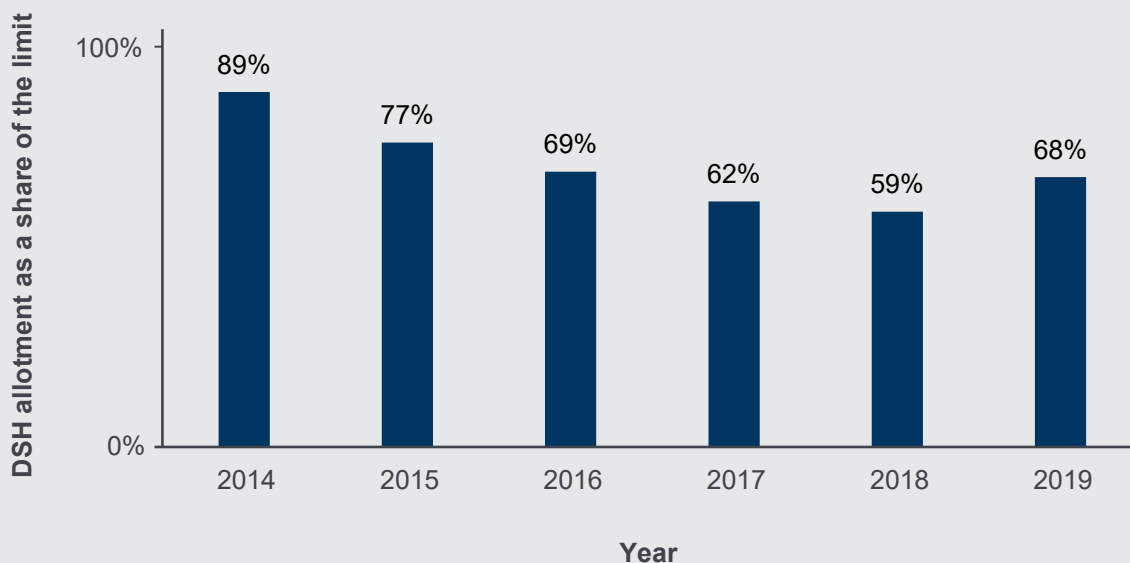
The statutory requirement that CMS compare DSH allotments to total state Medicaid spending creates delays in finalizing allotments. Section 1923(f)(3)(B) of the Social Security Act specifies that DSH allotments cannot exceed 12 percent of medical assistance spending at the individual state level.<sup>20</sup> However, state Medicaid spending amounts are not finalized until at least two years after the payments are made, which delays CMS's ability to perform this calculation.

This limit was put in place in the 1990s to ensure that DSH spending remained below 12 percent of the national amount of medical assistance expenditures (Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, P.L. 102-234) (CRS 2016) (42 CFR § 447.297). However, the limit no longer has any practical effect on DSH spending. When this legislation was passed, total DSH spending was 15.2 percent of Medicaid spending, but

in FY 2016, total DSH payments were 3.6 percent of Medicaid spending (Figure 1-6).

In recent years, no state has had its DSH allotment lowered to meet the limit described in Section 1923(f)(3)(B) of the Social Security Act (CMS 2022, 2019, 2018, 2017, 2016).<sup>21</sup> In our review of CMS data, no state has been within 10 percent of the limit since 2014, when many states expanded Medicaid coverage to adults younger than age 65 with incomes below 138 percent of the FPL. In 2014, New Hampshire was closest to the limit with an allotment that was 89 percent of the limit, and by 2019, New Hampshire's allotment was 68 percent of the limit (Figure 1-7).<sup>22</sup> Because Medicaid spending tends to grow faster than inflation, and DSH allotments are pegged to inflation, it is unlikely that any state would exceed the 12 percent limit in the future.

**FIGURE 1-7.** State with the Highest Allotment as a Percent of the Section 1923(f)(3)(B) Limit



**Notes:** DSH is disproportionate share hospital. The bar chart shows the final allotment as a percentage of the CMS calculated DSH allotment limit as outlined under Section 1923(f)(3)(B) of the Social Security Act. According to this provision, DSH allotments are not allowed to exceed 12 percent of total medical assistance spending in the state. In 2014 and 2017–2019, New Hampshire's DSH allotment was closest to the limit. From 2015 to 2016, Louisiana's DSH allotment was closest to the limit.

**Source:** MACPAC analysis of CMS 2022, 2019, 2018, 2017, 2016.



## Implications

**Federal spending.** According to the CBO, this recommendation would have no effect on federal spending because no state is likely to have DSH spending close to the existing limit on DSH allotments as a share of state Medicaid spending. This recommendation would reduce federal administrative burden needed to finalize DSH allotments because CMS would no longer need to review medical spending data before finalizing DSH allotments.

**States.** This recommendation would help provide more certainty to states about available DSH funds in a timely manner. By helping CMS to finalize DSH allotments sooner, this policy would help states plan for how to spend available DSH funds with fewer concerns about needing to recoup funding at a later date.

**Enrollees.** This recommendation would likely have no direct effect on enrollees.

**Plans.** This recommendation would likely have no direct effect on Medicaid managed care plans.

**Providers.** This recommendation would help hospitals receive DSH payments in a timelier manner, since states would be able to send out DSH payments on a more rapid basis when DSH allotments are finalized with less concern about these payments being recouped.

## Endnotes

<sup>1</sup> 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 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 and 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.

<sup>2</sup> A hospital qualifies to receive DSH payments if the facility meets specific statutory requirements. This includes having a Medicaid inpatient utilization rate of 1 percent and having 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). Medicaid inpatient utilization rate is defined as the total number of Medicaid inpatient days divided by the total number of inpatient days.

<sup>3</sup> 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. The Omnibus Budget Reconciliation Act of 1981 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).

<sup>4</sup> 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.

<sup>5</sup> 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 (Appeals 2002).

<sup>6</sup> 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.

<sup>7</sup> This analysis excludes DSH payments to institutions for mental diseases and Section 1115 supplemental payments that are financed by DSH allotments and diverted to the Section 1115 demonstration.

<sup>8</sup> Deemed DSH hospitals are hospitals with a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receives Medicaid payments or a low-income utilization rate that

exceeds 25 percent. Low-income utilization rate is defined as the sum of two fractions. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Social Security Act). For more on deemed DSH and other DSH hospitals, please refer to Chapter 4: Annual analysis of Medicaid disproportionate share hospital allotments to states in MACPAC's March 2023 Report to Congress on Medicaid and CHIP (MACPAC 2023b).

<sup>9</sup> Under Section 1115 demonstration authority, CMS has authorized uncompensated care pools in some states that also pay for unpaid costs of care to uninsured individuals.

<sup>10</sup> DSH payment data is provided to CMS from states on Medicaid DSH audits. These audits are reported on a state plan rate year basis, which often corresponds to the state fiscal year and does not align with the federal fiscal year.

<sup>11</sup> 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 have 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.

<sup>12</sup> The GAO prototype model triggers an enhanced FMAP that is automatically implemented nationally when 26 or more states show increased unemployment (defined as a decrease in the three-month average employment-to-population ratio over the prior year) for two consecutive months. The GAO model ends temporary assistance once fewer than half of states show a decline in their year-over-year employment-to-population ratio over two consecutive months (GAO 2011).

<sup>13</sup> Because Section 1115 demonstrations often include multiple populations with different FMAP rates, CMS applies an average FMAP rate (referred to as the "composite federal share") that is based on federal funding for all demonstration expenditures divided by total state and federal spending under the demonstration.

<sup>14</sup> Providers in states that generate the non-federal share for DSH payments through a provider tax or an assessment would benefit if the state reduces the provider contribution in the form of tax relief. However, provider tax relief would not be implemented immediately. Many states have laws that require funds generated through a provider tax in a separate

fund, which can be used only to finance payments for the taxed providers. States may find themselves with a surplus in the fund at the end of the year, which they will use to reduce the tax or assessment in the subsequent year.

<sup>15</sup> States can target non-DSH Medicaid payments by creating different payment policies for classes of hospitals that meet state-specified characteristics.

<sup>16</sup> These states were chosen because they have different characteristics regarding the unspent allotment within the state and state strategies in financing the non-federal share for DSH payments.

<sup>17</sup> For each month from April 1, 2023, through June 30, 2024, states must submit data related to the unwinding that the Secretary of HHS (the Secretary) must make publicly available. Although the Consolidated Appropriations Act of 2023 requires that the data must be submitted to the Secretary on a timely basis, the law does not specify a timeline for sharing the data publicly. The required data reporting includes the number of eligibility renewals initiated, the total number of beneficiaries renewed, and the beneficiaries renewed on an ex parte basis; the number of individuals whose Medicaid, CHIP, or pregnancy-related coverage was terminated and the number terminated for procedural reasons; the number of children enrolled in separate CHIP; the number of individuals determined eligible for a qualified health plan or the basic health program, and of these, the number of eligible individuals who selected a qualified health plan or were enrolled in the basic health program; in states using the federal exchange or a non-integrated state-based exchange, the number of account transfers to the exchange; call center volume, average wait times, and call abandonment rates; and other information related to eligibility redeterminations and renewals as identified by the Secretary.

<sup>18</sup> The automatic countercyclical financing model is triggered when a majority of states have a decline in their three-month average employment-to-population ratio for two consecutive months when compared with the prior year. The use of the three-month average helps to smooth out monthly outliers, while the use of a year-over-year trend over two consecutive months controls for seasonal employment differences.

<sup>19</sup> State-level increases in the FMAP are determined by measuring the degree to which employment and salaries declined. States with lower levels of employment and salary or wage declines would receive a greater federal match. Both measures indicate the extent to which Medicaid would

need to cover a growing share of the population and the degree to which states can finance the non-federal share as its tax revenue declines.

<sup>20</sup> A 12 percent DSH allotment limit means that federal allotments cannot be greater than the total amount of Medicaid medical assistance expenditures (i.e., federal and state medical benefit spending, which does not include spending on administrative activities).

<sup>21</sup> Tennessee did not receive a DSH allotment in FY 2014, and its DSH allotment is set to \$53,100,000 from FY 2015 to FY 2025 under the provisions of Section 1923(f)(6). Louisiana was not subject to the 12 percent limit until FY 2015 because its allotment is determined under provisions under Section 1923(f)(3)(C) and (D), which froze Louisiana's DSH allotment at FY 2004 levels (CRS 2016).

<sup>22</sup> New Hampshire's non-DSH-related medical spending declined by \$2.1 billion (11 percent) in FY 2019 when compared with the year prior.

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# APPENDIX 1A. State Effects of DSH Allotment Policy

**TABLE 1A-1.** DSH Allotments under Different Policy Scenarios, FY 2018 and FY 2019 (millions)

State	Percentage point change in FMAP (2018–2019)	Federal DSH allotment				Total available state and federal DSH funding			
		Allotment based on federal funding (current law)		Allotment based on total funding		FY 2018	Allotment based on federal funding (current law)		Percent change
		FY 2019	Percent change	FY 2019	Percent change		FY 2019	Percent change	
<b>Total</b>		<b>\$12,244</b>	<b>2.4%</b>	<b>\$12,593</b>	<b>2.9%</b>	<b>\$21,706</b>	<b>\$22,135</b>	<b>2.0%</b>	<b>2.4%</b>
Alabama	0.44%	345	2.4	355	3.0	482	491	1.8	2.4
Alaska	–	23	2.4	23	2.4	46	47	2.4	2.4
Arizona	-0.08	116	2.4	116	2.3	162	166	2.5	2.4
Arkansas	-0.36	50	2.4	49	1.9	68	70	2.9	2.4
California	–	1,258	2.4	1,258	2.4	2,457	2,516	2.4	2.4
Colorado	–	106	2.4	106	2.4	207	212	2.4	2.4
Connecticut	–	230	2.4	230	2.4	448	459	2.4	2.4
Delaware	1.12	10	2.4	11	4.4	18	18	0.4	2.4
District of Columbia	–	70	2.4	70	2.4	98	100	2.4	2.4
Florida	-0.92	230	2.4	226	0.9	363	377	3.9	2.4
Georgia	-0.88	308	2.4	304	1.1	440	456	3.7	2.4
Hawaii	-0.86	11	2.4	11	0.8	20	21	4.0	2.4
Idaho	-0.04	19	2.4	19	2.3	26	27	2.5	2.4
Illinois	-0.43	247	2.4	245	1.5	475	490	3.3	2.4
Indiana	0.37	245	2.4	247	3.0	365	372	1.8	2.4
Iowa	1.45	45	2.4	46	4.9	75	75	-0.1	2.4
Kansas	2.36	47	2.4	49	6.8	84	83	-1.8	2.4
Kentucky	0.50	166	2.4	168	3.1	228	232	1.7	2.4
Louisiana	1.31	787	2.4	803	4.5	1,207	1,211	0.3	2.4
Maine	0.18	120	2.4	121	2.7	183	187	2.1	2.4
Maryland	–	88	2.4	88	2.4	171	175	2.4	2.4
Massachusetts	–	350	2.4	350	2.4	684	700	2.4	2.4

**TABLE 1A-1. (continued)**

State	Percentage point change in FMAP (2018–2019)	Federal DSH allotment						Total available state and federal DSH funding					
		FY 2018		Allotment based on federal funding (current law)		Allotment based on total funding		FY 2018		Allotment based on federal funding (current law)		Allotment based on total funding	
				FY 2019	Percent change	FY 2019	Percent change			FY 2019	Percent change	FY 2019	Percent change
Total		\$12,244	\$12,538	2.4%	\$12,593	2.9%	\$21,706	\$22,135	2.0%	\$22,227	2.4%	2.4%	
Michigan	-0.33%	297	304	2.4	303	1.9	458	472	2.9	469	2.4	2.4	
Minnesota	–	84	86	2.4	86	2.4	167	171	2.4	171	2.4	2.4	
Mississippi	0.74	171	175	2.4	177	3.4	226	229	1.4	231	2.4	2.4	
Missouri	0.79	531	544	2.4	550	3.7	822	831	1.2	841	2.4	2.4	
Montana	0.16	13	13	2.4	13	2.7	19	20	2.2	20	2.4	2.4	
Nebraska	0.03	32	32	2.4	32	2.5	60	62	2.3	62	2.4	2.4	
Nevada	-0.88	52	53	2.4	52	1.0	79	82	3.8	81	2.4	2.4	
New Hampshire	–	179	184	2.4	184	2.4	359	367	2.4	367	2.4	2.4	
New Jersey	–	721	739	2.4	739	2.4	1,443	1,478	2.4	1,478	2.4	2.4	
New Mexico	0.10	23	23	2.4	23	2.5	32	32	2.3	32	2.4	2.4	
New York	–	1,800	1,843	2.4	1,843	2.4	3,600	3,687	2.4	3,687	2.4	2.4	
North Carolina	-0.45	331	339	2.4	336	1.7	489	504	3.1	501	2.4	2.4	
North Dakota	–	11	11	2.4	11	2.4	21	22	2.4	22	2.4	2.4	
Ohio	0.31	455	466	2.4	469	2.9	725	739	1.9	743	2.4	2.4	
Oklahoma	3.81	41	42	2.4	44	9.1	69	67	-3.9	71	2.4	2.4	
Oregon	-1.06	51	52	2.4	51	0.7	80	83	4.1	82	2.4	2.4	
Pennsylvania	0.43	629	644	2.4	649	3.2	1,214	1,233	1.6	1,243	2.4	2.4	
Rhode Island	1.12	73	75	2.4	76	4.6	142	142	0.2	145	2.4	2.4	
South Carolina	-0.36	367	376	2.4	374	1.9	513	528	2.9	525	2.4	2.4	
South Dakota	1.37	12	13	2.4	13	4.9	22	22	-0.1	23	2.4	2.4	
Texas	1.31	1,072	1,097	2.4	1,123	4.8	1,884	1,886	0.1	1,929	2.4	2.4	
Utah	-0.55	22	23	2.4	22	1.6	31	32	3.2	32	2.4	2.4	

**TABLE 1A-1.** (continued)

State	Percentage point change in FMAP (2018–2019)	Federal DSH allotment				Total available state and federal DSH funding			
		Allotment based on federal funding (current law)		Allotment based on total funding		Allotment based on federal funding (current law)		Allotment based on total funding	
		FY 2019	Percent change	FY 2019	Percent change	FY 2019	Percent change	FY 2019	Percent change
<b>Total</b>		<b>\$12,244</b>	<b>\$12,538</b>	<b>2.4%</b>	<b>\$12,593</b>	<b>2.9%</b>	<b>\$21,706</b>	<b>\$22,135</b>	<b>2.0%</b>
Vermont	0.42%	25	26	2.4	26	3.2	47	48	1.6
Virginia	–	98	101	2.4	101	2.4	196	201	2.4
Washington	–	207	212	2.4	212	2.4	415	425	2.4
West Virginia	1.10	76	77	2.4	79	3.9	103	104	0.9
Wisconsin	0.60	106	108	2.4	110	3.4	180	183	1.4
Wyoming	–	0	0	2.4	0	2.4	1	1	2.4

**Notes:** DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. Under current law, federal DSH allotments increase based on inflation, and under our recommendation to base allotments on total funding, total available DSH funding increases based on inflation. Under either policy, states must provide non-federal funding to spend all available state and federal DSH funds. List of states does not include Tennessee because its federal DSH allotment was \$0 in FY 2014 and is set in statute through FY 2025 and does not increase automatically based on inflation like other states.

– Dash indicates zero. 0.0% and \$0 are non-zero amounts that round to zero.

**Source:** MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.

**TABLE 1A-2. DSH Allotments under Different Policy Scenarios, FY 2014 and FY 2019 (millions)**

State	Percentage point change in FMAP (2014–2019)	Federal DSH allotment				Total available state and federal DSH funding			
		Allotment based on federal funding (current law)		Allotment based on total funding		FY 2014	Allotment based on federal funding (current law)		Percent change
		FY 2014	FY 2019	Percent change	FY 2019	Percent change	FY 2014	FY 2019	Percent change
<b>Total</b>		<b>\$11,663</b>	<b>\$12,538</b>	<b>7.5%</b>	<b>\$12,648</b>	<b>8.4%</b>	<b>\$20,759</b>	<b>\$22,135</b>	<b>6.6%</b>
Alabama	3.76%	328	353	7.5	372	13.4	482	491	1.9
Alaska	–	22	23	7.5	23	7.5	43	47	7.5
Arizona	2.58	108	116	7.5	121	11.6	161	166	3.5
Arkansas	0.41	46	50	7.5	50	8.1	66	70	6.9
California	–	1,170	1,258	7.5	1,258	7.5	2,341	2,516	7.5
Colorado	–	99	106	7.5	106	7.5	197	212	7.5
Connecticut	–	214	230	7.5	230	7.5	427	459	7.5
Delaware	2.24	10	10	7.5	11	11.9	17	18	3.3
District of Columbia	–	65	70	7.5	70	7.5	93	100	7.5
Florida	2.08	214	230	7.5	238	11.3	363	377	3.8
Georgia	1.69	287	308	7.5	316	10.3	435	456	4.8
Hawaii	2.07	10	11	7.5	12	11.8	20	21	3.4
Idaho	-0.51	18	19	7.5	19	6.7	24	27	8.3
Illinois	0.31	230	247	7.5	248	8.2	459	490	6.8
Indiana	-0.96	228	245	7.5	242	6.0	341	372	9.1
Iowa	2.00	42	45	7.5	47	11.2	73	75	3.9
Kansas	0.19	44	47	7.5	47	7.9	77	83	7.1
Kentucky	1.84	155	166	7.5	171	10.3	222	232	4.7
Louisiana <sup>1</sup>	4.02	732	787	7.5	839	14.6	1,200	1,211	0.8
Maine	2.97	112	120	7.5	126	12.7	182	187	2.6
Maryland	–	81	88	7.5	88	7.5	163	175	7.5
Massachusetts	–	326	350	7.5	350	7.5	651	700	7.5



**TABLE 1A-2. (continued)**

State	Percentage point change in FMAP (2014–2019)	Federal DSH allotment				Total available state and federal DSH funding			
		Allotment based on federal funding (current law)		Allotment based on total funding		FY 2014	Allotment based on federal funding (current law)		Percent change
		FY 2019	Percent change	FY 2019	Percent change		FY 2019	Percent change	
<b>Total</b>		<b>\$11,663</b>	<b>7.5%</b>	<b>\$12,538</b>	<b>8.4%</b>	<b>\$20,759</b>	<b>\$22,135</b>	<b>6.6%</b>	<b>7.5%</b>
Michigan	-1.87%	283	7.5	304	4.5	427	472	10.6	7.5
Minnesota	–	80	7.5	86	7.5	159	171	7.5	7.5
Mississippi	3.34	163	7.5	175	12.4	223	229	2.8	7.5
Missouri	3.37	506	7.5	544	13.3	815	831	2.0	7.5
Montana	-0.79	12	7.5	13	6.2	18	20	8.8	7.5
Nebraska	-2.16	30	7.5	32	3.3	55	62	11.9	7.5
Nevada	1.77	49	7.5	53	10.5	78	82	4.6	7.5
New Hampshire	–	171	7.5	184	7.5	342	367	7.5	7.5
New Jersey	–	687	7.5	739	7.5	1,374	1,478	7.5	7.5
New Mexico	3.06	22	7.5	23	12.3	31	32	2.9	7.5
New York	–	1,715	7.5	1,843	7.5	3,429	3,687	7.5	7.5
North Carolina	1.38	315	7.5	339	9.8	479	504	5.3	7.5
North Dakota	–	10	7.5	11	7.5	20	22	7.5	7.5
Ohio	0.07	434	7.5	466	7.6	688	739	7.4	7.5
Oklahoma	-1.64	39	7.5	42	4.7	60	67	10.3	7.5
Oregon	-0.58	48	7.5	52	6.5	77	83	8.5	7.5
Pennsylvania	-1.27	599	7.5	644	4.9	1,119	1,233	10.1	7.5
Rhode Island	2.46	69	7.5	75	12.8	138	142	2.5	7.5
South Carolina	0.65	350	7.5	376	8.5	495	528	6.5	7.5
South Dakota	3.17	12	7.5	13	13.9	22	22	1.5	7.5
Texas	-0.50	1,021	7.5	1,097	6.6	1,739	1,886	8.4	7.5
Utah	-0.63	21	7.5	23	6.5	30	32	8.5	7.5



**TABLE 1A-2. (continued)**

State	Percentage point change in FMAP (2014–2019)	Federal DSH allotment				Total available state and federal DSH funding			
		Allotment based on federal funding (current law)		Allotment based on total funding		FY 2014	Allotment based on federal funding (current law)		Allotment based on total funding
		FY 2019	Percent change	FY 2019	Percent change		FY 2019	Percent change	FY 2019
<b>Total</b>		<b>\$11,663</b>		<b>\$12,538</b>	<b>7.5%</b>	<b>\$12,648</b>	<b>\$20,759</b>	<b>\$22,135</b>	<b>\$22,316</b>
Vermont	-1.22%	24		26	7.5	25	44	48	47
Virginia	–	94		101	7.5	101	187	201	201
Washington	–	197		212	7.5	212	395	425	425
West Virginia	3.25	72		77	7.5	81	101	104	109
Wisconsin	0.31	101		108	7.5	109	171	183	184
Wyoming	–	0		0	7.5	0	0	1	1

**Notes:** DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. Under current law, federal DSH allotments increase based on inflation, and under our recommendation to base allotments on total funding, total available DSH funding increases based on inflation. Under either policy, states must provide non-federal funding to spend all available state and federal DSH funds. List of states does not include Tennessee because its federal DSH allotment was \$0 in FY 2014 and is set in statute through FY 2025 and does not increase automatically based on inflation like other states.

– Dash indicates zero. 0.0% and \$0 are non-zero amounts that round to zero.

<sup>1</sup> Louisiana's FMAP represents its FMAP for DSH payments. Louisiana had an enhanced FMAP in 2014 that was increased under the Stafford Act; however, the Stafford Act FMAP increase only applies to non-DSH Medicaid payments.

**Source:** MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.

## 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 April 14, 2023.

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### Automatic Adjustments to Medicaid Disproportionate Share Hospital Allotments

- 1.1 In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.
- 1.2 Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital funding is not affected by changes in the federal medical assistance percentage.
- 1.3 Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:
  - an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
  - an upper bound of 100 percent on adjusted matching rates;
  - an increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and
  - an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group)
- 1.4 To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare & Medicaid Services compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

1.1-1.4 voting results	#	Commissioner
<b>Yes</b>	15	Allen, Bella, Bjork, Brooks, Carter, Cerise, Davis, Duncan, Gerstorff, Giardino, Gordon, Johnson, Meadows, Scanlon, Weno
<b>Not present</b>	1	Heaphy

## Chapter 2:

# Integrating Care for Dually Eligible Beneficiaries: Different Delivery Mechanisms Provide Varying Levels of Integration

# Integrating Care for Dually Eligible Beneficiaries: Different Delivery Mechanisms Provide Varying Levels of Integration

## Key Points

- Dually eligible beneficiaries, the 12.2 million people eligible for both Medicaid and Medicare in 2022, often experience fragmented care and poor health outcomes when their benefits are not coordinated. Integrating their Medicaid and Medicare coverage has the potential to improve their care, eliminate incentives for cost shifting between the two programs, and reduce spending that may arise from duplication of services or poor care coordination. About 21 percent of dually eligible beneficiaries were enrolled in integrated products in 2022.
- In MACPAC's June 2022 report to Congress, the Commission recommended that all states be required to develop a strategy to integrate care, with federal support. Building on our recommendation, in this chapter, MACPAC explores the different delivery mechanisms that states use to provide Medicaid coverage to dually eligible beneficiaries and opportunities for integration. Our review includes Medicaid fee for service, Medicare Advantage dual eligible special needs plans (D-SNPs), and the Medicare-Medicaid plans (MMPs) under the Financial Alignment Initiative demonstration.
- In 2022, the Centers for Medicare & Medicaid Services (CMS) made regulatory changes that will sunset the MMPs, a long-standing capitated demonstration model that was seen as an example of full integration but had a limited reach. CMS is encouraging states to transition their MMP enrollees to integrated D-SNPs, a transition the Commission is continuing to monitor. This change effectively makes D-SNPs the primary vehicle for states to integrate care, which may expand enrollment in these products.
- States that choose to contract with D-SNPs can leverage contracting tools to increase integration for beneficiaries. CMS has already incorporated certain MMP elements into the regulations governing D-SNPs, and states transitioning away from MMPs may use their three-way contracts as models for their new contracts with D-SNPs.
- Whatever the delivery mechanism states are using to provide coverage to dually eligible beneficiaries, including Medicaid managed care or fee for service, states have access to different system design options to increase integration. MACPAC recognizes that fully integrated coverage is available only to a limited number of dually eligible beneficiaries and that state circumstances vary widely. Identifying options for states across delivery mechanisms is an ongoing area of focus.

## CHAPTER 2: Integrating Care for Dually Eligible Beneficiaries: Different Delivery Mechanisms Provide Varying Levels of Integration

For individuals enrolled in both Medicaid and Medicare, known as “dually eligible beneficiaries,” integrating the coverage they receive has the potential to improve the experience for beneficiaries and reduce federal and state spending. Dually eligible beneficiaries often experience fragmented care and poor health outcomes due to inadequate coordination of services and misaligned financial incentives between the two programs (MACPAC 2020a, 2020b). This lack of coordination and the population’s overall higher health needs contribute to disproportionate federal and state spending. Although dually eligible beneficiaries made up 19 percent and 14 percent of all Medicare and Medicaid enrollees, respectively, they accounted for 34 percent of total Medicare spending and 30 percent of total Medicaid spending in calendar year (CY) 2020 (MACPAC and MedPAC 2023). Many dually eligible individuals also experience functional limitations along with challenging health-related social needs. They are more likely to have disabilities

than non-dual Medicare beneficiaries. They are also more likely than non-dual Medicare beneficiaries to be Black (21 percent compared to 9 percent, respectively) or Hispanic (17 percent compared to 6 percent, respectively), and therefore, the fragmented care that dually eligible individuals receive may have compounding effects on health equity across race and ethnicity (MACPAC and MedPAC 2023).

The Commission’s long-term vision is that all dually eligible beneficiaries should have access to integrated care. Our prior work has focused on three key goals: increasing enrollment in integrated products, making integrated products more widely available, and promoting greater integration in existing products. States are at different stages of integrating coverage for dually eligible beneficiaries, and the availability of integrated models as well as the level of integration offered in those models varies. Some states have achieved high levels of integration, while others offer few or no integrated coverage options. To provide an impetus for action, in June 2022, the Commission recommended that all states develop an integrated care strategy—including integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, and quality measurement—that would be structured to promote health equity. To support states in developing their strategies and raising the bar on integrated care, the Commission also recommended that Congress provide additional federal funding to states to assist them in their efforts to integrate Medicaid and Medicare coverage for dually eligible beneficiaries (MACPAC 2022a) (Box 2-1).

### BOX 2-1. Recommendation, June 2022

Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy, to be specified by the Secretary. The strategy should include the following components—integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, quality measurement—and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries (MACPAC 2022a).

Building on the Commission's recommendation, we have set out to take an expansive view of the different delivery mechanisms states use to provide Medicaid coverage to dually eligible beneficiaries and opportunities for integration across the two programs. We have organized our review of delivery mechanisms into three categories: Medicaid fee for service (FFS), Medicare Advantage (MA) dual eligible special needs plans (D-SNPs), and Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative (FAI).

Our review of the varied delivery mechanisms comes at a time of change in the Medicaid-Medicare integration landscape. Access to D-SNPs has been growing since they were permanently authorized in the Bipartisan Budget Act of 2018 (P.L. 115-123). In 2023, 94 percent of Medicare beneficiaries reside in areas with access to D-SNPs, compared to 89 percent in 2019 (MedPAC 2023). State participation in the MMP model under the FAI demonstration has been relatively low, and three states have exited the demonstration to pursue other models.<sup>1</sup> California is the most recent state to leave the demonstration. In response, the Centers for Medicare & Medicaid Services (CMS) incorporated several features of the MMPs into the regulations governing D-SNPs, such as the requirement for an enrollee advisory committee for which the state solicits input from beneficiaries on their experience, and announced it will sunset the MMPs at the end of 2023. For states that opted for a final two-year extension, CMS required that MMP enrollees are transitioned to integrated D-SNPs by the end of 2025 (CMS 2022a).<sup>2</sup> This change effectively makes D-SNPs, and the state contracts under which they operate, the primary vehicle available to states for integrating Medicaid and Medicare. As the eight remaining MMP states begin the transition to D-SNPs, they may provide an example for other states of how to establish an integrated program for dually eligible beneficiaries.

Consistent with MACPAC's prior work calling for states to develop integrated care strategies, which we began in June 2022, this chapter begins by describing the mechanisms available for integrating Medicaid and Medicare for dually eligible beneficiaries. States may cover Medicaid benefits for their dually eligible population through Medicaid FFS or managed care, and the tools for maximizing integration in these mechanisms differ. The chapter details the changing landscape of integrated program design, as illustrated

by the sunset of the MMP model, a substantial change that may expand enrollment in D-SNPs. In the discussion of the changing landscape, we also describe MACPAC's framework for monitoring the MMP transition and how D-SNPs are the primary vehicle for integration moving forward. This discussion is informed by insights from beneficiaries about their experience receiving coverage through these models. Finally, the chapter concludes with next steps in our ongoing work to advance integrated care for dually eligible beneficiaries, building on our June 2022 recommendation to require states to develop a strategy.

## Background

In 2020, 12.2 million individuals were dually eligible for Medicaid and Medicare (MACPAC and MedPAC 2023). Most were full-benefit dually eligible beneficiaries (72 percent), who received coverage of Medicaid and Medicare services. Partial-benefit dually eligible beneficiaries—who did not receive Medicaid-covered services but rather Medicaid benefits to assist in paying Medicare premiums, and in some cases, Medicare cost sharing—made up the other 28 percent (MACPAC and MedPAC 2023). Medicaid and Medicare offer dually eligible beneficiaries different benefits. Medicare generally serves as the primary payer for services that overlap with those offered by Medicaid, providing coverage for services such as inpatient hospital care and physician services, while Medicaid covers long-term services and supports (LTSS) and other services that Medicare does not, such as certain behavioral health services.

Even as the dually eligible population has grown, the number of beneficiaries enrolled in integrated care products remains relatively small. In 2022, about 21 percent of full-benefit dually eligible beneficiaries, or about 1.75 million individuals, were enrolled in integrated products under managed care arrangements (CMS 2023a). Although partial-benefit dually eligible beneficiaries may also be enrolled in integrated care products, efforts tend to focus on full-benefit dually eligible beneficiaries because they have Medicaid services to coordinate with Medicare coverage (MACPAC 2022a).



Integrated care for dually eligible beneficiaries can address misaligned incentives between Medicaid and Medicare. When different entities bear risk for Medicaid and Medicare services, there is an opportunity to shift costs from one program to the other. For example, a state Medicaid agency may be disinclined to pay for additional services in a nursing facility that could prevent hospital readmissions because the financial risks of subsequent hospitalizations would be borne by Medicare. On the other hand, Medicare may seek to limit its spending by discharging patients from the hospital more quickly, which could lead to beneficiaries requiring a greater level of LTSS, a benefit covered by Medicaid.

Integrated care typically occurs in a managed care environment through either MMPs under the FAI or through D-SNPs (Box 2-2).<sup>3</sup> With some exceptions—such as for Medicaid benefits that the state has carved out—MMPs cover all Medicaid and Medicare benefits under a single entity through a three-way contract between CMS, the state, and the health plan.<sup>4</sup> This three-way contract allows for integrated state and federal oversight, including integrated medical loss ratios that reflect both Medicaid and Medicare payments and spending. All MMPs offer fully integrated coverage, and as a result, appeals and grievances, member materials, and customer service are integrated (CMS 2023b).

## BOX 2-2. Integrated Models on a Continuum

### Low level of integration

- **Coordination-only dual eligible special needs plans (CO D-SNPs).** These plans are required to meet only minimal levels of integration and coordination defined by the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) and the Bipartisan Budget Act of 2018 (P.L. 115-123). CO D-SNPs cover all Medicare services, while Medicaid services—specifically, behavioral health and long-term services and supports (LTSS)—are typically covered by the state Medicaid program. Federal regulations require only low levels of integration for CO D-SNPs, but each state may set requirements in its state Medicaid agency contract with a D-SNP that raises the bar to moderate levels of integration.

### Moderate level of integration

- **Managed fee for service.** Available in one state for dually eligible beneficiaries under the Financial Alignment Initiative demonstration, this model is centered on health homes, which provide comprehensive care coordination services to a high-cost, high-risk subpopulation of dually eligible beneficiaries. The state is eligible to share in savings to Medicare that may result from improvements in quality due to better care coordination.
- **Highly integrated dual eligible special needs plan (HIDE SNP).** These plans must cover behavioral health or LTSS through an aligned Medicaid managed care plan operating under the same parent organization as the D-SNP, but they may cover both. Starting in 2025, a HIDE SNP's aligned Medicaid managed care plan must cover the entire service area of the D-SNP (CMS 2022a).

### High level of integration

- **Medicare-Medicaid plan.** Under the Financial Alignment Initiative, Medicare-Medicaid plans enter into three-way contracts with CMS and the state to provide all Medicaid and Medicare services, excluding any the state carved out.
- **Fully integrated dual eligible special needs plan (FIDE SNP).** D-SNPs are designated as FIDE SNPs if they cover LTSS, in addition to other Medicaid benefits. Starting in 2025, FIDE SNPs must cover behavioral health, home health, durable medical equipment, and Medicare cost sharing; operate with exclusively aligned enrollment; and contract to provide Medicaid services covering the entire service area of the D-SNP (CMS 2022a).

D-SNPs are MA plans that limit enrollment to dually eligible beneficiaries. These plans vary widely in the level of integrated care and member experiences they provide as well as the degree to which they coordinate or provide Medicaid services, pursuant to certain federal and state requirements. Plans might coordinate only Medicaid services that are covered by the state Medicaid agency, while the most integrated D-SNPs cover nearly all Medicaid and Medicare services within one health plan. Three different designations of D-SNPs are defined in federal regulation and range from low to high levels of integration, but there may be notable variation even between plans within a single designation (MACPAC 2021a).

Although use of managed care by dually eligible beneficiaries is growing, most still receive coverage of their Medicaid services through FFS.<sup>5</sup> About half of states do not enroll their dually eligible population in Medicaid managed care, and a number of states that enroll dually eligible beneficiaries in Medicaid managed care do so on a voluntary basis. In CY 2020, 40 percent of dually eligible beneficiaries were enrolled exclusively in Medicaid FFS, and 19 percent were enrolled in Medicaid FFS with a limited-benefit Medicaid managed care plan (MACPAC and MedPAC 2023).

## Integration in States Covering Dually Eligible Beneficiaries under Medicaid FFS

States that cover dually eligible beneficiaries under FFS are working to identify pathways forward to better integrate Medicaid and Medicare coverage. In June 2021, the Commission detailed how states, including those covering dually eligible beneficiaries under FFS for their Medicaid benefits, might maximize integration through their state Medicaid agency contracts (SMACs) with D-SNPs (MACPAC 2021a). For example, states can require in the SMAC that D-SNPs limit enrollment to full-benefit dually eligible beneficiaries, as is the case with the MMPs. This strategy allows uniformity for plan enrollees, including a single set of benefits and rules around care coordination. However, it may disrupt

coverage for partial-benefit dually eligible beneficiaries who would have to disenroll from the D-SNP. Several states use this strategy, including Indiana and Washington (Bean and Emans 2022).

In the following sections, we describe several methods that states that primarily serve dually eligible beneficiaries under FFS are using to better align Medicaid and Medicare coverage in their respective delivery systems.

**Contracting directly with D-SNPs to cover Medicaid benefits.** States that deliver Medicaid services for dually eligible beneficiaries through FFS, or states in which there is no overlap between the parent organizations of D-SNPs and Medicaid managed care plans, can achieve higher levels of integration by contracting directly with D-SNPs for coverage of some or all Medicaid benefits. Alabama, Florida, and Idaho are examples of states that have used this strategy.

States leveraging this approach enter into agreements with D-SNPs and capitate payments for the plan to cover some or all Medicaid benefits, enabling the state to use a set of strategies that is typically available only to states with Medicaid managed care for dually eligible beneficiaries. In doing so, states organically implement exclusively aligned enrollment, which means that the state's contracts with D-SNPs allow the plans to enroll only full-benefit dually eligible individuals who choose to receive some or all of their Medicaid benefits from the D-SNP or the D-SNP's affiliated Medicaid managed care plan. For example, Idaho has contracted directly with D-SNPs since 2007, at which time it covered dually eligible beneficiaries under FFS. It has since instituted mandatory Medicaid managed care for dually eligible beneficiaries that opt out of integrated coverage. Idaho maximized its authority under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) and is providing fully integrated care to its full-benefit dually eligible population through a fully integrated dual eligible special needs plan (FIDE SNP), which is explained in greater detail later in this chapter (Spencer et al. 2018). These FIDE SNPs essentially contract with the state as Medicaid managed care organizations and must meet the federal requirements for Medicaid managed care.

Both Idaho and the District of Columbia, which also contracts directly with D-SNPs, use this approach to provide Medicaid services to dually eligible

beneficiaries through a voluntary managed care arrangement. However, a state may contract directly with D-SNPs to provide other Medicaid benefits while still covering Medicaid services for dually eligible beneficiaries under FFS. For example, Alabama only capitates Medicare cost sharing to its D-SNPs to managed care organizations, which can simplify provider billing.

**Managed FFS.** Managed FFS is currently available for dually eligible individuals in one state through its model under the FAI. In its demonstration, Washington contracted with health homes to provide comprehensive care coordination services to a high-cost, high-risk subpopulation of dually eligible beneficiaries. Health homes primarily provide care coordination and referrals to community and social supports. These health homes receive monthly Medicaid payments for care coordination services. Through its memorandum of understanding with CMS, Washington is eligible to share in savings to Medicare that may result from improvements in quality due to better care coordination (CMS 2012).

**Primary care case management.** Primary care case management (PCCM) is an approach to administering Medicaid benefits in which beneficiaries are assigned to a primary care provider (PCP) who receives a monthly management fee, in addition to payment through FFS for care provided, to coordinate and monitor beneficiary care and provide referrals. PCCM has historically been used for Medicaid populations with complex health care needs and is more common in states with substantial rural populations that pose operational challenges for managed care plans; for example, Alabama specifically targets dually eligible beneficiaries with its PCCM program (Rizer 2022). Although PCCMs provide low levels of integration and coordination, these programs, along with other value-based payment models, could serve as a basis for building greater levels of integration, such as by requiring PCCMs to partner with D-SNPs (Rizer 2022).

## Insights from state panel

In September 2022, MACPAC asked three state Medicaid officials to join a panel to discuss their efforts to integrate care for dually eligible beneficiaries in

a FFS delivery system. Representatives from the District of Columbia, Maine, and Washington spoke with the Commission about the challenges they face, such as limited resources for integrated care efforts and a lack of expertise in Medicare program rules among state staff. Although the District of Columbia and Washington have Medicaid managed care programs for some Medicaid beneficiaries, in all three cases, most dually eligible beneficiaries receive their Medicaid coverage through FFS.

Information provided by panelists represents state perspectives from a point in time and are not an exhaustive list of state approaches to integrating care in FFS. Both states on the panel and the District of Columbia are operating in different political and geographic contexts that affect the approaches they can take to integration.

The District of Columbia excludes dually eligible beneficiaries from mandatory Medicaid managed care, but it offers voluntary enrollment in its Dual Choice D-SNP program. Previously, the District of Columbia paid for Medicaid services through FFS, while the D-SNP covered only Medicare benefits. As of February 2022, the District of Columbia began providing a capitation payment to D-SNPs serving full-benefit dually eligible individuals to coordinate and cover Medicaid services, excluding behavioral health services, thereby establishing highly integrated dual eligible special needs plans (HIDE SNPs) (DCDHCF 2022).

Maine does not have a Medicaid managed care program for any of its beneficiaries. The state features several accountable care organizations (ACOs), many of which partner with the state's Medicaid agency under its Accountable Communities program, which aims to reduce costs and improve care for Medicaid beneficiaries (MEDHHS 2022). Currently, Maine does not offer integrated care models for dually eligible beneficiaries above the level of a coordination-only D-SNP (CO D-SNP), although it has several alternate payment model initiatives aimed at better coordinating care more broadly for all patients at the provider level.<sup>6</sup> Maine has previously told the Commission that it would involve its ACOs in any future integrated care strategy.

Washington enrolls certain dually eligible beneficiaries in Medicaid health homes as part of its managed FFS model under the FAI demonstration. Evaluations of the demonstration have identified Medicare program savings, but Medicaid effects were not measured because of a lack of data. Under the demonstration authority, the state is eligible to receive a portion of the Medicare savings that are generated through this model by preventing avoidable hospitalizations or other high-cost services. The state is seeking CMS certification of the program to allow it to continue permanently (WAHCA 2022). Washington is the only remaining state to integrate care in a FFS environment under the FAI and may provide an example for other states.

Our panelists highlighted three main areas in which federal support facilitated integration in their state's FFS delivery system, or further flexibility could assist them to develop integrated care models. The discussion included financing, state capacity, consumer choice, and transitioning Medicaid coverage to managed care.

**Financing.** As the state on the panel with the most developed integrated model, Washington noted the importance of up-front investments in its success. In 2011, Washington received \$1 million in funding through CMS's State Demonstrations to Integrate Care for Dual-Eligible Individuals program (CMS 2010). With that funding, along with technical support provided by CMS in designing its integrated model, Washington used the money to hire dedicated staff. Then, in 2013, as part of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), Washington received an enhanced 90/10 federal Medicaid match for eight quarters for its health home model, which serves as the basis of the state's managed FFS demonstration. By 2016, the state received its first shared savings payment from CMS followed by another in 2017, which the state said allowed the program to break even without the health home enhanced match and provided Medicaid agency staff with a business case to secure continued funding from the state legislature. By 2018, Washington said shared savings were producing a surplus that could be reinvested into the program.<sup>7</sup>

**State capacity.** State capacity was a pressing concern for all panelists. State officials noted the need for dedicated staff to do the work of establishing an integrated program, in addition to developing Medicare expertise among state staff that primarily

have experience with the Medicaid program. For the District of Columbia, its Medicaid staff acquired Medicare expertise through close collaboration with the insurer that offers its D-SNPs as the agency sought to leverage its SMAC to improve care for dually eligible beneficiaries.

States that previously participated in a MACPAC roundtable on state efforts to integrate care said they valued the technical assistance they received from CMS and expressed interest in technical assistance in the form of peer-to-peer learning, in which one state can learn from another similarly situated state, in addition to federal financial support (MACPAC 2021a). At MACPAC's September 2022 panel, Maine told us that it has engaged in peer-to-peer learning with another panelist, Washington, about its health home model and managed FFS program. Additionally, Maine said that it is in the process of hiring a consultant to assist with developing a strategy for pursuing integrated care, in line with the Commission's recommendation in its June 2022 report to Congress (MACPAC 2022a).

**Consumer choice.** All three panelists voiced the importance of developing integrated models that allow for the greatest level of consumer choice. For the District of Columbia, a decision to move much of its Medicaid population to managed care was balanced by making that enrollment voluntary for dually eligible beneficiaries and only offered as part of an integrated care program.<sup>8</sup> Meanwhile, Washington state said it emphasized the need for consumer choice beginning with the program's initial development. Washington's health home model is founded on community care organizations, which coordinate care for beneficiaries among a range of partners, including federally qualified health centers, behavioral health agencies, and Area Agencies on Aging. As the state moves to make its managed FFS program permanent, Washington said it intends to leverage its SMACs to require that D-SNPs provide access to health home care coordination, allowing D-SNP enrollees a choice of which delivery system they prefer to use for their care.

**Transition to managed care.** Of the three panelists, only the District of Columbia is working to transition its dually eligible population from FFS to Medicaid managed care for coverage of Medicaid benefits.<sup>9</sup> Washington has experienced success with its managed FFS model, while Maine noted the difficulties



it would face creating a managed care program given its older, rural population.<sup>10</sup>

In 2019, the District of Columbia announced plans to move its entire Medicaid program, including dually eligible beneficiaries, into managed care. It has begun this transition in incremental steps, starting with its non-dually eligible populations. As part of the process, the District of Columbia is working to integrate community-based behavioral health, which had previously been carved out, into its managed care contracts. The District of Columbia noted that its incremental, staggered move to managed care may be a positive for providers who have been slowly adjusting to the new delivery system.

## Integrating Care through Managed Care Arrangements

Dually eligible beneficiaries in managed care are primarily enrolled in two types of integrated models: D-SNPs or MMPs. D-SNPs are more widely available and enroll more people than MMPs. However, MMPs generally provide a higher level of integration because eligible individuals enroll in a single plan that is responsible for all aspects of their coverage. The MMP receives a blended payment that combines Medicaid and Medicare Part A, Part B, and Part D.<sup>11, 12</sup> In the following sections, we discuss these two models.

### D-SNPs

D-SNPs are a type of MA plan that limits enrollment to dually eligible beneficiaries. To operate, D-SNPs must contract with CMS to provide Medicare benefits as an MA plan; in addition, they must sign contracts with Medicaid agencies in the states in which they operate to at least coordinate Medicaid benefits for their members. States are not required to contract with D-SNPs though, and D-SNPs may not operate in states without a contract. SMACs, as required under MIPPA and sometimes referred to as “MIPPA contracts,” define how D-SNPs will coordinate Medicaid and Medicare benefits.

Relative to other integrated models, D-SNPs serve the greatest number of dually eligible beneficiaries and are the most widely available. As of March 2023, D-SNPs were available in 45 states and the District of Columbia with enrollment of nearly 4.9 million beneficiaries, or about 40 percent of all dually eligible beneficiaries nationwide (CMS 2023c) (Figure 2-1). As defined in regulation, D-SNPs can offer three levels of integration between Medicaid and Medicare. In the following sections, we list these types from lowest to highest level of integration. See Table 2A-1 for more information on which plan types are available in which states.

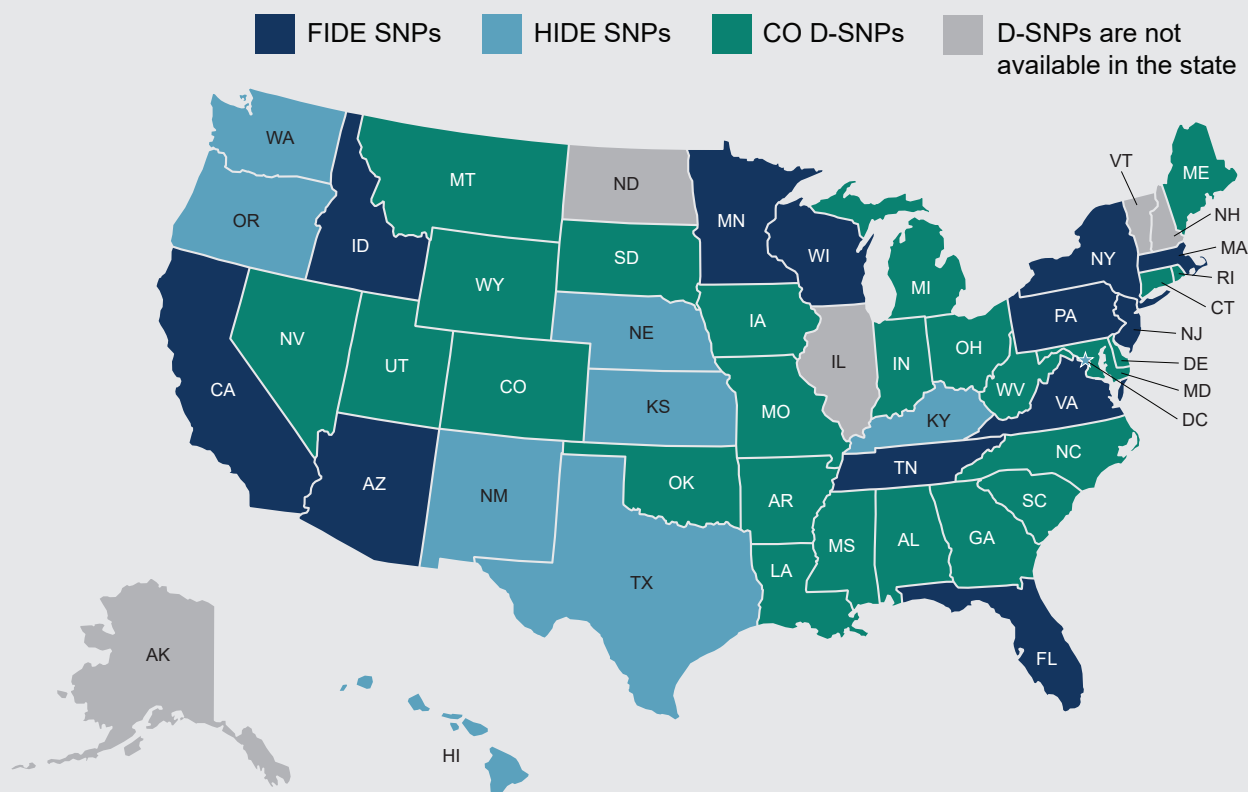
**CO D-SNPs.** CO D-SNPs are the most common type of D-SNP. They are available in 38 states and the District of Columbia and enroll more than 2.8 million beneficiaries, or about 57 percent of dually eligible beneficiaries in D-SNP products (CMS 2023c). These plans are required to provide only minimal levels of integration, coordinating Medicaid benefits as required under MIPPA and subsequent legislation. CO D-SNPs cover all Medicare services, while Medicaid services are typically covered by the state Medicaid program. However, some states may capitate CO D-SNPs to provide some Medicaid benefits without qualifying as a more integrated type of D-SNP. For example, a state may require a CO D-SNP to cover Medicare cost sharing, or the state may require coverage of a broad array of Medicaid behavioral health services and LTSS but have carve outs that preclude qualifying as one of the following plan types.

**HIDE SNPs.** Beginning in 2021, D-SNPs can be designated as HIDE SNPs if they have a contract with the state Medicaid agency to cover LTSS, behavioral health services, or both. HIDE SNPs provide moderate to high levels of integration for beneficiaries. HIDE SNPs are available in 15 states and the District of Columbia, enrolling more than 1.7 million beneficiaries, or about 35 percent of all dually eligible beneficiaries enrolled in D-SNP products (CMS 2023c).<sup>13</sup>

**FIDE SNPs.** D-SNPs can be designated as FIDE SNPs if they cover LTSS, in addition to other Medicaid benefits, unless the state carves behavioral health services out of the capitation rate (CMS 2023c, MACPAC 2020a).<sup>14</sup> FIDE SNPs provide the highest level of integration in a D-SNP. Enrolling about 403,000 beneficiaries in 12 states, or about 8 percent of dually eligible beneficiaries in D-SNP products, these plans must cover all Medicaid and Medicare benefits (CMS 2023c).

In 2019, CMS published regulations that defined new requirements for certain subsets of D-SNPs that qualify as applicable integrated plans (AIPs) to establish an integrated appeals and grievances process (42 CFR 422.629). D-SNPs that use exclusively aligned enrollment, which the state can require in its SMAC, are considered AIPs. Exclusively aligned enrollment occurs when D-SNP enrollment is limited to full-benefit dually eligible beneficiaries who receive their Medicaid benefits through the D-SNP or

**FIGURE 2-1.** Most Integrated Dual Eligible Special Needs Plan Available by State, 2023



**Notes:** FIDE SNP is fully integrated dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. CO D-SNP is coordination-only dual eligible special needs plan. This figure shows the most integrated type of D-SNP available in the state or the District of Columbia as of February 2023. States may have more than one type of D-SNP available, and plans are not always available statewide. HIDE SNPs were first available starting in 2021.

In 2017, Illinois chose not to continue contracts with D-SNPs to focus on Medicare-Medicaid plans as a platform for integrating care (MedPAC 2019). Washington does not have comprehensive Medicaid managed care for dually eligible beneficiaries, but it does have HIDE SNPs formed by aligning D-SNPs with organizations that cover behavioral health services.

**Source:** CMS 2023c.

an affiliated Medicaid managed care plan under the same parent organization. In 2022, CMS updated the AIP regulations to apply the designation more broadly to include all subsets of D-SNPs meeting the criteria, not just HIDE SNPs and FIDE SNPs (CMS 2022a). Also in that rule, CMS required FIDE SNP and HIDE SNP service areas to align with their companion Medicaid plans, and it tightened the definition of a FIDE SNP to facilitate greater integration (CMS 2022a).<sup>15</sup>

## FAI demonstrations

The FAI demonstration is authorized under Section 1115A of the Social Security Act to test models to increase financial alignment between Medicaid and Medicare and integrate primary, acute, behavioral health, and LTSS for beneficiaries eligible for both programs (CMS 2023a). State participation in the FAI is optional. States can choose a capitated model or a managed FFS model or propose an alternative model. Currently, eight states are participating in the capitated model. These states hold three-way contracts with CMS and MMPs. One state, Washington, operates a managed FFS model, and Minnesota operates an alternative model. The earliest demonstrations began in July 2013, and CMS worked with states to provide opportunities to extend demonstrations beyond their initial three-year window. All states with current demonstrations requested and received approval for multiple extensions, typically for periods of two years at a time. Because most participating states selected the capitated model, our focus is on those demonstrations in which coverage is provided through MMPs.

The capitated model demonstrations under the FAI introduced several innovations aimed at improving care coordination for those dually eligible as well as integrating and aligning administrative processes. These demonstrations are operated under three-way contracts through which the MMPs provide coverage to dually eligible beneficiaries. These contracts allow for passive enrollment of beneficiaries and the opportunity for states to share in Medicare

savings. Notably, these three-way contracts require integrated member materials, dedicated funding for an ombudsman program, reporting of specific quality outcome measures, and coverage of additional member benefits beyond the benefits traditionally covered by Medicaid and Medicare (e.g., \$0 copays for prescription drugs or fitness benefits).

Enrollment in MMPs has been lower than expected, in part due to high opt-out rates and disenrollment (Grabowski et al. 2017). As of March 2023, about 309,000 dually eligible beneficiaries were enrolled (Table 2-1).<sup>16</sup> According to the most recent publicly available data, participation rates in the MMPs ranged from 8.4 percent of eligible beneficiaries in New York to 61.7 percent in Ohio (Griffin et al. 2022, Snow et al. 2022). Some states have experienced operational challenges that have slowed or paused implementation of passive enrollment, a tool that is associated with higher rates of enrollment (Holladay et al. 2022, MACPAC 2019). Recent evaluations of the demonstrations under the FAI, based in part on interviews with state and health plan staff, have also pointed to increasing competition from MA in the marketplace as a cause for static or declining enrollment (Griffin et al. 2022, Khatutsky et al. 2021).



**TABLE 2-1.** Monthly Enrollment in Medicare-Medicaid Plans under the Financial Alignment Initiative Demonstration by State, March 2023

State	MMP enrollment
<b>Total</b>	<b>309,045</b>
Illinois	88,821
Massachusetts	39,089
Michigan	42,214
New York	1,716
Ohio	76,319
Rhode Island	13,618
South Carolina	12,471
Texas	34,045

**Notes:** MMP is Medicare-Medicaid Plan. MMP enrollment is current as of March 2023. Data for New York include only the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities demonstration.

**Source:** ICRC 2023.

## Changing Integrated Care Landscape

States are charting a course toward integrated care amid an evolving landscape. In 2022, after a series of regulatory updates to D-SNP requirements, CMS announced it would end the capitated demonstrations under the FAI at the end of CY 2023, with the possibility of an extension through 2025 contingent on states transitioning their MMP enrollees to integrated D-SNPs (CMS 2022a).<sup>17</sup> In its final rule, CMS cited the opportunity to implement integrated care on a broader scale through D-SNPs as a reason for winding down the capitated model demonstrations as well as the potential for stability and reduced state administrative burden by transitioning from time-limited demonstration models to permanent structures. The rule also made a series of regulatory changes that shrank the gap between integrated D-SNPs and MMPs by incorporating features of the MMPs into the regulations governing D-SNPs, reinforcing CMS's decision to end the capitated model demonstrations. Other changes in MA policy that allowed benefit flexibilities in D-SNPs for coverage of benefits related to social determinants of health—such as transportation, which previously did not exist outside of the capitated model demonstrations—also played a role (CMS 2022a, MACPAC 2022b).

MACPAC has developed a framework for monitoring the transition from MMPs to integrated D-SNPs in the years ahead to identify operational concerns that could lead to disruptions for beneficiaries or states. Although these transitions may incorporate some elements of the FAI demonstrations into D-SNPs, such as the requirement for an enrollee advisory committee, not all aspects of these demonstrations will necessarily transfer to D-SNP models.

### CMS sunsets the MMP model

For states intending to transition their MMPs to D-SNPs by the end of 2025, CMS required them to submit preliminary transition plans by October 1, 2022, that addressed key elements of the transition. These elements included how states will maximize integration throughout the transition, how the ombudsman program required under the demonstrations would be sustained in the states' new D-SNP models without continued federal funding, how states would engage stakeholders for feedback on transition plans, and the identification of policy and operational steps needed to achieve these goals (CMS 2022a). Although the current proposed timelines in state transition plans are non-binding, most demonstration states said they view those dates as high-level benchmarks to meet.

States are early in the process of converting their capitated model demonstrations to D-SNP models and receiving guidance from CMS, so specific detail in the transition plans is unavailable. To date, they reflect the early stages of planning around operational changes. Intended to kick off discussions with stakeholder groups, the transition plans represent letters of intent as opposed to final policy decisions.

Not all elements of the demonstrations are transferable to the D-SNPs under current statutory authority. For example, states may lose the ability to share in savings generated by the demonstration with the federal government and the ability to passively enroll beneficiaries. Although the three-way contract under the capitated model established a shared savings mechanism, a comparable mechanism is not currently available for D-SNPs. Similarly, passive enrollment is not possible outside of the three-way contract. Several states noted the importance of the opportunity for shared savings to the sustainability of their programs, as states must spend resources to implement an integrated program but see the savings from those programs accrue to Medicare in the form of decreased hospital and emergency department use. Other elements of the demonstrations may be possible under the D-SNP model, but there are concerns that comparable levels of integration may be difficult to attain. For example, Massachusetts noted the loss of passive enrollment and how that might impact its ability to enroll and retain eligible beneficiaries, even with the use of default enrollment. Overall, Massachusetts said states need clearer guidance from CMS on which pieces of their demonstration—not preserved in the final rule—may still be possible under other authorities.<sup>18</sup>

## Framework for monitoring transition away from MMPs

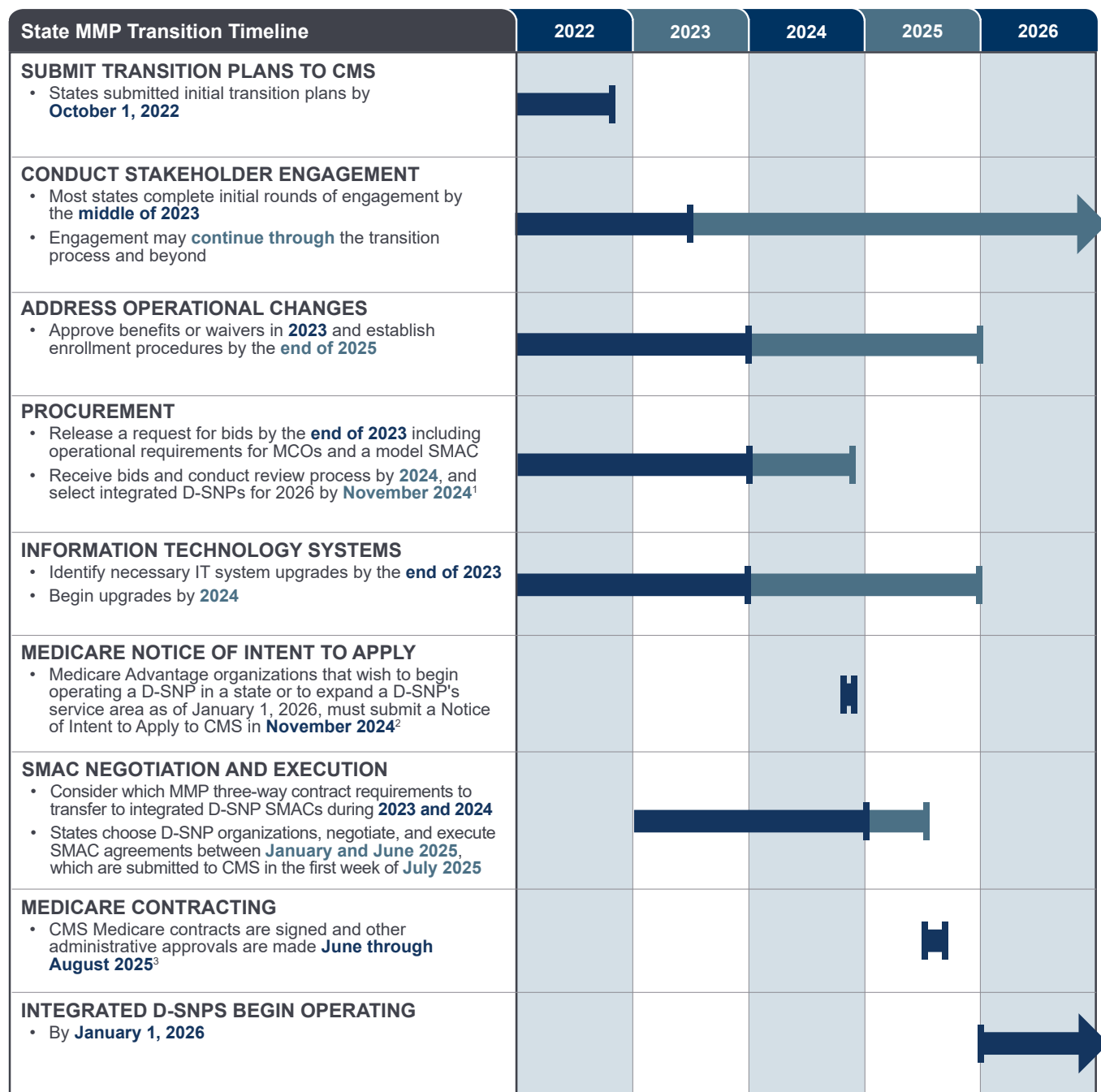
To better understand how states are approaching the transition process and their operational concerns, MACPAC interviewed five of the eight states with capitated FAI demonstrations about the status of their plans to transition to D-SNPs.<sup>19</sup> Through our interviews, we identified a framework with four primary areas for monitoring state progress as states transition

their MMPs: stakeholder engagement, Medicaid managed care procurement, information technology system changes, and enrollment processes.

Most states expressed confidence in their ability to successfully transition their demonstrations into integrated D-SNP products by the end of 2025. All current demonstration states have requested the extension through 2025 to have sufficient time to prepare (Figure 2-2). To ease the transition process, some states we spoke with indicated they plan to focus on existing MMP enrollees, but they may roll out changes to include D-SNPs covering the dually eligible population that did not participate in the FAI demonstration. For example, South Carolina said it will transition its MMP enrollees to HIDE SNPs initially, since many of the state's current MMP enrollees are not LTSS users, but it will look to move toward requiring FIDE SNP designation for plans serving its broader dually eligible population in the future as the state transitions LTSS coverage into Medicaid managed care.

CMS has also asked for a commitment from states to continue ombudsman programs that provide person-centered assistance to dually eligible beneficiaries, a requirement under the FAI demonstration. However, as the demonstrations sunset, states will no longer receive federal funding for ombudsman programs. States told us they plan to continue the programs, although some indicated that the source of state-only dollars to fund the programs was still to be determined. For some states, such as Rhode Island and Ohio, ombudsman services for dually eligible beneficiaries will transition to existing long-term care ombudsman offices.

As states flesh out their plans, both federal and state officials are discussing how to assess their progress in implementing the transition. MACPAC will continue to monitor the transition process through ongoing conversations with states using our framework.

**FIGURE 2-2. State Transition Timeline from Medicare-Medicaid Plans to Dual Eligible Special Needs Plans**


**Notes:** MMP is Medicare-Medicaid plan. CMS is the Centers for Medicare & Medicaid Services. MCO is managed care organization. SMAC is state Medicaid agency contract. D-SNP is dual eligible special needs plan. IT is information technology.

<sup>1</sup> Some states may not need to undergo procurement. However, D-SNPs still need to file a Medicare Notice of Intent to Apply to CMS in November to ensure access to the Health Plan Management System. SMACs may be provisional and finalized before upload to the Health Plan Management System during the Medicare contracting phase.

<sup>2</sup> Only organizations that intend to offer a new product or expand their service area need to submit a Medicare Notice of Intent to Apply.

<sup>3</sup> Based on the calendar year 2022 deadline for Medicare Advantage plan bids (CMS 2022b).

**Source:** MACPAC review of state transition plans and interviews with state officials, 2023.

**Procurement.** As part of the transition, most states will need to undergo a Medicaid managed care procurement, the process through which states competitively award contracts to managed care organizations to provide coverage to Medicaid beneficiaries.<sup>20</sup> Nearly all interviewees acknowledged procurement strategy as a near-term decision, given the potentially lengthy runway needed to complete the process. Medicaid managed care procurement requirements vary by state and may not align with the timeline that CMS established for the transition or the MA bid and enrollment cycle. For states in which the demonstration transition timeline and Medicaid procurement do coincide, opportunities may exist to create alignment among Medicaid and Medicare offerings, such as requiring parent organizations bidding for Medicaid managed care contracts to offer an affiliated D-SNP. The Medicaid procurement process typically takes 18 to 24 months from development of the request for proposals to awarding and implementing contracts.<sup>21</sup> As states plan their procurement timelines, they must take into account that MA organizations intending to offer new D-SNPs or to expand D-SNP service areas in 2026 must submit a Medicare Notice of Intent to Apply in November 2024.

Several states said they are in early discussions about their procurement needs, which may require other state action to proceed. Meanwhile, Michigan said that it initially planned to transition its demonstration to a FIDE SNP model. However, state law requires the state to carve out specialty behavioral health services from its capitated Medicaid managed care contracts to be administered by counties, which prevents the use of a FIDE SNP. In November 2022, an amendment to exempt dually eligible beneficiaries from this statutory requirement failed to pass the state legislature. Therefore, Michigan has revised its plan to target a HIDE SNP model instead. For some states, not all of their existing Medicaid managed care plans offer companion D-SNP products in the same service area. In its transition plan, Rhode Island set November 2023 as a tentative start date for its procurement process, and although it currently has no FIDE SNPs, it said potential Medicaid managed care bidders will be expected to take the steps necessary to qualify as a FIDE SNP.

The states we spoke with expressed confidence that they would be able to complete these changes within the two-year demonstration extension period. However, state familiarity with the procurement process may vary depending on the maturity of its Medicaid managed care program or experience with D-SNP contracting. Experts we spoke with suggested this would be a key area for monitoring progress and any potential challenges in the transition.

Federal and state officials did suggest that the substance of demonstration states' three-way contracts with MMPs could be largely lifted to form the states' new contracts with integrated D-SNPs, a potential advantage for states less familiar with D-SNP contracting. This would enable states to ensure they incorporate requirements they established for their MMPs, such as single ID cards or specific care coordination strategies.

**Stakeholder engagement.** States are sharing their transition plans with stakeholder groups to gather feedback that will help to refine the transition plans and determine how D-SNPs will operate in each state. States differed in how developed their stakeholder outreach strategies were at the time of our interviews at the end of 2022. Massachusetts planned to regularly consult its One Care Implementation Council, a unique consumer-led working committee that provides feedback to the state on issues like access and quality, as the state develops and implements its transition plan. Other states, such as Ohio and Michigan, were in the beginning stages of creating a robust stakeholder engagement strategy. Meanwhile, South Carolina, which does not currently enroll its dually eligible population in Medicaid managed care outside the demonstration, said it would build a communication strategy for those beneficiaries and the state's providers to correct misperceptions about managed care.

Several states said they planned to publicly post their transition documents and have since done so. Most states said they anticipate their initial round of stakeholder outreach to continue through the middle of 2023, but also noted that they plan to engage with stakeholders throughout the transition.

### Enrollment processes and related systems

**improvements.** We heard from several stakeholders that enrollment is a potential area of concern as states take on responsibilities for enrolling beneficiaries that were previously handled by an enrollment broker under the MMP demonstration.

A number of states plan to use default enrollment. Under default enrollment, states and CMS can approve D-SNPs to automatically enroll a Medicaid managed care member becoming eligible for Medicare into the Medicaid managed care organization's affiliated D-SNP if the beneficiary will remain enrolled in the Medicaid managed care organization after becoming eligible for Medicare (MACPAC 2021a). This contracting strategy can ensure a smooth transition from Medicaid-only coverage to integrated coverage for those becoming dually eligible. People who are default enrolled have the option to opt out and choose other Medicare coverage. We heard from states that using default enrollment may require information technology system upgrades to facilitate data sharing between states and plans on member eligibility. Additionally, many states relied on a third-party enrollment broker to manage enrollment into the MMPs. For states that lack experience enrolling dually eligible beneficiaries into coverage, enrollment could become more difficult than under the demonstrations.

The transition to integrated D-SNPs may require some states to take on a greater role in processing enrollments than they have in the past and necessitate improvements to facilitate data sharing with health plans. For example, states may need to share prospective Medicare eligibility information with D-SNPs if they are allowing default enrollment, in which Medicaid managed care plan enrollees who are becoming eligible for Medicare would be automatically enrolled into the managed care plan's affiliated D-SNP. States may also need to learn how to better leverage Medicare data they already exchange with CMS, such as the Medicare Modernization Act file, for purposes of default enrollment.<sup>22</sup> These changes may be needed as several states said they anticipate using default enrollment. Additionally, as states move to implement exclusively aligned enrollment outside the FAI demonstrations, the process may require states to revise their current Medicaid enrollment policies and periods.

### Leveraging SMACs

As the integrated care landscape changes after the sunset of the MMPs, former MMP states in particular may be looking for opportunities to leverage their SMACs in an effort to maintain the levels of integration achieved in the MMPs. States' ability to use strategies to promote integration depends on several factors. These include the availability of D-SNPs, whether D-SNPs are operated by the same parent company or legal entity as those operating Medicaid plans in the service area, state priorities, administrative capacity, and existing state statute and policy.

States that enroll dually eligible beneficiaries in Medicaid FFS can leverage their SMACs to require that D-SNPs use specific or enhanced coordination methods, such as requiring that D-SNPs train their care coordinators to be familiar with Medicaid benefits to help beneficiaries access these services. States can also require D-SNPs report data for oversight of operations and quality of care, which can help the state obtain a comprehensive picture of which Medicaid and Medicare services enrollees are using and identify areas for improvement. Contract language can also ensure the state receives enrollee communication materials designed by the D-SNP for review before use, which could ensure consistency in Medicaid benefit descriptions across D-SNPs in the state. This requirement could also make enrolling easier for beneficiaries who may find the number of coverage options available to them confusing, especially the diversity of Medicare plans. Finally, states can partner with D-SNPs to develop supplemental benefit packages that complement the Medicaid benefits already available to full-benefit dually eligible beneficiaries, preventing duplication (Table 2-2). Certain levers for maximizing integration through an SMAC are available only to states that enroll dually eligible beneficiaries in Medicaid managed care (MACPAC 2021a).



**TABLE 2-2.** Strategies for State Contracts with Dual Eligible Special Needs Plans, 2021

Strategy
<b>All states can use these strategies:</b>
Limit D-SNP enrollment to full-benefit dually eligible beneficiaries
Contract directly with D-SNPs to cover Medicaid benefits <sup>1</sup>
Require D-SNPs to use specific or enhanced care coordination methods
Require D-SNPs to send data or reports to the state for oversight purposes
Require state review of D-SNP materials related to delivery of Medicaid benefits
Partner with D-SNPs to develop supplemental benefit packages that complement Medicaid benefits
<b>Only states with Medicaid managed care can use these strategies:</b>
Selectively contract with D-SNPs or Medicaid managed care plans that offer affiliated plans
Require complete service area alignment
Require D-SNPs to operate with exclusively aligned enrollment
Allow or require D-SNPs to use default enrollment
Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization
Incorporate Medicaid quality improvement priorities into the D-SNP contract
Automate Medicaid crossover claims payment processes for payment of Medicare cost sharing

**Notes:** D-SNP is dual eligible special needs plan. These strategies are available to states under authority established in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275).

<sup>1</sup> Some states may have statutes that could complicate use of this strategy. For example, Mississippi state law requires action from the state legislature to expand Medicaid managed care contracts.

**Source:** Mathematica, 2021, analysis for MACPAC of MIPPA strategies for contract years 2020 and 2021 and interviews with stakeholders.

States that carve out behavioral health or LTSS from Medicaid managed care face difficulties achieving a high level of integration. When a benefit is carved out, the plan is not responsible for providing the benefit and does not receive payment for it. States carve out benefits for a number of reasons, including plans' inability to provide access to specialized providers, state statutory requirements, or use of county-based models (Inkelas 2005). An evaluation of Michigan's demonstration under the FAI noted that integrating previously carved-out benefits can create substantial operational challenges for states, highlighting Michigan's difficulties with communication between the MMPs and the prepaid inpatient health plans that cover behavioral health services in the state around health assessments (Holladay et al. 2019). Other states voiced concerns

that leveraging their SMAC authority too heavily could reduce the number of D-SNPs willing to enter the market. By definition, selective contracting makes fewer contracts available, which results in fewer D-SNPs available in the state and potentially lower D-SNP enrollment. For example, if a state offers three Medicaid managed care plan contracts, only three aligned D-SNPs would be available. Finally, MA penetration, and therefore D-SNP availability, is often limited in rural areas relative to metropolitan areas due to difficulties achieving financial viability with the small number of covered individuals and building an adequate provider network, which means that D-SNP contracting may have limited efficacy in integrating care in states with large rural populations (MedPAC 2022, MACPAC 2021a).

About half of states do not enroll dually eligible beneficiaries in Medicaid managed care, making integrating care through a managed care arrangement a challenge for many states (MACPAC 2021a). However, there are opportunities to coordinate Medicaid and Medicare coverage for dually eligible beneficiaries in a FFS environment. The Commission views the development of an integrated care strategy as a valuable tool for all states, even those states providing Medicaid coverage to dually eligible beneficiaries through FFS, and MACPAC continues to monitor state efforts in this area.

## Beneficiary Experiences in Integrated Care

Although the Commission has examined the range of integrated models available and heard from states about their efforts to integrate coverage for their dually eligible populations, we had not solicited input from beneficiaries enrolled in these models. To better understand the experience of receiving coverage through integrated care and how beneficiary protections might improve that experience, MACPAC contracted with NORC at the University of Chicago (NORC) to conduct focus groups with full-benefit dually eligible beneficiaries. We selected participants representing the continuum of integration from minimal levels of integration in most CO D-SNPs to high levels of integration in MMPs under the FAI demonstration. The focus groups occurred virtually from November 2022 through January 2023 in five states: Nebraska, New York, South Carolina, Texas, and Washington. We recruited participants from a diverse set of states located in different geographic regions and with different political leanings. We also considered population size, rurality, and the type of integrated models present in the state.

We recruited beneficiaries enrolled in different types of D-SNPs as well as FAI enrollees. We spoke to beneficiaries enrolled in each of the available D-SNP types: CO D-SNPs, HIDE SNPs, and FIDE SNPs. We talked to MMP enrollees in New York, South Carolina, and Texas and to managed FFS enrollees in Washington. We chose New York so we could hear from enrollees in the state's Fully Integrated Duals Advantage for Individuals with Intellectual and

Developmental Disabilities (FIDA-IDD) program. New York's FIDA-IDD program is unique among integrated care models in that it integrates coverage for people who are dually eligible with intellectual disabilities or developmental disabilities (ID/DD), a population typically left out of integrated care efforts to date.

NORC conducted 10 focus groups with 40 participants, including one Spanish-speaking group with 5 participants. Due to challenges in recruitment, NORC also conducted 15 one-on-one interviews with participants who could not attend the focus groups. We also spoke with eight individuals who were caregivers of dually eligible beneficiaries, most of whom were family members. In total, we heard from 55 beneficiaries and caregivers. Overall, 34 focus group participants were enrolled in HIDE SNPs, FIDE SNPs, MMPs, or managed FFS. Twenty-one participants were enrolled in CO D-SNPs. To obtain a diverse set of perspectives, our focus group participants represented a range of different races and ethnicities, ages, and geographic locations.

## Limitations

Our summary should not be taken as representative of all dually eligible beneficiaries or of all integrated programs. There is substantial variation across states and across programs in terms of the level of integration offered, the types of benefits available, and the performance of the health plans providing the services. For example, fully integrated programs, such as MMPs under the FAI demonstration or FIDE SNPs, are not widespread. We sought enrollees in those models as well as individuals in lower levels of integration so that we could reflect beneficiaries' varied experiences, but we did not attempt to capture a representative sample of any one type of model. Additionally, dually eligible beneficiaries are a diverse group with wide variation in their health care needs. Most are age 65 or older, but many are also younger and have disabilities. What these distinct groups are looking for from their health plans will affect their perceptions of that coverage, and we did not attempt to control for those differences in how we characterized their experiences. This chapter reports on the experiences of the dually eligible beneficiaries to provide context for the Commission's work to advance integration of Medicaid and Medicare coverage.



Recruiting dually eligible beneficiaries to talk to us about their experiences was challenging. Full-benefit dually eligible beneficiaries enrolled in integrated programs are a relatively small population, made up of about 1.7 million individuals in 2022, relative to Medicaid enrollees who total more than 87 million people in fiscal year 2021 on an ever-enrolled basis (CMS 2023a, MACPAC 2022c). We limited our recruitment to five states, which further limited our available pool of participants. Dually eligible enrollees in those states made up about 7 percent of all dually eligible beneficiaries. We applied selection criteria reflecting full-benefit dually eligible beneficiaries, living in one of the states we selected, enrolled in an integrated plan offering minimal to full levels of integration, with internet or phone access to participate, and not living in an institution. For the Spanish-speaking group, we added the additional language criteria.

Although we experienced limitations in conducting this work, we see value in hearing from individuals about their experiences and how they perceive the care they are receiving. Their perspective is one the Commission set out to highlight through these focus groups.

## Themes from beneficiary focus groups

Several themes emerged from the focus groups with dually eligible beneficiaries about their experiences in integrated coverage.

**Enrollment experiences.** Participants commonly cited the ability to keep their existing PCPs, specialists, or health systems, in addition to cost, as the most important factors in choosing a plan. Participants described taking various approaches to choosing their plans and receiving assistance from different sources. Many participants described getting help from family or friends and conducting their own research on the internet to choose a plan, with several using the Medicare Plan Finder tool. Some participants detailed their experiences using enrollment brokers, such as a broker employed by a health plan, but were not always specific about the type of broker they used. Those who used brokers described positive interactions. For example, a few participants noted they would reach out to their brokers if they had issues with their plans. Finally, several enrollees in New York's FIDA-IDD program

described hearing about the plan at its inception through information sessions targeted to the ID/DD community.

**Access to providers.** Generally, study participants did not report issues accessing primary or specialty care providers. Most of what we heard about access was focused on Medicare-covered services such as primary care, urgent care, and specialty care. Most participants reported having and liking their PCPs. Some participants used telehealth when they had a more urgent primary care need. Many participants also relied on urgent care—for example, when they needed a same-day appointment and their PCPs did not have any openings or on the weekend when their PCP offices were closed.

Most focus group participants reported seeing specialists, noting that they did not have difficulty finding specialists who were taking new patients and accepted their plans; however, they did describe long wait times for an initial appointment. Once established, participants largely described regular appointments and sufficient access. In cases in which PCPs made referrals, participants described shorter wait times. A few participants, however, described calling their plans and getting recommendations for providers who were no longer accepting their insurance, indicating outdated or inaccurate provider directories. Participants living in rural areas also reported challenges accessing providers due to a lack of local specialists and transportation barriers (e.g., having to drive long distances), which is consistent with larger national trends of limited access to specialists and transportation barriers in rural areas.

Dually eligible beneficiaries in our focus groups reported challenges accessing mental health providers, consistent with trends across the country and across our health care system with access to this type of provider. They reported a general lack of local providers, high turnover among existing providers, and long wait times. Some participants also noted how few of the available providers accepted their coverage, and therefore, they paid out of pocket or turned to other options, like the county health system or telehealth services. This finding also aligns with national trends regarding mental health providers not accepting health insurance, particularly with the increased demand for mental health services after the COVID-19 pandemic.

**Care coordination.** Overall, about half of focus group participants reported having a care coordinator employed by their health plans with some variation across states. For example, all the focus group participants in the New York FIDA-IDD demonstration and in Washington's managed FFS demonstration reported having care coordinators. In Texas, focus group participants were more mixed, with some reporting that they had care coordinators and others reportedly declining the service.

Participants reported mixed experiences with care coordination and formal care planning. A subset of focus group participants enrolled in New York's FIDA-IDD demonstration and in Washington's managed FFS demonstration reported positive and robust relationships with their care coordinators. In Washington's demonstration, care coordinators are employed by the health homes, which contract with the state. Focus group participants appreciated how they retained the same care coordinator even if they switched plans. Most of the focus group participants in these same two state demonstrations also reported having care plans that they revisited regularly and contained goals related to their health. Some participants in the other states noted frequent turnover of care coordinators and did not feel like they were getting much value out of the service. Most did not report having formal care plans.

**Coverage of additional benefits.** A few caregivers and participants described receiving Medicaid home- and community-based services (HCBS), as well as rehabilitation services after a hospitalization, and the importance of these services. Caregivers for beneficiaries in New York's FIDA-IDD plan in particular emphasized the plan's coordination of HCBS as a strength of the plan. A caregiver in another state, however, shared that they found the residential services and employment support services for their adult child to be lacking. Several participants also described difficulties with obtaining and retaining home health aides, noting high turnover of these workers.

Most participants had positive feedback about receiving additional benefits from their plan, such as food allowances and an over-the-counter benefit, which provided funds for purchasing certain non-prescription drugs and health-related items, which for some participants had not been available in their prior coverage. In Nebraska and South Carolina,

people reported the ability to use these funds to pay utility bills, which they described as helpful. Several participants also described incentives for participating in certain preventive screenings, such as mammograms and annual physicals. Several focus group participants noted that dental services were not covered by their plans.

Participants reported mixed experiences with transportation benefits.<sup>23</sup> Generally, participants with transportation barriers were grateful for this benefit. Several participants who used this benefit noted extended wait times or long travel times. Another recounted how their driver dropped them off at the wrong location. And in one state, participants expressed frustration with this benefit and did not understand if they qualified for it. These findings are largely consistent with what we heard in prior focus groups on Medicaid's non-emergency medical transportation (NEMT) benefit (PerryUndem 2021). Participants in those focus groups said NEMT plays a vital role in facilitating their access to care and was essential to maintaining their health; however, they also reported variation in quality and satisfaction. For example, most participants had experienced at least one late pickup or driver no-show, and some people reported waiting as long as three hours to be picked up for their return trips (PerryUndem 2021).

### **Experiences resolving issues with health plans.**

Study participants' experiences resolving issues with their health care coverage largely centered around contacting their plan, with most participants unfamiliar with ombudsman programs. However, dedicated ombudsman programs are largely available only to dually eligible beneficiaries enrolled in an MMP. Since no dedicated ombudsman program is required for D-SNP enrollees, they likely have access only to their state's ombudsman program for LTSS users to the extent they assist with non-nursing facility issues. When faced with an issue with their coverage, most participants said they would call their health plan's customer service line for help. All of the participants in the Spanish-speaking group said their plans offered assistance in Spanish, with one person noting there could be long wait times.

Focus group participants also had limited understanding of the appeals and grievances processes through which beneficiaries can appeal a coverage decision by a health plan or file a grievance

to make a complaint about their coverage. In the MMPs, the appeals and grievance processes were unified across Medicaid and Medicare, meaning that beneficiaries could file an appeal for either a Medicaid- or Medicare-covered benefit through a single process. Outside of a unified process, Medicaid and Medicare have different processes for filing appeals and grievances, which can cause confusion for beneficiaries and gaps in coverage during an appeal. Although most participants were familiar with an appeal, few had used the process. Participants had less understanding of filing a grievance, and few had done so. A few participants described filing complaints with providers or with their health plans, most often due to issues with transportation and dental services. One caregiver for an enrollee in New York's FIDA-IDD program demonstrated the most robust understanding of these processes, detailing how they were currently going through the appeals process.

Some participants reported receiving unexpected medical bills and working with either their providers or their plans to resolve it. In all cases, these bills were sent in error, and participants were not ultimately responsible for paying them. However, focus group participants reported that the experience caused stress and frustration. A few people described having to communicate with their plans and providers multiple times before the issues were resolved or that the plans did not respond until a formal appeal was filed. One person worked with their care manager to figure out how to resolve the unexpected bill.

**Overall satisfaction with integrated care.** When asked about overall satisfaction with their health care coverage, most focus group participants reported a positive experience. For example, most participants did not report having any unmet needs. Those who did reiterated points they had made earlier in the discussion that reflect national concerns, such as a lack of mental health providers or access to dental coverage. On a scale of one to five, with five being the highest, most participants rated their coverage at a three or higher.

**Conclusions.** Although the beneficiaries we talked with do not constitute a representative sample of dually eligible beneficiaries enrolled in integrated care, we heard that they are largely satisfied with their coverage and able to access the care they need. We did not hear meaningful differences between the

experiences of dually eligible beneficiaries enrolled in different types of integrated coverage, and it was not our intention to assess different plan types relative to each other.

Although the focus groups were intended to obtain feedback from beneficiaries about their overall experiences in integrated programs, we heard from a number of beneficiaries about challenges accessing Medicaid benefits in particular, including behavioral health services, HCBS, and NEMT. The challenges that participants noted align with prior MACPAC work that found access challenges in these areas more broadly, not specific to dually eligible beneficiaries (MACPAC 2021a, 2021b). The feedback from the focus groups underscores the important role that states play in oversight and monitoring of integrated products and ensuring that beneficiaries have access to Medicaid services.

Hearing directly from beneficiaries is important for policymakers to make informed decisions about policies affecting their care. This work may serve as an example of the benefits of stakeholder engagement and feedback on integrated products, particularly as states prepare for the transition away from the FAI demonstration. Although the themes from the focus groups are not generalizable to the entire dually eligible population and cannot be interpreted to indicate that people enrolled in integrated care are more satisfied with this coverage than with other types of coverage, hearing from a small subset of beneficiaries that they are generally satisfied with their coverage may support continued investment in this area. Additionally, this continued investment in integrated care could include individuals with complex care needs, such as people with ID/DD. Elements of integrated care, such as care coordination and person-centered care planning, emerged from the focus groups as particularly beneficial for individuals with disabilities and may advance equity among subpopulations of dually eligible beneficiaries.

## Next Steps

The Commission remains focused on identifying options for integrated care across delivery mechanisms, such as the variety of FFS and managed care possibilities identified in this chapter, so that states can

design an integrated care strategy for their dually eligible beneficiaries that meets their needs. The Commission views these integrated care strategies as a path for all states to advance the goals of making integrated care more widely available, increasing enrollment in integrated care, and increasing the level of integration in existing models. States have access to many tools to adopt the approaches that we have described in this chapter. As D-SNPs are now present in almost all states and enrolling millions of dually eligible beneficiaries, the Commission plans to build on our earlier work highlighting strategies states can use to increase integration in their contracts with D-SNPs. We plan to explore ways that states can optimize their contracts with D-SNPs, informed by the beneficiary experience in these models. We also plan to continue monitoring the sunset of the MMP model as state plans to transition to D-SNPs develop over the next several years. In the eight states making the transition from MMPs to D-SNPs, states may have an opportunity to develop a comprehensive strategy for integrating Medicaid and Medicare coverage for dually eligible beneficiaries, consistent with our June 2022 recommendation, so that all dually eligible beneficiaries in the states would ultimately have access to an integrated coverage option.

## Endnotes

<sup>1</sup> Three states that originally operated capitated model demonstrations under the FAI have since ended those demonstrations, including Virginia in 2017, New York in 2019, and California in 2022 (CMS 2023a). New York ended its Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities demonstration, which transitioned into its current Integrated Appeals and Grievances Demonstration that began in 2020, and the state maintains a separate demonstration under the FAI targeting its intellectually and developmentally disabled population.

<sup>2</sup> If states opted to end their demonstrations in 2023, there is no requirement to transition MMP enrollees to an integrated D-SNP. However, all current states participating in the MMP model requested the two-year extension.

<sup>3</sup> Other delivery mechanisms are designed to provide integrated care to dually eligible beneficiaries who do not fall into the categories described previously. One notable example is the Program of All-Inclusive Care for the Elderly (PACE), which is a Medicare program that was permanently established under the Balanced Budget Act of 1997 (P.L.

105-33). We did not include it in our analysis because it serves relatively few beneficiaries. Low enrollment reflects both the resource intensity of establishing a PACE site and competition with state-operated programs (Gross et al. 2004). PACE programs intend to provide comprehensive medical, pharmaceutical, and psychosocial services—including the full range of Medicaid and Medicare benefits—to frail adults age 55 or older with nursing facility level of care needs who are living in the community. PACE programs receive capitated payments from both CMS and states to provide Medicare and Medicaid benefits, respectively. Under this model, beneficiaries enrolled in PACE may only receive Medicaid and Medicare services from their PACE organization. PACE programs do not cover the Medicare hospice benefit, and PACE participants must disenroll from the program if they elect to receive hospice benefits (42 CFR 460.154(i)). PACE programs are currently available in 32 states and the District of Columbia, but these programs are limited in scale, serving around 63,000 individuals, most of whom are dually eligible beneficiaries (NPA 2023).

<sup>4</sup> For example, South Carolina carved nursing facility services out of its MMP model.

<sup>5</sup> In CY 2020, 41 percent of dually eligible beneficiaries were enrolled in Medicare managed care—including MA, MMPs, and PACE—compared with 35 percent of Medicare beneficiaries who were not dually eligible for Medicaid. Among those in managed care, 51 percent were enrolled in a D-SNP (MACPAC and MedPAC 2023).

<sup>6</sup> Maine noted that it participates in the Primary Care First model under the Centers for Medicare and Medicaid Innovation, in which the state took dually eligible beneficiaries into account in the model's methodology and reimbursement structure. The state additionally requires its CO D-SNPs to fund its nursing facility partners to connect directly to the statewide health information exchange to facilitate care transitions.

<sup>7</sup> During the panel, Washington said it has earned \$98.7 million in shared savings to date.

<sup>8</sup> The District of Columbia also has two health homes that coordinate care for certain beneficiaries, and it has worked closely with its D-SNPs to leverage the SMAC for greater oversight of coordination efforts. The District of Columbia's two health homes are My DC Health Home, which serves Medicaid beneficiaries with severe mental illness, and My Health GPS, which serves beneficiaries with multiple chronic conditions (DCDHCF 2023). It also recently launched its first PACE program, which opened in March 2023, that the



District of Columbia said was the culmination of a decade of agency planning (PR Newswire 2023).

<sup>9</sup> Another state we spoke with as part of our interviews on the MMP transition, South Carolina, also announced plans to transition its dually eligible population from FFS to managed care. Like the District of Columbia, South Carolina already serves many of its Medicaid beneficiaries in managed care.

<sup>10</sup> Washington does mandatorily enroll dually eligible beneficiaries into integrated managed care plans known as Behavioral Health Service Only plans that cover Medicaid-covered behavioral health services (WAHCA 2020).

<sup>11</sup> The Bipartisan Budget Act of 2018, which permanently authorized D-SNPs, set further requirements for how D-SNPs operate, such as clarifying responsibility for coordinating benefits and assisting beneficiaries in navigating Medicaid appeals.

<sup>12</sup> SMACs, or MIPPA contracts, must cover eight minimum requirements, including the following: the MA organization's responsibilities to provide or arrange for Medicaid benefits; categories of eligibility for dually eligible beneficiaries to be enrolled under the D-SNP, including the targeting of specific subsets; Medicaid benefits covered under the D-SNP; cost-sharing protections covered under the D-SNP; information about Medicaid provider participation and how that information is to be shared; verification process of an enrollee's eligibility for both Medicare and Medicaid; service area covered under the SNP; and the period of the contract (MACPAC 2021a).

<sup>13</sup> This figure does not include the roughly 294,000 dually eligible beneficiaries in Puerto Rico who are enrolled in D-SNPs (CMS 2023c).

<sup>14</sup> D-SNPs are designated as FIDE SNPs when Medicaid services are covered by the same legal entity as the D-SNP providing Medicare benefits. FIDE SNPs must also use aligned care management and specialty care network methods to meet the needs of high-risk enrollees and "coordinate or integrate beneficiary communication materials, enrollment, communications, grievance[s] and appeals, and quality improvement" (42 CFR 422.2). FIDE SNPs are not required to cover behavioral health services, if the state carves them out of the capitation rate, until 2025. Plans may qualify as FIDE SNPs if they cover at least 180 days of nursing facility coverage during the plan year under its LTSS benefit, while other LTSS may be carved out. More details on these models can be found in chapter 1 of MACPAC's June 2020 report to Congress (MACPAC 2020a).

<sup>15</sup> The CMS final rule that sunsets the MMP models also requires that all plans with a FIDE SNP designation use exclusively aligned enrollment by 2025 (CMS 2022a).

<sup>16</sup> This level of enrollment is substantially lower than the year prior, when enrollment sat at nearly 426,000 beneficiaries, due to California's exit from the demonstration (ICRC 2023).

<sup>17</sup> Not all enrollees will be able to be transitioned to an integrated D-SNP at the start of January 2026 because CMS and states cannot automatically transition a beneficiary from a plan owned by one parent organization to a D-SNP owned by another parent organization. For example, if a parent organization that operates an MMP in a state does not offer a D-SNP in 2026, that MMP's enrollees would be returned to FFS Medicare with the option to voluntarily enroll in a different integrated D-SNP.

<sup>18</sup> The state also signaled an appetite for greater integration than either the MMPs or D-SNPs provide. In its transition letter, Massachusetts noted it would carefully consider adopting the option described in the Comprehensive Care for Dual Eligible Individuals Act (S. 4635), which was introduced by Senator Sherrod Brown and then-Senator Robert Portman on July 27, 2022. The legislation would create a new title under the Social Security Act allowing for an optional state-administered plan to provide fully integrated care for full-benefit dually eligible beneficiaries, should that legislation be passed and enacted.

<sup>19</sup> We also spoke with officials in California, which began the process of winding down its MMP demonstration and transitioning members to aligned D-SNPs before rulemaking by CMS. The state moved MMP enrollees into FIDE SNPs operated by the same parent company as that of their MMP at the start of 2023 in all seven of its demonstration counties. CMS told us it has worked closely with the state throughout its transition process and plans to use its experience as a template as it crafts technical assistance materials for the remaining MMP states. California noted that it largely preserved its MMP contract language in its D-SNP contracts. Beginning January 1, 2024, the California Department of Health Care Services will expand its integrated dually eligible beneficiary plans to five additional counties. This D-SNP program is already available in seven counties in the state (CA DHCS 2023).

<sup>20</sup> At least one state, South Carolina, contracts with any willing and qualified plan and does not undergo a competitive procurement process.

<sup>21</sup> Commissioners discussed Medicaid managed care procurement practices across states at the April 2022 Commission meeting (MACPAC 2022d).

<sup>22</sup> The Medicare Modernization Act file enables states to identify dually eligible beneficiaries and Medicaid beneficiaries who will become dually eligible based on an exchange of demographic data between states and CMS.

<sup>23</sup> Dually eligible beneficiaries use non-emergency medical transportation with greater frequency than those enrolled only in Medicaid. Of the 3.2 million non-emergency medical transportation users in fiscal year 2018, more than one-third were dually eligible (MACPAC 2021b).

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## APPENDIX 2A. State Use of Integrated Models

States use multiple models to serve dually eligible beneficiaries (Table 2A-1). Examples of integrated models include Medicare-Medicaid plans (MMPs) operating within demonstrations under the Financial Alignment Initiative (FAI), a managed fee-for-service (FFS) model under the FAI, Medicare Advantage dual eligible special needs plans (D-SNPs), or a Program of All-Inclusive Care for the Elderly (PACE).

Most D-SNPs offer minimal levels of integration and are referred to as coordination-only D-SNPs, or CO D-SNPs, because they are required to only coordinate Medicaid services, not cover them. Highly integrated dual eligible special needs plans (HIDE SNPs) must cover Medicaid behavioral health services, long-term services and supports (LTSS), or both. Fully integrated dual eligible special needs plans (FIDE SNPs) offer fully integrated coverage and must cover all Medicaid benefits, with limited exceptions for benefit carve outs through 2024.

States are testing two models under the FAI: (1) a fully integrated model, the MMP model, in which beneficiaries receive coverage of all their Medicaid and Medicare benefits under a single entity through a capitated arrangement; and (2) a FFS model that offers care coordination and a person-centered experience.

PACE offers another option for full integration and is available in 32 states and the District of Columbia (NPA 2023). PACE offers a day center providing comprehensive services to adults age 55 and older who are certified to need a nursing home level of care but can live safely in the community. Enrollees in PACE receive all their Medicare and Medicaid benefits through the PACE organization they are enrolled in.

**TABLE 2A-1.** Landscape of Integrated Care for Dually Eligible Beneficiaries by State, February 2023

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries <sup>1</sup>
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
<b>Total</b>	<b>8</b>	<b>33</b>	<b>39</b>	<b>16</b>	<b>12</b>	<b>29</b>
Alabama	—	Yes	Yes	—	—	—
Alaska	—	—	—	—	—	—
Arizona	—	—	—	Yes	Yes	Yes
Arkansas <sup>2</sup>	—	Yes	Yes	—	—	Yes
California <sup>3</sup>	—	Yes	Yes <sup>4</sup>	—	Yes <sup>4, 5</sup>	Yes
Colorado <sup>3</sup>	—	Yes	Yes	—	—	Yes
Connecticut	—	—	Yes	—	—	—
Delaware	—	Yes	Yes	—	—	Yes
District of Columbia	—	Yes	Yes	Yes <sup>4</sup>	—	No
Florida	—	Yes	Yes	Yes <sup>4</sup>	Yes <sup>4</sup>	Yes
Georgia	—	—	Yes	—	—	No
Hawaii	—	—	—	Yes	—	Yes
Idaho	—	—	Yes	—	Yes <sup>4</sup>	Yes
Illinois	Yes	—	—	—	—	Yes
Indiana	—	Yes	Yes	—	—	No

**TABLE 2A-1.** (continued)

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries <sup>1</sup>
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Iowa	–	Yes	Yes	–	–	Yes
Kansas	–	Yes	–	Yes	–	Yes
Kentucky	–	Yes	Yes	Yes	–	Yes
Louisiana <sup>6</sup>	–	Yes	Yes	–	–	–
Maine	–	–	Yes	–	–	–
Maryland	–	Yes	Yes	–	–	No
Massachusetts <sup>7</sup>	Yes	Yes	–	–	Yes <sup>4</sup>	Yes
Michigan	Yes	Yes	Yes	–	–	Yes
Minnesota <sup>8</sup>	–	–	–	Yes <sup>4</sup>	Yes <sup>4</sup>	Yes
Mississippi	–	–	Yes	–	–	No
Missouri	–	Yes	Yes	–	–	No
Montana	–	–	Yes	–	–	–
Nebraska	–	Yes	Yes	Yes	–	Yes
Nevada	–	–	Yes	–	–	No
New Hampshire	–	–	–	–	–	Yes
New Jersey	–	Yes	–	–	Yes <sup>4</sup>	Yes
New Mexico	–	Yes	–	Yes	–	Yes
New York <sup>3</sup>	Yes	Yes	Yes	Yes <sup>4</sup>	Yes <sup>4</sup>	Yes
North Carolina <sup>9</sup>	–	Yes	Yes	–	–	–
North Dakota	–	Yes	–	–	–	No
Ohio	Yes	Yes	Yes	–	–	Yes
Oklahoma	–	Yes	Yes	–	–	–
Oregon <sup>10</sup>	–	Yes	Yes	Yes	–	Yes
Pennsylvania	–	Yes	Yes	Yes	Yes <sup>5</sup>	Yes
Rhode Island <sup>11</sup>	Yes	Yes	Yes	–	–	–
South Carolina	Yes	Yes	Yes	–	–	No
South Dakota	–	–	Yes	–	–	–
Tennessee	–	Yes	Yes	–	Yes <sup>4</sup>	Yes
Texas <sup>3</sup>	Yes	Yes	Yes	Yes	–	Yes
Utah <sup>3</sup>	–	–	Yes	–	–	Yes
Vermont	–	–	–	–	–	Yes
Virginia	–	Yes	Yes	Yes	Yes <sup>4</sup>	Yes
Washington <sup>6</sup>	–	Yes	Yes	Yes	–	No
West Virginia	–	–	Yes	–	–	No

**TABLE 2A-1.** (continued)

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries <sup>1</sup>
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Wisconsin <sup>10</sup>	—	Yes	Yes	Yes	Yes <sup>4</sup>	Yes
Wyoming	—	—	Yes	—	—	—

**Notes:** D-SNP is dual eligible special needs plan. MMP is Medicare-Medicaid plan. PACE is Program of All-Inclusive Care for the Elderly. HIDE SNP is highly integrated dual eligible special needs plan. FIDE SNP is fully integrated dual eligible special needs plan. Forty-five states and the District of Columbia have D-SNPs in 2023. Integrated care programs may not be available statewide. Washington operates a managed fee-for-service (MFFS) model under the Financial Alignment Initiative (FAI). Minnesota operates an alternative model focused on administrative alignment under the FAI. HIDE SNPs also operate in Puerto Rico, which is not included in this table.

— Dash indicates state does not have the factor listed or it is not applicable to the state. For example, states that do not enroll any Medicaid beneficiaries in Medicaid managed care are marked with a dash.

<sup>1</sup> Medicaid managed care for dually eligible beneficiaries is as of 2018.

<sup>2</sup> In 2019, Arkansas implemented the mandatory Provider-Led Arkansas Shared Savings Entity (PASSE) program for certain individuals with developmental disabilities or individuals who use certain behavioral health services. Medicaid enrollees who qualify because of specific developmental disabilities or use of behavioral health services, including dually eligible beneficiaries who qualify, must enroll in a PASSE plan. The program provides comprehensive coverage for individuals with developmental disabilities.

<sup>3</sup> These states enroll dually eligible beneficiaries into certain Medicaid managed care programs on a mandatory basis and into other managed care programs on a voluntary basis.

<sup>4</sup> Designated as applicable integrated plan(s) by the Centers for Medicare & Medicaid Services, a designation that requires an integrated appeals and grievances process (42 CFR 422.629).

<sup>5</sup> Although these states currently contract with D-SNPs that meet the FIDE SNP designation, they will no longer qualify as FIDE SNPs in 2025 when those plans must begin covering behavioral health services.

<sup>6</sup> Louisiana and Washington operate behavioral health organization models that enroll full-benefit dually eligible beneficiaries, but we included only comprehensive managed care programs in this table. Washington also operates a demonstration under the FAI that provides fully integrated coverage to dually eligible beneficiaries through a managed FFS approach that relies on Medicaid health homes. The MFFS model is not listed in this table.

<sup>7</sup> Dually eligible beneficiaries can receive Medicaid benefits through Senior Care Options FIDE SNPs or One Care Medicare-Medicaid plans, but the state does not have a separate Medicaid managed care program serving dually eligible beneficiaries.

<sup>8</sup> Minnesota requires dually eligible beneficiaries and individuals eligible through the aged, blind, and disabled pathways who are age 65 and older to enroll in their Minnesota Senior Care Plus program unless those individuals enroll in the state's fully integrated D-SNP programs (Minnesota Senior Health Options and Special Needs Basic Care Plus).

<sup>9</sup> North Carolina implemented a new Medicaid managed care program in 2019. The state is required to transition full-benefit dually eligible beneficiaries to this program by 2026.

<sup>10</sup> These states enroll dually eligible beneficiaries into a Medicaid managed care program on a voluntary basis.

<sup>11</sup> Rhode Island ended its Medicaid managed care program for dually eligible beneficiaries in September 2018.

**Sources:** Mathematica analysis, 2021, under contract with MACPAC. CMS 2023. ICRC 2023.

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Chapter 3:

# Access to Medicaid Coverage and Care for Adults Leaving Incarceration

# Access to Medicaid Coverage and Care for Adults Leaving Incarceration

## Key Points

- Federal law prohibits the use of federal Medicaid funds for health care services provided to Medicaid enrollees while they are inmates of public institutions (e.g., state prisons and local jails), except in cases of inpatient care lasting 24 hours or more. This policy is known as the “inmate payment exclusion.”
- Although Medicaid coverage is limited while individuals are incarcerated, it is an important source of coverage for eligible individuals released into the community, particularly in states that have expanded Medicaid to low-income adults under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).
- Medicaid-eligible adults leaving incarceration often experience delays obtaining Medicaid coverage upon release. They may also lack access to needed medications and connections to community-based providers to initiate or continue their care after release. Limited data sharing between carceral and community-based providers contributes to discontinuity of care and poor health outcomes for this population.
- People of color, low-income individuals, and men are disproportionately represented among adults in the criminal justice system. Justice-involved adults tend to have considerable physical health, behavioral health, and health-related social needs as well as an elevated risk of death after incarceration.
- To improve care continuity and health outcomes for this population, some states have undertaken state-funded efforts to expedite Medicaid coverage upon reentry and provide targeted services to adults nearing release.
- States experience a number of challenges in these efforts. For example, some states lack the data-sharing capabilities needed to ensure immediate access to Medicaid benefits upon release. Additionally, the inmate payment exclusion’s prohibition on the use of federal Medicaid funds for health care services while an individual is incarcerated limits states’ ability to expand and sustain reentry services before release.
- In April 2023, the Centers for Medicare & Medicaid Services (CMS) issued guidance on a reentry Section 1115 demonstration opportunity through which states meeting certain conditions can receive federal financial participation for prerelease Medicaid services provided to eligible individuals leaving incarceration. California was the first state to receive CMS approval for such a demonstration, and more than a dozen other states have similar pending applications.
- The Commission identified key considerations for implementing prerelease Medicaid services, which can inform state approaches for operationalizing reentry Section 1115 demonstrations as well as future guidance and activities undertaken by CMS and other federal agencies to support states in those efforts. These considerations focus on the following:
  - collaboration between Medicaid and state and local carceral authorities;
  - lengths of stay and predictability of release dates for adults in jail;
  - data sharing and infrastructure to identify eligible enrollees, support care coordination, and facilitate Medicaid billing;
  - selection of prerelease service providers (e.g., carceral or community based) and provider capacity; and
  - monitoring and evaluation.
- The experience of states providing prerelease services to facilitate care transitions for incarcerated individuals returning to the community will illuminate future policy considerations for Medicaid’s role in serving this population. The Commission will monitor these state demonstrations, including any reporting on implementation and outcomes, and provide future guidance.

## CHAPTER 3: Access to Medicaid Coverage and Care for Adults Leaving Incarceration

Medicaid and the criminal justice system share responsibility for providing health care to Medicaid enrollees who are involved in the justice system. Medicaid generally covers health care services for eligible and enrolled individuals on parole and probation, while correctional authorities (e.g., counties and state departments of corrections) typically must pay for health care costs while individuals are confined in their facilities.<sup>1</sup> States can allow inmates of public institutions, such as state prisons and local jails, to maintain their enrollment or enroll in Medicaid while incarcerated. However, Section 1905(a)(31)(A) of the Social Security Act prohibits use of federal Medicaid funds for health care services for Medicaid enrollees when they are inmates of public institutions, except in cases of inpatient care lasting 24 hours or more (CMS 2016). This payment prohibition is commonly referred to as the “inmate payment exclusion.”

Although Medicaid’s role in covering services is limited while individuals are incarcerated, it is an important source of coverage for eligible individuals released into the community, particularly in states that have expanded Medicaid to low-income adults under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). However, Medicaid-eligible adults often face delays enrolling in Medicaid upon release. They may also lack needed medications and connections to community-based providers to initiate or continue their care after release, resulting in potentially concerning lapses in care. Limited data sharing between carceral health care providers and those in the community contributes to discontinuity of care and poor health outcomes for individuals leaving incarceration (ASPE 2023).

Adults in the criminal justice system are disproportionately low-income individuals and people of color (BJS 2022, MACPAC 2021). Disproportionate rates of incarceration among certain racial and ethnic groups are the product of decades-long inequities, stemming from structural racism and explicit and implicit biases that disadvantage communities of color.<sup>2</sup> A large

body of scientific evidence shows racial disparities in outcomes and racial bias in nearly all aspects of the criminal legal system (Bailey et al. 2021).

Justice-involved adults also tend to have considerable physical, behavioral, and health-related social needs (HRSNs) (MACPAC 2021, Maruschak et al. 2021a, Maruschak et al. 2021b, Greenberg and Rosenheck 2008, Rabury and Kopf 2015). Formerly incarcerated individuals have a substantially elevated risk of death in the period immediately after release, including from drug overdose, cardiovascular disease, and suicide (Binswanger et al. 2007). People leaving incarceration often face a host of social and economic challenges, which can create difficulties in accessing needed care (Binswanger et al. 2012).

States and the federal government are interested in improving health care transitions for this vulnerable population as they leave incarceration.<sup>3</sup> Many states have undertaken state-funded efforts to expedite Medicaid enrollment and provide in-reach services to adults leaving incarceration, with goals of improving care continuity and health outcomes as individuals reenter the community.<sup>4</sup> In April 2023, the Centers for Medicare & Medicaid Services (CMS) issued congressionally mandated guidance on Section 1115 demonstration opportunities for states to improve care transitions and provide short-term prerelease Medicaid services for individuals leaving incarceration.<sup>5</sup> California is the only state to receive CMS approval for such a demonstration, though 14 other states have similar pending applications.<sup>6</sup>

To understand how states are addressing transitions for Medicaid-eligible adults leaving incarceration, MACPAC contracted with AcademyHealth to interview officials in 16 states and examine time to benefit activation and health care use for adults leaving incarceration in Kentucky and Virginia.<sup>7</sup> The Commission also heard from an expert panel about state efforts to improve reentry as well as considerations for implementing prerelease Medicaid services.<sup>8</sup>

This chapter summarizes the demographic characteristics, health care status, and HRSNs of justice-involved adults as well as their ability to access Medicaid coverage.<sup>9</sup> Next, the chapter describes state efforts to provide timely Medicaid coverage, care continuity, and access to care for adults leaving state prisons and local jails, including Section 1115 demonstrations to provide Medicaid-covered

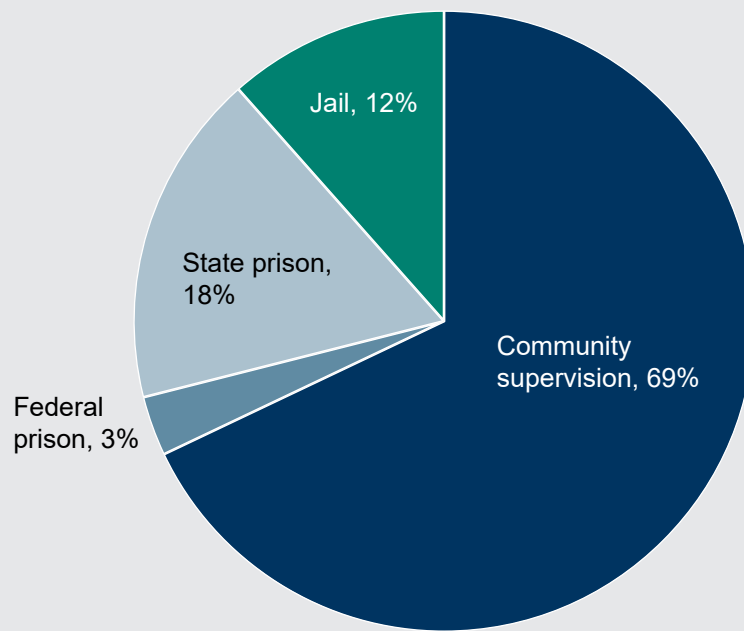
services during incarceration. We then examine key considerations for implementing prerelease Medicaid services, which can inform state approaches for doing so, as well as future guidance and activities undertaken by CMS and other federal agencies to support states in these efforts.

## Adults in the Criminal Justice System

Adults involved in the criminal justice system include those serving sentences in prisons and jails, those

awaiting trial or sentencing, and those under community supervision, such as parole or probation. At the end of 2021, roughly 7 in 10 (3,745,000) justice-involved individuals were supervised in the community, while about 3 in 10 (1,775,300) were incarcerated in a federal or state prison or local jail (Figure 3-1) (BJS 2023b).<sup>10</sup> Federal and state prisons detain individuals convicted of a felony who are typically serving sentences longer than one year. In contrast, jails house individuals awaiting trial or sentencing as well as those serving shorter sentences. In 2021, more than 6.9 million people cycled through local jails, and the average length of stay was 33 days, though stay lengths can vary substantially (Zeng 2022).<sup>11</sup>

**FIGURE 3-1.** Individuals Supervised by Adult Correctional Systems by Correctional Status, 2021



**Total adult correctional population: 5,444,900**

**Notes:** Estimates are rounded to the nearest percentage. Community supervision includes individuals on probation or parole. Prison counts are for December 31, 2021, while jail counts are for the last weekday in June 2021. The total correctional, community supervision, and incarcerated populations exclude persons with dual correctional statuses (defined as people on probation or parole who were held in prisons or jails, people on parole who were also on probation, or people in prison who were held in jail) to avoid double counting. This figure does not include individuals held in the U.S. territories, military facilities, U.S. Immigration and Customs Enforcement facilities, and jails in American Indian country.

Most correctional jurisdictions define adults as those age 18 or older. These data count as adults individuals age 17 or younger who were prosecuted as adults in criminal court. People age 17 or younger held in jail before or after they were adjudicated may be included in the count for local jails.

**Source:** BJS 2023b.

## Demographic characteristics

People of color, low-income individuals, and men are disproportionately represented among adults in the criminal justice system.

**Race and ethnicity.** In 2021, Black adults were incarcerated in state and federal prisons at more than five times the rate of white adults—1,186 per 100,000 Black adults and 222 per 100,000 white adults (Figure 3-2). The imprisonment rate was also substantially higher for Hispanic and American Indian and Alaska Native adults compared with white adults. Similar disparities exist in jails. In June 2021, 35 percent of individuals in jail were Black, whereas Black people represented just 13.6 percent of the general population (Zeng 2022, U.S. Census Bureau 2021).

**Income.** Adults involved in the criminal justice system tend to be poorer than the general population. In 2014 dollars, the median annual income of state prisoners before incarceration was \$19,185—41 percent less than the earnings of people who were not incarcerated. The majority of adults in state prisons (57

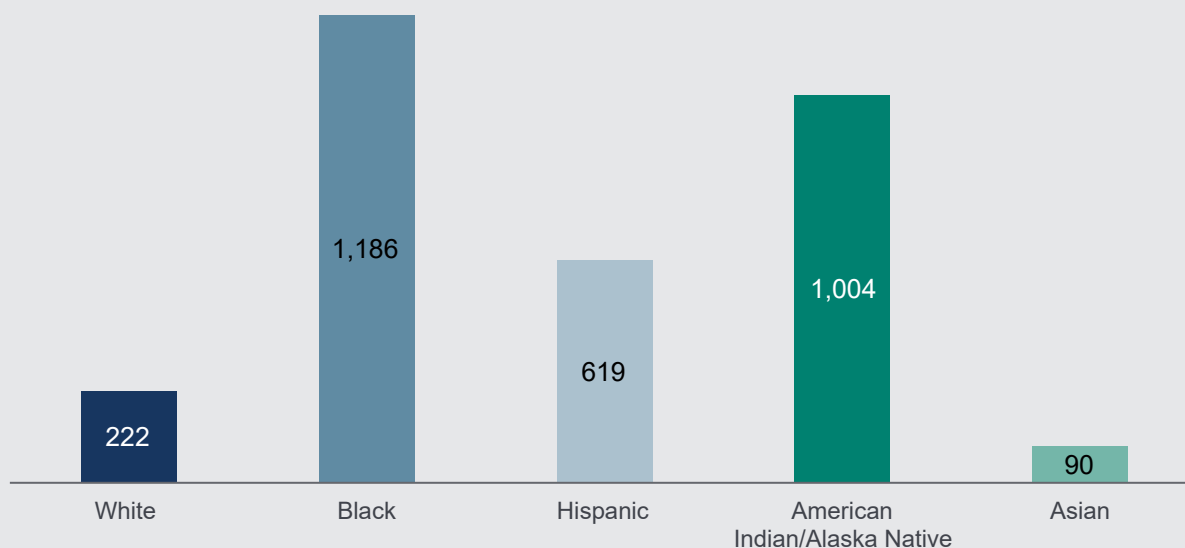
percent of men and 72 percent of women) earned less than \$22,500 annually before incarceration (Rabury and Kopf 2015).

**Gender.** Men make up the vast majority of individuals incarcerated in state prisons (93 percent), and the composition of jails is similar, with men comprising 87 percent of all jail inmates in 2021 (BJS 2022, Zeng 2022). Though most incarcerated individuals are men, the incarceration rate for women has been steadily increasing since 1980 (BJS 2022). Most women incarcerated in state or federal prisons (66 percent) are of reproductive age (between age 25 and 44) (BJS 2022).

## Health care needs and access

Adults involved in the criminal justice system report high rates of chronic physical and behavioral health conditions, disability, and traumatic experiences that can adversely affect their health (BJS 2021, MACPAC 2021, Maruschak et al. 2021a, Maruschak et al. 2021b, Maruschak et al. 2021c, Quandt and Jones

**FIGURE 3-2.** Imprisonment Rates of Adults Per 100,000 U.S. Residents by Race and Ethnicity, 2021



**Notes:** Imprisonment rate is the number of sentenced prisoners age 18 or older under state or federal jurisdiction per 100,000 U.S. residents age 18 or older in a given category. Rates are for December 31, 2021, and are based on prisoners with a sentence of more than one year. Resident population estimates are from the U.S. Census Bureau for January 1, 2022. Categories are non-Hispanic, with the exception of the group identified as Hispanic. Asian includes Native Hawaiians and Other Pacific Islanders.

**Source:** BJS 2022.

2021). After incarceration, justice-involved individuals are more likely to be hospitalized or admitted to the emergency department than those without criminal justice involvement (Frank et al. 2014). They also experience an elevated risk of death compared with the general population, including a 40 times higher risk of opioid overdose death in the first two weeks after incarceration (Ranapurwala et al. 2018).<sup>12</sup>

The relatively poor health status of justice-involved individuals may reflect, in part, the barriers they face in accessing health care services, such as cost and stigma (Moore and Tangney 2017, Sawyer 2017). They also tend to be mistrusting of the health care system and reluctant to seek care if they have experienced discrimination from community providers (MACPAC 2022). Individuals who are incarcerated are also often wary of the carceral health care system, which they may perceive to be low quality or unresponsive to their needs (Vandergrift and Christopher 2021, Young 2010).

**Physical health.** In 2016, 40 percent of state prisoners reported having a chronic physical health condition, the most common being high blood pressure (22 percent), arthritis (15 percent), and asthma (12 percent). Eighteen percent reported ever having an infectious disease, most commonly hepatitis C (9.5 percent) and sexually transmitted infections (4.4 percent).<sup>13</sup> However, nearly 20 percent of adults in state prisons did not have a health-related visit during their incarceration, and access to care, including curative therapies for hepatitis C, is often limited (Maruschak et al. 2021a, Thanhong-Knight 2018). Between April 2020 and April 2021, individuals who were incarcerated were more than three times as likely to contract COVID-19 and 2.5 times as likely to die from it than individuals who were not incarcerated (Marquez et al. 2021).<sup>14</sup>

**Behavioral health.** In 2016, more than half (56 percent) of state prisoners experienced serious psychological distress in the previous month or had a previously diagnosed mental health condition. The most commonly reported conditions were major depressive disorder (27 percent), bipolar disorder (23 percent), and anxiety disorders (22 percent). However, only 41 percent of state prisoners experiencing serious psychological distress in the past 30 days reported that they were receiving treatment (Maruschak et al. 2021b).

Substance use disorder (SUD), including opioid use disorder (OUD), is highly prevalent among adults involved in the criminal justice system. In 2016, nearly half (49 percent) of state prisoners met the criteria for SUD in the year before their incarceration (Maruschak et al. 2021c). Yet, state prisons in 18 states and most (90 percent) local jails do not offer any form of medication for opioid use disorder (MOUD) (Jail & Prison Project 2022). Most states offering at least one form of MOUD in state prisons do not make it available in every prison throughout the state.<sup>15</sup> Among individuals with a prior OUD diagnosis leaving state prisons or jails in Kentucky in 2019 to 2020, only 15 percent received MOUD within 30 days of release.

**Trauma.** Trauma is common among individuals with criminal justice involvement. The experience of incarceration can itself result in trauma, which can have consequences for an individual's physical and behavioral health. A growing body of research on the traumatic effects of incarceration has identified high rates of postincarceration syndrome, a condition similar to posttraumatic stress disorder (Liem and Kunst 2013). Additional research indicates that experiencing traumatic events while incarcerated is associated with a higher likelihood of posttraumatic stress disorder diagnosis after release and can trigger and worsen symptoms of mental illness (Quandt and Jones 2021).

**Disabilities.** In 2016, 40 percent of state prisoners reported having at least one disability, compared with just 15 percent of the general population.<sup>16</sup> The most commonly reported disabilities were cognitive (24 percent), ambulatory (12 percent), and vision related (12 percent). Roughly one in four state prisoners (26 percent) reported ever being told that they had an attention deficit disorder (BJS 2021).

## Health-related social needs

Adults involved in the criminal justice system tend to have HRSNs such as homelessness and food insecurity (Couloute 2018, Wang et al. 2013, Greenberg and Rosenheck 2008). They also face barriers to addressing those needs as a result of policies and practices that limit access to housing, employment, and federal benefits (Levins 2023).<sup>17</sup>



**Unemployment.** Adults involved in the criminal justice system are less likely to be employed than the general population. In 2008, 27 percent of formerly incarcerated adults were unemployed, compared with approximately 5 percent of the general population. Unemployment rates are highest among formerly incarcerated Black women (44 percent) and Black men (35 percent) (Couloute and Kopf 2018).

**Homelessness.** Justice-involved adults are also more likely than the general public to experience homelessness. In the year before incarceration, more than 15 percent of jail inmates reported at least one episode of homelessness (Greenberg and Rosenheck 2008). After incarceration, the rate of homelessness among justice-involved adults is 10 times that experienced by the general public. The likelihood of homelessness also increases for individuals who have been incarcerated multiple times (Couloute 2018).

**Food insecurity.** Adults with justice involvement often face food insecurity. One survey estimated that 91 percent of adults recently released from state prisons were food insecure, with 37 percent reporting that they did not eat for an entire day at least once in the past month (Wang et al. 2013).

## Access to Medicaid

A substantial portion of justice-involved adults living in the community are enrolled in Medicaid. Nationally, more than a quarter (28 percent) of adults under community supervision were enrolled in the program between 2015 and 2019 (MACPAC 2021). In states that cover low-income adults in Medicaid, the vast majority of those incarcerated may be eligible for Medicaid (Guyer et al. 2019). In Kentucky, for example, nearly 93 percent of adults released from state prisons and local jails in 2019 to 2020 were enrolled in Medicaid at some point in the previous five years.

The inmate payment exclusion prohibits the use of federal financial participation (FFP) for health care services provided to individuals who are incarcerated, except in the case of inpatient stays in a medical institution lasting 24 hours or more (CMS 2016). To ensure compliance, states have the option to suspend eligibility or benefits for adults who become incarcerated, which can expedite access to coverage upon release by eliminating the need to process new

Medicaid applications.<sup>18</sup> Eligibility suspension involves the state suspending an individual's eligibility so they are no longer eligible to receive Medicaid benefits for the duration of incarceration; the state must lift the suspension for Medicaid to pay for services furnished to an enrollee while admitted to a medical institution for an inpatient stay of at least 24 hours. Under a benefits suspension, an eligible individual continues to be enrolled in Medicaid, but Medicaid coverage is limited to qualifying inpatient stays (CMS 2023a). As of state fiscal year (SFY) 2019, 42 states suspend Medicaid eligibility or benefits for enrollees in jail, and 43 states do so for enrollees in state prison.<sup>19</sup> The remaining states terminate eligibility for enrollees who become incarcerated, and thus, individuals seeking Medicaid upon release must submit new applications for enrollment (KFF 2019).<sup>20</sup>

States often reinstate Medicaid eligibility or benefits quickly once an individual is released, though delays can occur. In Kentucky and Virginia, the majority of individuals with prior Medicaid coverage leaving incarceration had active Medicaid benefits within one day of release (77 percent in Kentucky and 68 percent in Virginia) (Appendix 3-1). In other states, however, the time to benefit reactivation can range from approximately 30 to 60 days after release.

For adults whose Medicaid eligibility was terminated, as well as those who were not previously enrolled in Medicaid, the need to process new applications can contribute to delays in coverage when reentering the community. Although states have mechanisms for processing new applications before release, some states report that the process can take up to three months to complete. It can be particularly difficult for individuals in jail to complete their Medicaid applications far enough in advance of their release given the short duration of most jail stays and the difficulty predicting release dates for the pretrial population.

In states with Medicaid managed care delivery systems, policies pertaining to managed care plan enrollment can affect care continuity and delay plan engagement with Medicaid enrollees leaving incarceration. For instance, some state policies prohibit such individuals from enrolling in a plan until after their release. Additionally, in some states, enrollment in a plan is not effectuated immediately but

occurs later—for example, on the first day of the month after plan selection. Although Medicaid enrollees awaiting effectuated plan enrollment can obtain services through the fee-for-service delivery system, they may experience discontinuity of care if their fee-for-service providers do not participate in the selected plan's provider network.

## State Strategies for Improving Access to Medicaid Coverage and Care

The health care needs of adults involved in the criminal justice system and the disproportionate effects of that system on individuals of color have prompted many states to pursue opportunities to improve access to Medicaid coverage and care upon release from state prisons and local jails. These efforts, which states undertook before the recent Section 1115 demonstration opportunity to provide release coverage, have primarily been financed with state funds due to the inmate payment exclusion.

Coordination between Medicaid and corrections agencies is the cornerstone of these efforts. Although most of the states we interviewed reported strong collaboration between Medicaid and corrections, particularly at the state level, working across state and local agencies to improve outcomes for adults leaving incarceration can be challenging because of siloed organizational structures, competing priorities, staff turnover, and limited funding due in part to the inmate payment exclusion.

The approaches taken by these states and the challenges they encountered, which are described in the following sections, may be instructive for other states considering similar state-funded efforts or Medicaid demonstration authority to receive federal matching funds for prerelease Medicaid services. Many of the states we interviewed cited the inmate payment exclusion as a barrier to timely Medicaid coverage and continuity of care for adults leaving incarceration and the state's goal of improving health outcomes among that population. Section 1115 demonstrations to provide prerelease Medicaid services, and considerations for implementing those initiatives, are discussed later in the chapter.

## Facilitating Medicaid enrollment

States' approaches for facilitating Medicaid enrollment for adults leaving state prisons and jails include suspending rather than terminating Medicaid benefits, improving data-sharing between corrections and Medicaid, and providing enrollment assistance before release.

**Suspending coverage.** All of the states we interviewed suspend rather than terminate Medicaid coverage for adults to expedite access to full Medicaid benefits upon release. This requires corrections agencies to share information about individuals entering their facilities, so that the state Medicaid agency can identify and place enrollees in a suspended status or limited benefit category. This in turn allows payment only for qualifying inpatient stays in a medical institution. Once information about the individual's release date is known, the corrections agency shares it with the state Medicaid agency so the individual's eligibility status can be changed as quickly as possible after release. For example, New York partially reactivates suspended Medicaid benefits 30 days before release so that enrollees have an active Medicaid identification number. This allows an individual (before release) to make an appointment with a community provider for postrelease care. Some providers may not arrange appointments for individuals without an active Medicaid identification number.

**Data transmission.** The method and frequency of data sharing between corrections and Medicaid affect how long it takes to reactivate benefits for individuals with suspended Medicaid coverage. Among states interviewed, time to benefit reactivation ranged from 0 to 60 days. Some states reported having a central data repository accessible by Medicaid and corrections, which can provide real-time updates about an individual's incarceration status and eligibility. Other states email secure files on a daily, weekly, or monthly basis. Some states reported using different systems for state prisons and local jails, particularly those in rural and frontier areas with less capacity to adopt new health information technology (IT) systems. Arizona's Medicaid agency facilitates an automated process for sharing data between the state and county corrections agencies, which is currently operational in state prisons and 5 of the state's 15 county jail systems (MACPAC 2022).

Time to benefit activation can also depend on whether systems support changes to an individual's eligibility status through an automated or manual process. In Delaware, which suspends benefits during incarceration, data are transmitted daily from corrections to Medicaid using an automated process to update an enrollee's incarceration status. This allows benefits and the method of payment to change within a day of release. In contrast, in Massachusetts, data are shared on a weekly basis, and eligibility changes are completed manually. Though processing times can vary, changes to eligibility are processed, on average, within three days of the Medicaid agency receiving notification of an individual's change in incarceration status.

**Enrollment assistance.** Every state interviewed reported having a process to begin Medicaid enrollment before release. Several states have dedicated staff to facilitate Medicaid enrollment in prisons. Some also prioritize applications for individuals with certain health conditions or needs for medical supplies (e.g., oxygen) upon release. Rhode Island and New Mexico use presumptive eligibility to expedite and address barriers to enrollment upon release; however, since enrollment is temporary, individuals must complete a full Medicaid application to maintain coverage after the initial presumptive eligibility period ends.<sup>21</sup> The Virginia Medicaid agency established an eligibility unit to process Medicaid applications and redeterminations as well as benefit suspension and reactivation for justice-involved individuals. The daily transmission of data from corrections to this dedicated eligibility unit started with state prisons and has been expanded to include 67 local jails.

**Challenges.** Nearly all of the states interviewed emphasized that facilitating Medicaid enrollment and reenrollment upon release is challenging. States cite cost as a barrier to making data infrastructure improvements needed to ensure timely enrollment and benefit reactivation, such as implementing automated systems and more frequent data transmission from corrections to Medicaid. Additionally, some states shared concerns about data quality, such as having mismatched or incomplete Social Security numbers, addresses, and phone numbers that require manual and sometimes time-intensive fixes.

Aligning benefit activation with an individual's release date can be particularly challenging in jails where, relative to state prisons, individuals are incarcerated for shorter periods and release dates can be less predictable.

## Providing reentry services

Some states offer targeted, state-only funded Medicaid reentry services beyond enrollment assistance to eligible adults leaving incarceration to minimize gaps in care and provide a more seamless transition to community living. Reentry programs may include services provided before release for which Medicaid payment is otherwise prohibited as well as services provided in the community after release that are eligible for federal reimbursement. Several states interviewed also reported providing reentry services funded through state general funds, the state department of corrections, and federal grants.

**In-reach programs.** In-reach programs are intended to assess the needs of individuals leaving incarceration and help them establish connections with community providers and managed care organizations (MCOs) (SHADAC 2019). Through the state-only funded MassHealth Behavioral Health Supports for Justice Involved Individuals program in Massachusetts, navigators work with individuals to develop personalized treatment plans and make referrals to social services such as housing and employment before release (MassHealth 2021). Other states require MCOs to conduct in-reach activities even though federal match is not available for these services. For example, Arizona provides administrative funding through capitation payments to support a requirement that all MCOs have justice in-reach care coordinators who help set up postrelease appointments with providers in the community and ensure that individuals have access to covered medical services (AHCCCS 2022). Several states also reported providing individuals with a 30- or 90-day supply of needed medications and naloxone kits, as well as training on how to use them, immediately upon release.

**Postrelease services.** Some states also provide Medicaid-covered services and supports designed to address the needs of enrollees who were previously incarcerated. For example, New York and Rhode

Island use Section 1945 health homes to provide care coordination and behavioral and physical health services to enrollees with criminal justice involvement.<sup>22</sup> In these states, health homes partner with certain entities (e.g., discharge units, parole boards, and the state behavioral health agency) to identify and address the needs of eligible individuals who have been recently released from prison or jail (MACPAC 2018, Spillman et al. 2017). In Arizona, MCOs are required to make incentive payments to providers who participate in integrated care activities, including 13 integrated clinics offering services to justice-involved individuals living in the community (CMS 2022). These clinics, which offer physical and behavioral health services and vocational training, are colocated with probation and parole offices, offering a “one-stop shop” for recently released adults (AHCCCS 2019).

**Challenges.** Although some states provide state-only funded in-reach services through the state Medicaid agency, these efforts are often limited in scope and scale. For example, Kentucky does not operate its jail in-reach program in every county, and Vermont limits in-reach services to certain high-risk populations (i.e., those with SUD, HIV, or hepatitis C). Several states noted that they lack resources to expand and sustain reentry programming, particularly before release, because the inmate payment exclusion prohibits Medicaid from paying for services.

States also reported limited or no health information sharing between corrections and community providers as well as difficulty helping individuals leaving incarceration set up prearranged appointments with community providers. Several states reported that some providers refuse to schedule appointments for individuals before their release if they do not have an active Medicaid identification number.

## Reentry Section 1115 Demonstrations

The care fragmentation and poor health outcomes often experienced by individuals leaving incarceration have prompted a growing number of states to seek Section 1115 demonstration authority to provide Medicaid-covered services to eligible individuals who are incarcerated and nearing release. New

federal guidance outlining the parameters for such demonstrations, as well as the recent approval of a reentry demonstration in California, may encourage additional states to pursue this opportunity.

### Federal guidance

In April 2023, CMS issued congressionally mandated guidance to states describing demonstration opportunities to improve care transitions for Medicaid-eligible individuals who are soon to be released from incarceration (CMS 2023a). The guidance describes opportunities for states to receive FFP for prerelease services furnished to incarcerated enrollees for a defined period before their release. Such demonstrations must meet certain requirements specific to the reentry demonstration opportunity as well as those applicable to Section 1115 demonstrations generally (e.g., budget neutrality, monitoring and evaluation).<sup>23</sup> To identify individuals who are eligible for demonstration services, states will be required to make prerelease outreach, eligibility services, and enrollment support available to all individuals in facilities included in the demonstration and to suspend rather than terminate Medicaid eligibility for individuals entering those facilities.

**Demonstration goals.** CMS expects that state reentry demonstrations will be designed to do the following:

- increase coverage, continuity of care, and appropriate use of services through assessment of eligibility and coverage for services just before release;
- improve access to services before release and improve transitions and continuity of care into the community upon release and during reentry;
- improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers;
- increase investments in health care and related services that improve care quality for enrollees in carceral settings and in the community after release;
- improve connections between carceral settings and community services upon release to address



physical, behavioral, and health-related social needs;

- reduce deaths in the near-term after release; and
- reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid enrollees through increased receipt of physical and behavioral health care.

**Eligibility.** States may cover prerelease services for individuals who are otherwise Medicaid eligible and soon to be released from state prisons, local jails, and youth correctional facilities.<sup>24</sup> CMS encourages states to propose broad criteria for inclusion among this group, though states have flexibility to target the populations covered (e.g., those with specified health conditions).

**Benefits.** At a minimum, states must cover prerelease case management, medication-assisted treatment (MAT) for all types of SUD, and a 30-day supply of prescription medications provided immediately upon release.<sup>25</sup> States may propose to cover additional services that promote coverage and quality of care to improve transitions for individuals being released back to the community.

**Duration of prerelease coverage.** States are expected to cover demonstration services beginning 30 days before release, though CMS will consider approving demonstrations that begin coverage up to 90 days before release.<sup>26</sup>

**Implementation and reinvestment plan.** Before claiming federal reimbursement for approved demonstration services, states must submit and receive CMS approval of an implementation plan documenting how the state intends to institute Medicaid coverage and delivery of prerelease services.<sup>27</sup>

As part of the implementation plan, states are expected to submit a reinvestment plan detailing how they will reinvest new FFP for demonstration services in cases in which those services are already provided or paid for by a correctional facility or authority. This requirement is intended to ensure that new Medicaid investments in reentry services do not supplant existing state and local investments and shift costs to the federal Medicaid programs.<sup>28</sup> States may reinvest

FFP for demonstration services in activities that increase access to or improve the quality of health care services for individuals who are incarcerated or were recently released or in health-related social services that reduce the likelihood of criminal justice involvement.

**Monitoring and evaluation.** Consistent with the requirements for all Section 1115 demonstrations, states with approved demonstrations will be required to undertake certain monitoring and evaluation activities.<sup>29</sup> This includes submitting to CMS quarterly and annual monitoring reports as well as a midpoint assessment describing the state's progress toward specific milestones and goals and outlining any necessary mitigation strategies.<sup>30</sup> States must also conduct an independent evaluation of the demonstration and submit specific evaluation deliverables to CMS (i.e., an evaluation design, interim report, and summative report).<sup>31</sup>

## Pending and approved demonstrations

In January 2023, California became the first state to receive approval under Section 1115 authority to provide Medicaid-covered services to certain individuals leaving incarceration. Under the demonstration, adults and youth incarcerated in state prisons and county jails meeting at least one specified health condition (e.g., mental illness, SUD, or HIV or AIDS) may be eligible for Medicaid-covered reentry services up to 90 days before their release.<sup>32</sup> Youth incarcerated in juvenile correctional facilities do not need to meet clinical criteria for eligibility. The state will receive federal Medicaid matching funds for specified prerelease services, such as in-reach case management, MAT, and peer navigation.<sup>33</sup>

The demonstration will be phased in over a two-year period as facilities demonstrate their readiness to provide prerelease services and meet other requirements.<sup>34</sup> To support implementation, CMS approved \$410 million for planning and IT investments through the Providing Access and Transforming Health program (DHCS 2023).<sup>35</sup>

As of April 21, 2023, 14 additional states have submitted Section 1115 demonstration applications to provide Medicaid-covered services to certain individuals who are incarcerated.<sup>36</sup> The proposed

Section 1115 demonstrations vary in terms of eligibility, covered services, and the duration of coverage offered before release (Table 3-1):

- Eligibility.** Almost all states would provide services to individuals in state prisons and jails, while a smaller number of proposals explicitly target youth in juvenile corrections facilities.<sup>37</sup> Ten states propose limiting eligibility for adults to those with specific conditions, such as SUD, serious mental illness, and intellectual and developmental disabilities. In Arizona, eligibility would also depend on an individual's risk for homelessness after incarceration.
- Benefits.** Most of the states are proposing to offer a limited set of prerelease Medicaid services, often including case management and referrals to community providers, behavioral health care, and a supply of medication upon release. A smaller number is seeking to provide full Medicaid benefits to some or all of the populations that would be covered under the demonstration.<sup>38</sup>
- Coverage duration.** The majority of states propose covering services up to 30 days before release, while others are looking at windows of up to 60 or 90 days.<sup>39</sup> Oregon would offer services

**TABLE 3-1.** Characteristics of Pending Medicaid Section 1115 Demonstrations to Waive the Inmate Payment Exclusion as of April 21, 2023

Characteristic	States
<b>Eligibility</b>	
All adults	4 states (OR, RI, VT, WA)
Adults with certain medical diagnoses	10 states (AZ, <sup>1</sup> KY, MA, MT, NH, NJ, NM, NY, UT, WV)
All youth	4 states (MA, OR, RI, WA)
Youth with certain medical diagnoses	1 state (NM)
<b>Benefits</b>	
Full benefits	5 states (MA, OR, <sup>2</sup> RI, UT, VT)
Limited benefits	10 states (AZ, KY, MT, NH, NJ, NM, NY, OR, <sup>2</sup> WA, WV)
<b>Duration of prerelease coverage</b>	
30 days	10 states (AZ, KY, <sup>3</sup> MA, <sup>4</sup> MT, NM, NY, RI, UT, WA, WV)
45 days	1 state (NH)
60 days	1 state (NJ)
90 days	2 states (OR, <sup>5</sup> VT)
36 months	1 state (KY <sup>3</sup> )
Throughout incarceration	2 states (MA, <sup>4</sup> OR <sup>5</sup> )

**Notes:** To receive demonstration services, individuals would have to meet all other Medicaid eligibility requirements under the state plan. The definition of youth varies by state (e.g., some states define youth as anyone younger than age 18, while others include individuals younger than age 19).

<sup>1</sup> In Arizona, eligibility would also be limited to individuals at high risk of homelessness upon release.

<sup>2</sup> Oregon would provide limited benefits to individuals in prison and state-run juvenile correctional facilities and full benefits to adults and youth in jail and youth in local juvenile correctional facilities.

<sup>3</sup> Kentucky would provide substance use disorder treatment and recovery services up to 36 months before release and care coordination services an average 30 days before release.

<sup>4</sup> Massachusetts would cover services 30 days before release for adults and throughout incarceration for youth.

<sup>5</sup> Oregon would cover services 90 days before release for individuals in prisons and certain state-run juvenile correctional facilities and throughout incarceration for adults and youth in jail and youth in local juvenile correctional facilities.

**Source:** MACPAC analysis of Section 1115 demonstration proposals on Medicaid.gov, 2023.



for the duration of stays in jail or certain juvenile correctional facilities, and Massachusetts would cover youth throughout their incarceration.

## Considerations for Implementing Prerelease Services

The Commission identified several key considerations for implementing prerelease Medicaid services. These considerations can inform how states institute their reentry Section 1115 demonstrations and underscore areas in which additional federal guidance, technical assistance, or other support would be helpful to states, localities, and providers. Based on feedback from state and local officials representing Medicaid and corrections, as well as other national experts, these considerations include:

- cross-agency collaboration;
- application to jails;
- data sharing and infrastructure;
- pre- and postrelease health and social services providers; and
- monitoring and evaluation.

Instituting prerelease Medicaid services will require a substantial investment of time and resources in many of these areas. In its guidance on the reentry Section 1115 demonstration opportunity, CMS notes that it will consider requests for time-limited FFP for certain expenditures that support implementation of state demonstrations. New spending may include hiring and training staff who will be working with justice-involved individuals and expenditures associated with activities that promote collaboration between corrections, Medicaid, and other organizations involved in planning and supporting the demonstration. States may also request approval of enhanced FFP for state Medicaid agency IT system expenditures incurred during implementation.<sup>40</sup>

**Cross-agency coordination.** Successful implementation of prerelease services will require strong coordination between state Medicaid agencies

and corrections officials who oversee state prisons and local jails (ASPE 2023, MACPAC 2022). The states MACPAC interviewed reported strong cross-agency collaboration; however, other state Medicaid agencies may have limited interaction with corrections agencies (MACPAC 2022). Although the state Medicaid agency is primarily responsible for designing and negotiating the terms of Section 1115 demonstrations, early engagement of state and local corrections leaders helps in gaining buy-in and anticipating and overcoming operational challenges associated with implementing prerelease Medicaid services (ASPE 2023, MACPAC 2022). Some corrections agencies may be reluctant to take on additional responsibilities they perceive to be beyond their scope. Yet in many instances, they are eager to partner with Medicaid to provide services that can improve health outcomes and reduce recidivism (MACPAC 2022). Medicaid and corrections agencies need to develop an understanding of each other's programs and collaborate in addressing areas in which their programs and goals may diverge (MACPAC 2022).

Some stakeholders have suggested that additional federal support is needed to promote cross-agency collaboration to support the adoption of prerelease Medicaid services as well as to disseminate promising approaches for improving the health of justice-involved individuals more generally (MACPAC 2022). This partnership should include convenings or other technical assistance provided jointly by CMS and the U.S. Department of Justice Bureau of Justice Assistance, which provides programmatic and policy support to state and local corrections agencies, reentry services providers, and other key partners (BJA 2023). Stakeholders have also suggested that additional investment is needed at the state and federal level to expand administrative capacity and enhance staff expertise so that agencies are better equipped to address the needs of justice-involved individuals (MACPAC 2022).

**Application to jails.** Determining how to implement Medicaid-covered services before release will be particularly challenging in jails, where individuals awaiting trial may be released without advanced notice—for example, when charges are dropped, an inmate posts bail, or the adjudication of a case results in an inmate's release (MACPAC 2022). Jail staff can estimate the expected length of stay for

individuals depending on the circumstances of their arrest; however, there is no set end-of-stay date for individuals awaiting trial, which represent 71 percent of the jail population nationally. This ambiguity may make it difficult for state Medicaid agencies and local correctional authorities to determine when an individual is eligible for reentry services under the state's approved Section 1115 demonstration. In addition, the length of jail stays—33 days on average—offers a limited window in which to identify and provide services to individuals who are eligible for them (Zeng 2022). State implementation plans will provide important insight into how states seek to address these challenges.

**Data-sharing and infrastructure.** State Medicaid agencies and state and local correctional authorities will need systems that support the timely exchange of relevant information, such as release dates and eligibility status. As of SFY 2019, only 23 states reported that their Medicaid and corrections agencies had electronic, automated data exchange processes to facilitate the suspension and reinstatement of benefits (KFF 2019).<sup>41</sup> Establishing these cross-sector data systems can be costly and time consuming and particularly challenging to accomplish with jails in rural and frontier areas that may have more limited resources and staff capacity (MACPAC 2022).

Improving data-sharing capacity between correctional and community providers is needed to promote care coordination and continuity as individuals leave incarceration. States should establish or update data systems to allow for timely and accurate sharing of relevant medical records, such as through an electronic health record or health information exchange. Currently, little information sharing occurs between correctional health care providers and providers in the community (ASPE 2023, Wishner and Mallik-Kane 2017). Correctional facilities often lack health care information systems capable of connecting to health information exchanges or other electronic data sharing methods. This disconnect can exacerbate issues in coordinating care for justice-involved individuals, both while incarcerated and upon their return to the community (Davis and Cloud 2015).

If correctional staff or their contracted health care providers are responsible for providing prerelease Medicaid services, correctional facilities will also need to establish systems for Medicaid billing.

Most correctional institutions are currently unable to bill services to Medicaid due to the inmate payment exclusion. Thus, incorporating a Medicaid billing infrastructure into county jail systems will require additional guidance and staffing resources (MACPAC 2022).

**Providers.** States must determine which providers will deliver prerelease services. Although CMS describes the use of community-based providers as the preferred approach to build trust with individuals who are incarcerated and strengthen the connection to care in the community upon release, states may choose to rely on carceral health care providers for delivery of some or all prerelease services. CMS guidance generally requires states to ensure that carceral providers furnishing prerelease services under Section 1115 demonstration authority comply with the state's Medicaid provider participation policies; however, under California's demonstration, carceral providers of prerelease services are not required to enroll in the state's Medicaid program (CMS 2023a, CMS 2023b).<sup>42</sup>

The delivery of health care in state prisons and jails varies considerably across states and correctional facilities. In the majority of state prisons, primary care and common outpatient services are delivered by a clinician employed by the state corrections agency or a private contractor (Pew 2018a). Many jails also contract with vendors to provide health care within their facilities (Pew 2018b). These carceral providers may not be enrolled in Medicaid given the general prohibition against Medicaid payment for services when an enrollee is incarcerated.

States will need to decide whether to use correctional or community providers for non-clinical prerelease services, such as case management and housing supports.<sup>43</sup> States may provide these services through partnerships with community-based organizations, which may not already be Medicaid-enrolled providers (MACPAC 2022).<sup>44</sup> These entities will have to establish Medicaid billing systems and relationships with managed care plans, which can be challenging (Activate Care 2021).

Whether community providers or corrections staff provide prerelease services has implications for continuity of care and the ability of those providers to meet the care needs of individuals with criminal justice involvement. Relying on community providers

to deliver prerelease services either in person or via telehealth can contribute to care continuity if enrollees can continue to see those providers after release. However, the availability of community providers to deliver prerelease services will be limited in certain areas such as rural and other underserved areas. Moreover, some community providers will have less experience working in correctional environments and addressing the complex needs of justice-involved individuals, including those related to trauma and criminogenic risk factors (ASPE 2023).<sup>45</sup> Additional education and training to prepare community-based providers to offer prerelease services, in addition to the consideration of security issues and processes, would be beneficial (MACPAC 2022).<sup>46</sup>

Peer support specialists with a personal history of mental illness, SUD, or criminal justice involvement provide culturally competent care before and after release when individuals may struggle to access health care services and address their needs related to housing, employment, and family reintegration (ASPE 2023, MACPAC 2022). Although most state Medicaid programs cover some type of peer support, it will be important for states to address formal and informal policies that limit the employment of people with criminal records in such roles (MACPAC 2022, Adams and Lincoln 2021, MACPAC 2019a). These include, for example, certain background check or insurance policy requirements that prohibit hiring individuals with criminal records.

To improve continuity of care and health outcomes for individuals once they reenter the community, many states will need to expand the capacity of community-based systems to address the physical health, behavioral health, and HRSNs of individuals leaving incarceration.<sup>47</sup> One expert noted that prerelease services alone will not “move the needle” toward improved health outcomes for this population without corresponding investments to improve access to care in the community (MACPAC 2022). She noted that “for reentry to be successful, community providers need to play a bigger role and to be supported in growing into that role.” Access to mental health and SUD treatment in particular is critical to preventing deaths and reducing substance use and decompensation, factors that often contribute to rearrest and incarceration (ASPE 2023, MACPAC 2022).

**Monitoring and evaluation.** Robust and timely monitoring and evaluation of initiatives to provide prerelease Medicaid services should be given priority because of the unprecedented nature of these efforts and the substantial physical health, behavioral health, and HRSNs of the populations affected (ASPE 2023, MACPAC 2022). However, Section 1115 demonstration evaluations have not historically been rigorous enough to assess whether demonstrations have achieved their goals, nor are they typically completed in time to inform decisions about the future of the policy being tested (MACPAC 2020). Moreover, evaluation results are not always distributed timely or made known to interested stakeholders (MACPAC 2022).

Given the typical lag in evaluation data, states should consider additional opportunities to enhance monitoring of implementation and progress toward the demonstration’s identified goals (MACPAC 2022). CMS is requiring states operating reentry demonstrations to conduct an independent midpoint assessment of their progress toward specific milestones and goals—an additional monitoring activity that is not required of all Section 1115 demonstrations.<sup>48</sup> However, states and CMS should consider additional ways to strengthen monitoring and evaluation, including by ensuring that people with lived experience and other beneficiary advocates play a role in oversight of implementation and milestones (MACPAC 2022). Beneficiary surveys and interviews are an important avenue for assessing beneficiary understanding of the program as well as their perceptions of access and quality.

Policy-specific guidance and tools, tailored to reentry demonstrations, may be helpful in supporting timely and robust monitoring and evaluation results. MACPAC’s prior work found that CMS guidance on strengthening state-led evaluations of certain Section 1115 demonstrations has been helpful in encouraging states to consider their demonstration goals and anticipated outcomes (MACPAC 2020). For example, CMS has provided monitoring templates and detailed guidance on developing hypothesis and research questions for evaluating Section 1115 demonstrations for enrollees with SUD, serious mental illness, and serious emotional disturbance.

## Looking Ahead

As states implement Section 1115 demonstrations to provide prerelease Medicaid services to improve the health of Medicaid enrollees leaving incarceration, state Medicaid and correction agencies and CMS will confront numerous implementation considerations, including those described in this chapter. The evolving policy landscape provides opportunities for state Medicaid programs to design, implement, and assess approaches for improving outcomes for individuals involved in the criminal justice system. MACPAC will monitor these state demonstrations, including any interim and final reports on implementation and outcomes, and future guidance. The experience of state demonstrations in providing prerelease services to facilitate care transitions for incarcerated individuals returning to the community will shed light on future policy considerations for Medicaid's role in serving this population.

## Endnotes

<sup>1</sup> Individuals on parole include people released through discretionary or mandatory supervised release from prison. In comparison, probation is a court-ordered period of correctional supervision in the community, typically viewed as an alternative to incarceration (MACPAC 2021).

Medicaid and the state corrections authority, which runs state prisons, are typically housed in different state agencies that report to the governor. Jails are generally operated at the local level by a sheriff, police chief, or other local official who may be appointed or independently elected (BJS 2023a). Six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) do not have county- or city-operated jails. In these unified corrections systems, the state operates facilities that hold people awaiting trial or serving shorter sentences (Henrichson 2019).

<sup>2</sup> Structural racism is defined as “the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, health care, and criminal justice” (Bailey et al. 2017). It is expressed as a set of institutional, multifaceted, and systemic laws and policies that result in more favorable outcomes for white communities and disadvantage communities of color (Michener 2022). Interpersonal racism, by contrast, is seen in biases and discriminatory behaviors of individuals (O’Kane et al. 2021).

<sup>3</sup> The Consolidated Appropriations Act, 2023 (CAA, P.L. 117-328), requires state CHIP and Medicaid programs, beginning January 1, 2025, to provide certain screenings and diagnostic services to eligible juvenile youth in public institutions in the 30 days before release or one week thereafter. States must also provide Medicaid-eligible youth-targeted case management services in the 30 days before release and for at least 30 days thereafter. For CHIP-eligible youth, states must provide case management services in the 30 days before release. States can receive federal financial participation (FFP) for these services. Also beginning January 1, 2025, states will have the option to receive FFP for Medicaid- and CHIP-covered services provided to eligible youth in public institutions during the initial period pending disposition of charges.

In Congress, there are bipartisan legislative efforts to provide Medicaid-covered services to adult inmates of public institutions, though these proposals have not become law. For example, the Medicaid Reentry Act (H.R. 2400, S. 1165) would require that state Medicaid programs cover services for eligible individuals up to 30 days before their release from incarceration and make FFP available for such services.

<sup>4</sup> Access to Medicaid is associated with a decreased likelihood of rearrest. For example, coverage for low-income adults under the ACA is associated with a 16 percent reduction in recidivism (Aslim et al. 2022). For those with serious mental illness released from jails, having active Medicaid coverage upon release is associated with a 16 percent reduction in the number of subsequent detentions (Morrissey et al. 2007).

<sup>5</sup> Section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) required the Secretary of the U.S. Department of Health and Human Services (the Secretary) to issue guidance on Section 1115 demonstration opportunities to improve care transitions for Medicaid-eligible individuals leaving incarceration, including through coverage of Medicaid services up to 30 days before release. Section 5032 also required the Secretary to convene stakeholders to identify best practices and to summarize those best practices in a report to Congress. That report, issued by the U.S. Department of Health and Human Services assistant secretary for planning and evaluation in December 2022, informs the CMS guidance on Section 1115 demonstration opportunities.

<sup>6</sup> As of April 21, 2023, 14 states have pending Section 1115 demonstration applications to provide Medicaid-covered



services to certain individuals who are incarcerated. These states are Arizona, Kentucky, Massachusetts, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, Washington, and West Virginia. CMS has indicated that it is engaging those states in review of their applications.

<sup>7</sup> MACPAC and AcademyHealth, in partnership with researchers at the University of Kentucky, conducted interviews with Medicaid officials in Arizona, Delaware, Kentucky, Louisiana, Michigan, Montana, New Mexico, New York, Pennsylvania, Rhode Island, Utah, Virginia, West Virginia, and Wisconsin as well as researchers at the University of Massachusetts Medical School with involvement in Massachusetts's Behavioral Health Supports for Justice-Involved Individuals demonstration. Interviews were also conducted with corrections officials in Delaware, Kentucky, Massachusetts, Michigan, New York, Rhode Island, Vermont, Virginia, and Wisconsin. Additionally, MACPAC and AcademyHealth partnered with researchers from Virginia Commonwealth University School of Medicine Department of Health Behavior and Policy and the University of Kentucky College of Medicine Institute for Biomedical Informatics to analyze Medicaid and corrections data in Virginia and Kentucky.

<sup>8</sup> MACPAC's work to date has not focused on justice-involved youth, who generally interact with different systems at the state and local level and often have different needs than adults. Similarly, this project did not examine reentry for federal prisoners, who are under the jurisdiction of the federal Bureau of Prisons. A 2023 report from the U.S. Government Accountability Office found little coordination between federal Bureau of Prisons and state Medicaid agencies to support the suspension and reactivation of Medicaid benefits for federal prisoners (GAO 2023).

<sup>9</sup> Adults are subject to the jurisdiction of an adult criminal court or correctional agency. In most states, the criminal justice system defines adults as individuals age 18 or older (BJS 2023b). This may differ from state definitions of adults for the purposes of Medicaid.

<sup>10</sup> The number of individuals supervised by the adult correctional system does not include those held in the U.S. territories, military facilities, U.S. Immigration and Customs Enforcement facilities, and jails in American Indian country. There are an estimated 102 federal prisons, 1,566 state prisons, and 2,850 local jails in the United States (Sawyer and Wagner 2022). Six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) do not have county- or

city-operated jails. In these unified corrections systems, the state operates facilities that hold people awaiting trial or serving shorter sentences (Henrichson 2019).

<sup>11</sup> In contrast, people released in 2018 spent an average of 2.7 years in prison (Kaeble 2021).

<sup>12</sup> Reduced drug tolerance after incarceration, when drugs are generally not available, contributes to higher rates of overdose death after release (Ranapurwala et al. 2018).

<sup>13</sup> Chronic physical health conditions include cancer, high blood pressure, stroke, diabetes, arthritis, asthma, cirrhosis of the liver, and heart- or kidney-related problems. Infectious diseases include tuberculosis, hepatitis B, hepatitis C, HIV and AIDS, and sexually transmitted diseases (Maruschak et al. 2021a).

<sup>14</sup> Researchers attribute documented high rates of COVID-19 in carceral settings to a number of factors, including overcrowding, poor ventilation, and limited resources for infection control and prevention (National Academies 2020).

<sup>15</sup> In the 32 states in which at least one form of MOUD is offered in state prisons, MOUD may not be available in every prison throughout the state. For example, in North Carolina, only 2 of the state's 57 prison facilities offer at least one form of MOUD (i.e., buprenorphine, methadone, and naltrexone) (Jail & Prison Project 2022).

<sup>16</sup> Any disability includes hearing, vision, cognitive, ambulatory, self-care (e.g., difficulty dressing or bathing), and independent living (e.g., difficulty doing activities on your own, including going outside, going to classes, going to meals) (BJS 2021). Justice-involved adults with disabilities, as well as those older than age 65 (representing 1 percent of the jail population and 4 percent of the prison population), may be dually eligible for Medicaid and Medicare (BJS 2022, Zeng 2022). However, national estimates of the share of inmates or formerly incarcerated individuals who are dually eligible are not available.

<sup>17</sup> For example, states can restrict benefits such as Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families based on an individual's criminal history (Wang et. al 2013).

<sup>18</sup> Section 1001 of the SUPPORT Act prohibits states from terminating Medicaid eligibility for eligible juveniles who become inmates of public institutions on the basis of their incarceration (CMS 2021a).

<sup>19</sup> States that reported suspending eligibility for individuals in state prisons and local jails were not asked to specify whether those processes were in place in every facility across the state (Gifford et al. 2019).

<sup>20</sup> For most states, SFY 2019 ran from July 1, 2018, through June 30, 2019. Exceptions include Alabama, the District of Columbia, and Michigan (October 1 through September 30); New York (April 1 through March 31); and Texas (September 1 through August 31) (KFF 2019).

<sup>21</sup> Medicaid programs often require multiple forms of identification for enrollment. Many incarcerated individuals may not have such identification, which may have been confiscated or absent at booking (MACPAC 2018). Presumptive eligibility allows individuals to quickly gain temporary Medicaid coverage before application completion, verification, and processing (Brooks 2014). The period of presumptive eligibility is the earlier between the day on which a decision is made on a Medicaid application and the last day of the month after the month in which presumptive eligibility was filed (42 CFR 435.1101, 42 CFR 435.1103(b)).

<sup>22</sup> Section 1945 of the Social Security Act allows states to establish health homes as a vehicle for coordinating primary, acute care, behavioral health, and long-term services and supports for individuals with certain chronic conditions, including those with SUD. Health home services must also include comprehensive transitional care from inpatient to other settings as well as referrals to social services and supports. States receive enhanced federal matching funds for health home services for an initial period.

<sup>23</sup> CMS will continue to require, as a condition of Section 1115 demonstration approval, that demonstrations be budget neutral. This means that the federal costs of the state's Medicaid program with the demonstration do not exceed what the federal government's costs would have been without the demonstration (CMS 2023a).

<sup>24</sup> States may not include federal prisons as a setting in which demonstration-covered prerelease services would be provided under their proposed Section 1115 demonstrations, given the role of the federal Bureau of Prisons in providing and paying for all health care for federal prisoners during incarceration (CMS 2023a).

<sup>25</sup> Case management services must assess and address physical, behavioral, and health-related social needs during and after incarceration. MAT includes medication in combination with counseling and behavioral therapies and should be available for all types of SUD as clinically

appropriate, not just OUD. States may cover these and other required benefits under the demonstration or propose how they otherwise plan to ensure access to these services before release (e.g., through a state-only program or the carceral system directly).

<sup>26</sup> Section 5032 of the SUPPORT Act required CMS to issue guidance on Section 1115 opportunities to improve care transitions for soon-to-be-released individuals, including through prerelease coverage provided for a period not exceeding 30 days before release. Given the Secretary's general authority to approve Section 1115 demonstration projects and associated expenditure authorities, which is unaffected by the SUPPORT Act provision, CMS will consider state requests to provide prerelease coverage up to 90 days before an individual's expected release date. However, such requests must have a purpose and related experimental hypotheses that go beyond improving care transitions for soon-to-be-released individuals (CMS 2023a).

<sup>27</sup> CMS identifies several required components of state implementation plans, including anticipated challenges and mitigation strategies associated with each demonstration milestone. Implementation plans must also describe how improved health care quality for enrollees receiving demonstration services will reduce disparities and improve health equity (CMS 2023a).

<sup>28</sup> CMS states that the demonstration opportunity does not absolve carceral authorities of their constitutional obligation to provide health care to inmates in their custody, nor is it meant to transfer the financial burden of that obligation from a federal, state, or local carceral authority to the Medicaid program (CMS 2023a).

<sup>29</sup> Section 1115 of the Social Security Act and its accompanying regulations require states to monitor and evaluate demonstrations (42 CFR 431.428, 42 CFR 431.424). Monitoring provides ongoing updates on implementation and collects data on process and outcome measures, which may help states and CMS identify whether mid-course corrections are needed. Evaluations are completed later in the demonstration period or after the demonstration is complete; they are intended to assess whether the demonstration has achieved its goals and to inform decisions about the future of the policy being tested. States are required to submit a series of evaluation deliverables for each Section 1115 demonstration, including an evaluation design, an interim report, and a summative report (MACPAC 2020).



<sup>30</sup> CMS will provide guidance to each participating state for developing a monitoring protocol for quarterly and annual monitoring reports. The midpoint assessment must be completed by an entity independent of the state between years two and three of demonstration implementation (CMS 2023a).

<sup>31</sup> CMS will provide individual state technical assistance to support required monitoring and evaluation activities (CMS 2023a).

<sup>32</sup> The clinical criteria include but are not limited to a confirmed or suspected mental health condition, SUD, chronic or considerable non-chronic clinical condition, intellectual or developmental disability, traumatic brain injury, HIV or AIDS, or pregnancy or within 12 months postpartum.

<sup>33</sup> California's in-reach case management activities involve community-based providers evaluating the medical, behavioral, and social needs of individuals before release and developing a plan for addressing those needs. Other covered services include physical and behavioral health clinical consultation services, lab and radiology services, medications and medication administration, medication-assisted treatment and accompanying counseling, and services of community health workers and peer navigators with lived experience. Medicaid-eligible individuals who meet these criteria can also obtain up to a 30-day supply, as clinically appropriate, of prescribed and over-the-counter drugs and durable medical equipment (CMS 2023b).

<sup>34</sup> The California Department of Health Care Services (DHCS) will consider a number of factors when determining whether a facility is ready to participate in the reentry demonstration. This includes whether the facility can provide prerelease enrollment assistance and screenings to determine eligibility for prerelease services as well as the full set of covered prerelease services. DHCS will also consider the facility's ability to coordinate with health system partners and report data to support program monitoring, evaluation, and oversight (CMS 2023b).

<sup>35</sup> The Providing Access and Transforming Health program is a five-year initiative to increase participation of community providers in Medi-Cal. Funding is available to community organizations, such as public hospitals and community-based organizations, for necessary improvements to capacity and infrastructure (DHCS 2023).

<sup>36</sup> CMS encourages states that submitted demonstration applications before the release of the agency's guidance in April 2023 to review those proposals and engage with CMS about any changes they may wish to make (CMS 2023a).

<sup>37</sup> Montana proposes to provide prerelease services in state prisons only.

<sup>38</sup> In Massachusetts, Oregon, Rhode Island, and Vermont, Medicaid covers comprehensive adult dental services. Utah generally provides only emergency dental benefits to non-pregnant adults enrolled in Medicaid. Under its proposed Section 1115 demonstration, Utah would cover limited dental services only for certain incarcerated adults (NASHP 2022, Utah Department of Health 2020).

<sup>39</sup> Kentucky is proposing to provide MCO care coordination services 30 days before release and SUD treatment and recovery services up to three years before release (Kentucky 2020).

<sup>40</sup> States may request federal approval for a 90/10 enhanced federal match for the design, development, and implementation of Medicaid Enterprise Systems initiatives that contribute to the economic and efficient operation of the program, including technology that supports data sharing between state Medicaid agencies, state correctional agencies, and participating correctional facilities. States may also request a 75/25 enhanced federal match for ongoing operations of CMS-approved systems (CMS 2023a).

<sup>41</sup> These data are based on survey responses from state Medicaid officials. The survey did not ask respondents to specify which correctional authorities (e.g., state departments of corrections, local sheriffs) state Medicaid agencies have established automated electronic data-sharing relationships for the purposes of suspending and reinstating Medicaid benefits (KFF 2019).

<sup>42</sup> States use the Medicaid screening and enrollment process as the primary regulatory mechanism for ensuring that providers meet Medicaid standards. This process must be conducted before a provider can receive Medicaid payments; it gives states an opportunity to identify unqualified providers before they provide services to beneficiaries, which both protects patients and prevents improper payments. At regular intervals, providers must demonstrate that they continue to meet state requirements through a process known as "reenrollment" or "revalidation" (MACPAC 2019b).

<sup>43</sup> Medicaid programs can pay for housing-related services that promote health and community integration, such as assistance in finding and securing housing, and home modifications when individuals transition from an institution to the community. However, Medicaid cannot pay for rent or for room and board, except in certain medical institutions (CMS 2021b).

<sup>44</sup> Community-based organizations are public or private not-for-profit entities that address the health and social needs of their communities or a targeted population within the community (ASPR 2023).

<sup>45</sup> Criminogenic risk factors are aspects of a person's life that are associated with criminal behavior, such as a history of antisocial behavior, antisocial personality traits, family and/or marital strain, problems at school and/or work, and substance use (Van Deirse et al. 2021).

<sup>46</sup> In California, CMS is requiring that all providers and provider staff, including corrections providers, have necessary experience and receive appropriate training before furnishing services under the reentry demonstration (CMS 2023b).

<sup>47</sup> Concerns about shortages of mental health providers, for example, have been well documented over the past decade (Hogue et al. 2013; SAMHSA 2013, 2007). General shortages and geographic maldistribution of behavioral health providers, coupled with the unwillingness of some providers to service individuals enrolled in Medicaid, are key factors that limit access to mental health treatment.

<sup>48</sup> Midpoint assessments are typically required of states implementing systematic changes to delivery of services under Section 1115 demonstration authority (e.g., demonstrations to improve the continuum of care for beneficiaries with SUD, serious mental illness, or serious emotional disturbance).

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## APPENDIX 3A: Medicaid Enrollment After Incarceration in Kentucky and Virginia

**TABLE 3A-1.** Cumulative Percentage of Individuals Released with Active Medicaid Benefits by Days After Incarceration, Kentucky and Virginia, 2019–2021

State	Individual characteristics	1 day	30 days	180 days
Kentucky	<b>Medicaid status</b>			
	All individuals	73%	78%	89%
	No prior Medicaid	23	41	77
	Prior Medicaid	77	81	90
	Prior OUD	79	84	93
	Prior mental health condition	78	83	92
	<b>Race and ethnicity</b>			
	White, non-Hispanic	74	80	90
	Black, non-Hispanic	71	76	88
	Hispanic	73	77	90
	Other	70	76	86
Virginia	<b>Medicaid status</b>			
	All individuals	67	75	82
	No prior Medicaid	62	66	72
	Prior Medicaid	68	76	85
	Prior OUD	77	82	90
	Prior mental health condition	70	78	85
	<b>Race and ethnicity</b>			
	White, non-Hispanic	68	76	83
	Black, non-Hispanic	67	73	82
	Hispanic	60	64	70
	Other	77	78	84

**Notes:** OUD is opioid use disorder. The table includes individuals released from state prisons and local jails between January 1, 2019, and December 31, 2020, in Kentucky and individuals released from state prisons between July 1, 2019, and June 30, 2021, in Virginia. This analysis excludes dually eligible individuals and others with partial benefits as well as those who never had benefits suspended. Prior and no prior Medicaid reflects whether an individual had Medicaid benefits at any point in the five years preceding incarceration. Individuals were identified as having a prior OUD or mental health condition based on prior Medicaid claims. Virginia expanded Medicaid under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) on January 1, 2019, whereas Kentucky implemented the expansion five years earlier on January 1, 2015.

**Source:** AcademyHealth 2022, analysis of Kentucky and Virginia Medicaid and corrections data.



Chapter 4:

# Access to Home- and Community- Based Services

# Access to Home- and Community-Based Services

## Key Points

- Medicaid home- and community-based services (HCBS) are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or a homelike setting in the community. HCBS encompass a wide range of services, such as personal care services provided in a community setting, supported employment, non-medical transportation, and home-delivered meals.
- HCBS are optional services for states, but all states cover some HCBS benefits. Variation exists in how benefits are delivered, the types of services covered, the populations served, and the criteria used to determine eligibility. Over the past decade, more than half of all spending on LTSS has been on HCBS compared to institutional care.
- Despite the array of HCBS programs, individuals needing community-based options can face barriers accessing these services. Some of the key challenges include limited provider availability, state budgetary constraints, waiver waiting lists, and gaps in beneficiary knowledge about the services that are available.
- States are frequently managing multiple HCBS programs and benefit packages, each with its own set of eligibility criteria, which creates administrative burdens for states. Additional challenges for states include budgetary constraints, limited staff capacity to manage HCBS programs, and limited state systems capacity, all of which reduce a state's ability to expand access to HCBS.
- Differences in access to HCBS for LTSS subpopulations may exist across a range of factors, including by race and ethnicity, by geographic location, and by age. However, the extent to which these differences occur is challenging to identify given that more data are necessary, particularly related to race and ethnicity.
- Over the next year, the Commission will work to identify policies that drive toward a more streamlined HCBS delivery system with increased access for beneficiaries and reduced administrative burden for states.

## CHAPTER 4: Access to Home- and Community-Based Services

Medicaid home- and community-based services (HCBS) are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or a homelike setting in the community. HCBS encompass a wide range of services, such as personal care services provided in a community setting, supported employment, non-medical transportation, and home-delivered meals. HCBS are optional for states, but all states cover some HCBS benefits.

States can cover HCBS in their state plans, which generally require such benefits to be made available to all Medicaid enrollees, or through various waiver authorities that can be targeted to certain populations.<sup>1</sup> Section 1915(c) waivers and Section 1115 demonstrations are some of the most common mechanisms through which states cover HCBS. In 2020, more than 3 million Medicaid beneficiaries received HCBS under these two authorities. In comparison, more than 2.5 million people received state plan benefits, including about 734,500 individuals who received mandatory home health services, which states are required to offer (O'Malley Watts et al. 2022a).

Despite the array of HCBS programs, individuals needing community-based options can face barriers accessing these services. Some of these barriers include limited provider availability, state budgetary constraints, waiver waiting lists, and gaps in beneficiary knowledge about the services that are available (MACPAC 2020a). Studies have also shown that the availability of HCBS fluctuates across populations, and the complexity associated with the range of HCBS authorities, such as varied eligibility requirements and differing benefit packages, can create barriers for beneficiaries to access these services and administrative burdens for states (Hayes et al. 2021, Sowers et al. 2016).

Over the past few years, MACPAC has examined ways to increase access to HCBS for beneficiaries. This work has included identifying potential opportunities for additional rebalancing of LTSS away from institutional settings, such as providing

additional federal support for state rebalancing efforts and improving communication around care transitions. We have also explored HCBS waiver capacity and state management of waiting lists and summarized state efforts to address the primary drivers of Medicaid HCBS workforce shortages (MACPAC 2022a; Bernacett et al. 2021; MACPAC 2020a, 2020b). In addition, MACPAC contracted with the Center for Health Care Strategies (CHCS) to conduct an expert roundtable in December 2021 to consider the delivery of HCBS and the idea of establishing a core HCBS benefit.

Over the past year, MACPAC has conducted additional work on access to HCBS, including an environmental scan, stakeholder interviews, and two panels. In an effort to understand what HCBS are currently being offered by states, including for what populations and under what authorities, MACPAC conducted an environmental scan between May and July 2022. To further improve our understanding of the challenges that beneficiaries and states face in accessing and administering HCBS, we contracted with CHCS to conduct interviews with stakeholders. CHCS, with the support of its subcontractor RTI International, conducted 18 interviews between September and November 2022 with federal and state officials, beneficiary advocates representing a range of HCBS populations, and national experts.<sup>2</sup> In the fall of 2022, the Commission continued discussions on access by hosting a panel of experts to discuss streamlining delivery of HCBS. The Commission also hosted a panel in January 2023 on states' early experiences with implementation of the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2).

This chapter synthesizes the findings from MACPAC's work and outlines an HCBS access framework that will guide the Commission's continued work in this area. The chapter begins with an overview of Medicaid coverage of HCBS, including eligibility, benefits, and spending. As part of this overview, we explain the range of federal HCBS authorities and describe the results of our environmental scan, which summarizes the number of states offering HCBS by certain taxonomy categories and type of population. Next, we introduce findings from our research, which are consistent with recent studies indicating that beneficiaries can face barriers to access HCBS and states can face administrative complexity when managing their HCBS programs. We map the findings

to four components of MACPAC’s access framework for HCBS: (1) provider availability and accessibility, (2) use of services, (3) beneficiary perceptions and experiences of care, and (4) administrative complexity. The chapter concludes with next steps that will further the Commission’s work to address access to HCBS and challenges experienced by states.

## Medicaid Coverage of HCBS

Beneficiary preferences to remain in the community, along with growing demand for HCBS in recent decades, is both a response to the Americans with Disabilities Act of 1990 (P.L. 101-336) and the 1999 *Olmstead v. L.C.* decision that states must facilitate community integration for beneficiaries with disabilities (Chidambaram and Burns 2022, MACPAC 2019).<sup>3</sup> Medicaid is the primary payer for LTSS, which includes both institutional care and HCBS. States have been required to cover institutional LTSS, such as nursing facility care, since the program’s enactment. In 1981, Medicaid coverage of HCBS was first authorized under Section 1915(c) of the Social Security Act (the Act) as an alternative to institutional LTSS. Since then, Congress has enacted various state plan authorities

that states can use to cover HCBS. Medicaid beneficiaries who use LTSS are a diverse group, ranging in age from children to older adults, with varied cognitive and physical disabilities. People who use LTSS often receive services and supports for years or even decades. HCBS can be administered through fee-for-service (FFS) or managed LTSS (MLTSS) programs. These services and supports allow people to live in their homes or a homelike setting and remain integrated with the community.

### Eligibility

To be determined eligible for Medicaid, individuals generally must fit into a specific eligibility category, meet certain income thresholds, and meet asset tests under certain circumstances. To qualify for LTSS, they must meet additional functional criteria that are based on an individual’s physical or cognitive status.

Multiple Medicaid eligibility pathways exist for LTSS. States are required to cover beneficiaries who receive Supplemental Security Income (SSI) through the mandatory SSI-related pathway. All states choose to cover individuals through one or more optional pathways (Table 4-1).

**TABLE 4-1.** Overview of Selected Medicaid Eligibility Pathways and Criteria for Medicaid LTSS Coverage, 2022

Eligibility pathway	Definition	Number of states using pathway	Income thresholds	Asset limits
SSI-related	SSI is a federal income support program for people who have limited income and resources and are also age 65 or older, blind, or have disabilities. This is a mandatory pathway. In most states, individuals receiving SSI are automatically eligible for Medicaid.	50 states and DC; 8 states have elected the Section 209(b) option <sup>1</sup>	74% FPL (\$841 per month for an individual and \$1,261 for a couple in 2022)	\$2,000 for an individual and \$3,000 for a couple
Poverty-related	Optional pathway that allows a state to cover LTSS for individuals with incomes up to 100 percent FPL who have disabilities or are age 65 and older.	24 states and DC	Up to 100% FPL (\$13,590 a year for an individual in 2022)	Typically same as SSI limits, but some states have higher limits



**TABLE 4-1.** (continued)

Eligibility pathway	Definition	Number of states using pathway	Income thresholds	Asset limits
Medically needy	Optional pathway that allows states to cover certain individuals who have high medical expenses relative to their income. These individuals would be categorically eligible but have income that exceeds the maximum limit for that pathway. Individuals become eligible for Medicaid once they have spent down their excess income on their medical expenses.	32 states and DC	At state discretion; median in 2022 was 43% FPL for an individual	Typically same as SSI limits, but some states have higher limits
Katie Beckett pathway for children with disabilities	Optional pathway that provides Medicaid services for at least some children with severe disabilities whose family income would otherwise be too high to qualify. Only the child's own income and assets are counted.	43 states and DC	300% of SSI benefit rate (\$2,523 per month for an individual in 2022)	\$2,000
Medicaid buy-in	Optional pathway that covers individuals with disabilities who work and have incomes too high to qualify for Medicaid via other pathways. Many states charge premiums for this group.	47 states and DC	At state discretion; median in 2022 was 250% FPL for an individual	Seven states do not have an asset limit for this group
Special income level	Optional pathway for individuals who have income up to 300 percent of the SSI benefit rate and who meet level of care criteria for nursing facility or other institutional care.	42 states and DC	Up to 300% of SSI benefit rate	Typically same as SSI limits
Section 1915(i) state plan HCBS	Section 1915(i) of the Social Security Act allows states to offer HCBS under the state plan to people who need less than an institutional level of care.	5 states	150% FPL for individuals who meet functional eligibility criteria, or 300% of SSI benefit rate for individuals receiving Section 1915(c) waiver services	None

**Notes:** LTSS is long-term services and supports. SSI is Supplemental Security Income. DC is District of Columbia. FPL is federal poverty level. HCBS is home- and community-based services. For married individuals, spousal impoverishment provisions are applied first (§ 1924 of the Social Security Act).

<sup>1</sup> Section 209(b) states may use eligibility criteria (related to income and assets, disability, or both) that are more restrictive than SSI program criteria, but they may not use more restrictive criteria than those in effect in the state on January 1, 1972.

**Sources:** SSA 2023, MACPAC 2022b, Musumeci et al. 2022, Colello and Morton 2019.

Once individuals are determined eligible for Medicaid, they are entitled to the full range of covered services in the state. HCBS are optional services, and all states choose to cover HCBS. Some states cover HCBS through an amendment to their state plan (e.g., 37 states covered personal care services under the state plan in 2020), but most states cover HCBS via Section 1915(c) waivers (47 states) and Section 1115 demonstrations (12 states) (O'Malley Watts et al. 2022b). Waiver authorities and demonstrations give states flexibility to limit the number of beneficiaries

receiving HCBS, target services to particular populations, or provide services in certain parts of the state (Table 4-2). Section 1915(c) waivers also allow states to cover additional types of HCBS that are not available under the state plan as long as the spending under the waiver is cost effective compared to what the state would have spent if the beneficiary received institutional LTSS.<sup>4</sup> In contrast, HCBS that are covered under the state plan must be offered to all eligible beneficiaries; however, they are typically more limited in scope than those provided under waivers.

**TABLE 4-2. Statutory Authorities for Medicaid Home- and Community-Based Services**

Type of authority	Authority	Description
Waiver	Section 1915(c)	Allows states to cover a wide range of HCBS as a cost-effective alternative to institutional care. Also allows states to forgo certain Medicaid requirements to target HCBS benefits to specific populations, cap the number of beneficiaries who receive these benefits, or create waiting lists for people who cannot be served under the cap.
	Section 1115	Not specific to HCBS, Section 1115 demonstration authority is a broad authority that allows states to test new delivery models that advance the goals of the Medicaid program.
State plan	Section 1905(a)(7)	States are required to cover home health care services, which include nursing; home health aides; and medical supplies, equipment, and appliances. States also have the option of covering additional therapeutic services, including physical therapy, occupational therapy, and speech pathology and audiology services.
	Section 1905(a)(24)	Allows states to cover personal care services but does not give beneficiaries using self-direction the authority to manage their own individual service budget. <sup>1</sup>
	Section 1915(i)	Allows states to offer HCBS to people who need less than an institutional level of care, the typical standard for Medicaid coverage of HCBS. States can also establish specific criteria for people to receive services under this authority.
	Section 1915(j)	Gives authority for self-directed personal assistance services (PAS), providing beneficiaries with the ability to hire and direct their own PAS attendant. States may also give beneficiaries the authority to manage their own individual service budget.
	Section 1915(k)	The Community First Choice option, established in the ACA, provides states with a 6 percentage point increase in the FMAP for HCBS attendant services.

**Notes:** HCBS is home- and community-based services. ACA is the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). FMAP is federal medical assistance percentage.

<sup>1</sup> Under self-direction, beneficiaries, or their representatives if applicable, have decision-making authority and responsibility for managing all aspects of their service delivery in a person-centered planning process, with the assistance of a system of available supports. States may allow self-direction under Section 1915(c) waivers, Section 1115 demonstrations, and Sections 1915(i), 1915(j), and 1915(k) state plan options (CMS n.d.).

**Sources:** Sections 1115, 1905(a)(7), 1905(a)(24), 1915(c), 1915(i), 1915(j), and 1915(k) of the Social Security Act; 42 CFR 440.70(b).

To receive HCBS, beneficiaries must meet certain functional eligibility criteria. Eligibility determinations for LTSS generally focus on measures of functional status—referred to as “level of care” (LOC) criteria—rather than the existence of specific clinical conditions. To make these determinations, states use functional assessment tools, which are sets of questions that collect information on an applicant’s health conditions and functional needs. Such tools may also be used to develop a care plan of specific services that an individual will receive upon being determined eligible. The tools that states use to measure the need for these services and supports can vary by service, program, and HCBS subpopulation (MACPAC 2016).

## Benefits

Given the design flexibilities available to states, Medicaid benefits differ across states. This variation applies to HCBS, including how benefits are delivered, the types of services covered, the populations served, and the criteria used to determine eligibility. States often use different terminology to refer to the same or similar services. To organize unique state approaches, researchers developed the HCBS taxonomy, a uniform classification system composed of 18 service categories, including more than 60 specific services (Table 4A-1). States began using the HCBS taxonomy to report HCBS waiver claims in the Medicaid Statistical Information System (MSIS) in 2010, but the extent to which all states do so varies (Peebles et al. 2017). In a recent analysis of 2019 Transformed MSIS (T-MSIS) analytic files examining LTSS users, several data quality issues were documented across a number of states, such as challenges identifying Medicaid beneficiaries and the high number of claims reported to the T-MSIS analytic files (Kim et al. 2022).

MACPAC conducted an environmental scan in 2022 to identify the authorities that states use to cover HCBS. We included all 50 states and the District of Columbia in our scan. We reviewed Section 1915(c) waivers (47 states) and Section 1115 demonstration authority documents (13 states) and Section 1915(i) (14 states) and Section 1915(k) state plan authorities (9 states).<sup>5</sup> Every state plus the District of Columbia uses one or more of these authorities to cover HCBS.<sup>6</sup> We then mapped the services offered under each authority to the appropriate HCBS taxonomy category and population, where possible.

For Section 1915(c) waivers, the Centers for Medicare & Medicaid Services (CMS) provides a list of 12 populations from which states can choose their target HCBS populations (CMS 2022a).<sup>7</sup> The term “aged” is used in the Section 1915(c) waiver application, and to remain consistent, we used the same term for our environmental scan. The HCBS waiver technical guidance document notes that although generally, “aged” refers to individuals age 65 and older (aligning with § 1905(a)(iii) of the Act), states can identify a minimum age that is lower than 65 to align with state systems. In our review, we found that many waivers often serve more than one of these populations, so we consolidated them into seven population groupings. This mirrors other studies that used similar groupings and allows for easier comparisons across similar populations (O’Malley Watts et al. 2022b, Ross et al. 2021). The seven population groupings we used are:

- aged;
- individuals with intellectual disabilities or developmental disabilities (ID/DD), including autism;
- individuals with physical or other disabilities;
- individuals with brain injury;
- individuals with mental illness or serious emotional disturbance;
- individuals with HIV/AIDS; and
- individuals who are medically fragile or technology dependent.

These seven population groupings are not mutually exclusive; some beneficiaries may belong to two or more populations, such as being aged and having an intellectual disability. Furthermore, some states have developed separate programs targeting specific populations, while other states more recently have consolidated their waivers to target multiple populations under one authority.

Unlike Section 1915(c) waivers and Section 1915(i) state plan authority, for which all states identified their selected target groups to receive services, there is no defined list of target groups to indicate which populations are served under Section 1115 demonstrations and Section 1915(k) state plan

authority. This lack of consistency made summarizing which populations are covered across states challenging. For Section 1115 demonstration authority, if populations covered were not clearly identified in the waiver, we relied on an existing study to confirm or identify the populations (O'Malley Watts et al. 2022b). For Section 1915(k) state plan authority, services covered must be available statewide for eligible beneficiaries and may not be limited to a target group.

In our review of waivers and state plan authorities authorized under sections 1915(c), 1115, and 1915(i), we found certain commonalities among the populations states select to receive HCBS and the services states choose to cover (Table 4A-2). (HCBS covered under Section 1915(k) state plan authority are included in a separate table given that services are not directed to one particular HCBS population.) All states and the District of Columbia cover HCBS for individuals with ID/DD or autism as well as for the aged population. Forty-nine states cover HCBS for individuals with physical or other disabilities. About half of states cover HCBS for individuals with brain injuries or mental illness or those who are medically fragile or technology dependent. Ten states cover HCBS targeted specifically to individuals with HIV/AIDS.

Among the services in the HCBS taxonomy, caregiver support and home-based services are the most common and are covered for all seven populations based on our review of Sections 1115, 1915(c), and 1915(i). Equipment, technology, and modifications services are covered for six populations, and day services are covered for five populations. Rent and food expenses for live-in caregivers is the least common service and is covered for two populations. Across HCBS subpopulations, we found that certain services, such as supported employment, are covered for individuals with ID/DD or people with autism more often than for the aged population. We also identified the top five most common services covered for each target population (Table 4A-3).

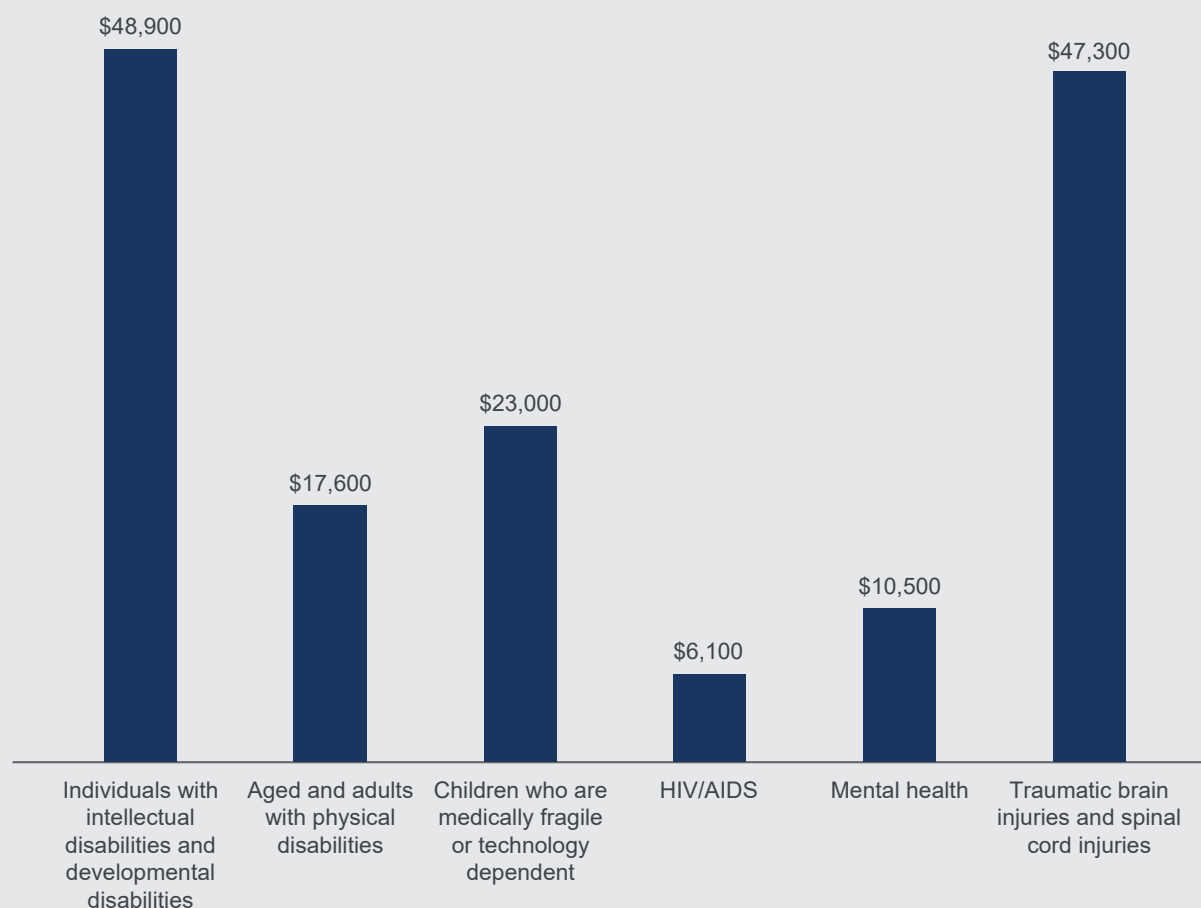
Based on our review of Section 1915(k) authority, 11 different taxonomy services are covered among the 9 states. Home-based services; participant training; and equipment, technology, and modifications are the most common services (Table 4A-4).

## Spending

Nationally, since fiscal year (FY) 2013, spending on HCBS as a proportion of total LTSS expenditures has exceeded spending on institutional care. However, in some states and for some HCBS populations, spending on institutional care exceeds spending on HCBS. In FY 2019, nationally, HCBS expenditures as a share of total Medicaid LTSS reached 58.6 percent. In 29 states and the District of Columbia, HCBS made up 50 percent or more of total LTSS spending; among all states, rebalancing ratios ranged from 83 percent to 33 percent (Murray et al. 2021a).<sup>8</sup>

The most recently available data on Medicaid spending for HCBS are limited to services delivered through FFS and do not capture Medicaid spending on HCBS delivered through managed care. In FY 2021, total federal and state spending on Medicaid HCBS delivered through FFS was \$88 billion (or about 62 percent of all LTSS FFS spending), compared to about \$54.5 billion on institutional LTSS (38 percent of total LTSS FFS spending). Total federal and state spending on all Medicaid benefits was \$717 billion, of which LTSS spending was 19.5 percent (12 percent of spending was on HCBS and 7.5 percent was on institutional services) (MACPAC 2022c). These figures do not account for spending in MLTSS, and as a result, total spending on HCBS is likely much higher. In FY 2019, the most recent year for which there are data on MLTSS expenditures, 65 percent (\$30.9 billion) of total MLTSS expenditures were for HCBS (Murray et al. 2021a).<sup>9</sup>

There are limited data on spending by population; however, the data that we do have indicate that per-person spending on HCBS is highest for individuals with ID/DD. For example, one study of FY 2018 data that analyzed HCBS spending compared to institutional spending by population type found that for people with ID/DD, including autism spectrum disorder, about 79 percent of LTSS spending was for HCBS. In contrast, about one-third of LTSS expenditures for older adults and people with physical and other disabilities was for HCBS. For individuals with behavioral health conditions, it was just over 49 percent (Murray et al. 2021b).

**FIGURE 4-1.** Section 1915(c) Waiver Per-Person Spending by Target Population, FY 2020

**Note:** FY is fiscal year.

**Source:** O'Malley Watts et al. 2022a.

More recent data from FY 2020 that reflect per-person spending by target population among Section 1915(c) waivers show the highest spending is for the ID/DD population (\$48,900 per person on average) (Figure 4-1). Spending on the ID/DD population, however, accounted for a disproportionate share of total Section 1915(c) spending (67 percent) compared to the share of people with ID/DD who received these services in FY 2020 (43 percent). In comparison, older adults and individuals with physical disabilities comprised 54 percent of total Section 1915(c) waiver users but

accounted for 31 percent of total expenditures. The other populations combined accounted for about 3 percent of people served and about 3 percent of spending, although per-person spending among these groups varied widely: from \$6,100 for individuals with HIV/AIDS to \$47,300 on average for people with traumatic brain injuries and spinal cord injuries (O'Malley Watts et al. 2022a).



## Access to HCBS

In its June 2022 *Report to Congress on Medicaid and CHIP*, the Commission discussed a new Medicaid access monitoring framework with three key domains of access: (1) provider availability and accessibility, (2) use of services, and (3) beneficiary perceptions and experiences of care (MACPAC 2022d). For purposes of analyzing access to HCBS for Medicaid beneficiaries, we mapped our findings to these three domains and added an additional category, administrative complexity, to capture the challenges that states face in operating their HCBS programs (Figure 4-2).

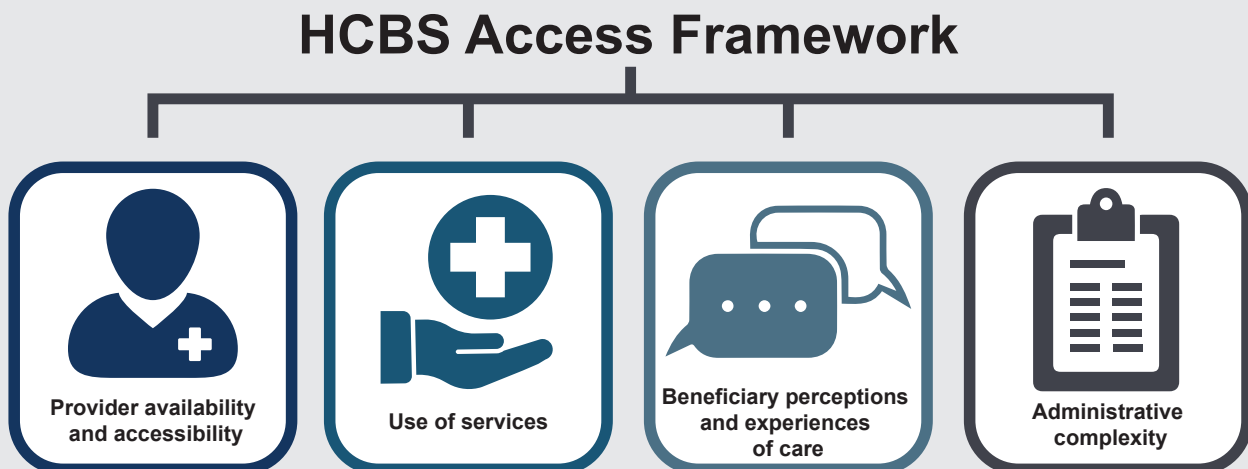
### Provider availability and accessibility

Provider availability and accessibility measures capture potential access to providers and services, regardless of whether the services are used. Provider availability is a function of the presence of providers in the state or region (i.e., supply) as well as their participation in Medicaid and CHIP (MACPAC 2022d,

2011; Kenney et al. 2016). This domain also includes other measures of availability, such as timeliness of appointments, travel time, and accessibility for individuals with language barriers and disabilities.

**HCBS provider capacity.** HCBS providers include several types of workers—direct care workers (DCWs), direct support professionals, and independent providers—who assist beneficiaries with activities of daily living, such as mobility, personal hygiene, and eating.<sup>10</sup> In addition to these essential basic functions, HCBS workers also assist beneficiaries in community integration by providing support with instrumental activities of daily living such as grocery shopping and managing finances. The tasks they perform may be specialized, depending on the needs of the population (e.g., children, people with ID/DD, adults with physical disabilities, and people with dementia). HCBS workers are typically employed either by an agency that serves as a provider enrolled with the state Medicaid agency or as an independent provider working via self-directed waiver services.<sup>11</sup>

**FIGURE 4-2.** HCBS Access Framework



**Notes:** HCBS is home- and community-based services.

**Source:** MACPAC 2022d.



HCBS workers tend to earn low incomes, and many are Medicaid beneficiaries themselves. In 2021, the median home health and personal care aide hourly wage was \$14.15 (BLS 2022). In 2020, 43 percent of DCWs lived in households with incomes under 200 percent of the federal poverty level (FPL), and more than half (53 percent) used public assistance programs, including 30 percent who were enrolled in Medicaid. The majority of DCWs are women (85 percent) and people of color (64 percent identified as being a race other than white in 2020) (PHI 2022). Additionally, wage disparities exist within the workforce; women earn less than men on average, and people of color earn less than white people (Campbell et al. 2021).

Roughly 2.6 million workers provided services to Medicaid beneficiaries in their homes and other community settings in 2021 (PHI 2022). Workforce shortages, however, limit the ability of Medicaid programs to serve more people in the community. The COVID-19 pandemic has exacerbated the workforce shortage and highlighted its drivers, including low wages, limited opportunities for career advancement, and high turnover (MACPAC 2022a).

Nearly all interviewees cited limited provider capacity and shortages of DCWs as key barriers to increasing access to HCBS. Persons with ID/DD and behavioral health needs may experience particular challenges due to the limited availability of HCBS workers because of the additional training required to serve these populations. One federal official shared that providers do not have workers available or financial capacity to meet population needs in states. A lack of HCBS funding coupled with limited provider capacity creates challenges for states to have a person-centered approach to HCBS delivery.

**HCBS provider payment.** Workforce shortages are an ongoing barrier to expanding services (Bernacot et al. 2021, MACPAC 2020a). Interviewees underscored how low wages for DCWs and high turnover rates lead to challenges delivering care and providing person-centered services. A state official shared that multiple wage increases were not sufficient to make wages competitive with other employment opportunities. Interviewees reported that additional funding could help states improve payment rates for HCBS providers, which would in turn improve the delivery of services.

Section 9817 of ARPA provided a temporary increase in the federal medical assistance percentage (FMAP) for state Medicaid programs to support the HCBS infrastructure.<sup>12</sup> States are using ARPA funds on activities that enhance, expand, or strengthen HCBS, such as initiatives to increase provider payment rates and expand provider capacity. Nearly all states have one or more ARPA-funded initiatives related to provider payment, such as rate increases (32 states), requirements for funds to be passed on to DCWs (20 states), and conducting studies on new rate structures (23 states) (ADvancing States 2023). For example, Maine used ARPA funds to provide two bonuses of \$1,000 to existing DCWs and their immediate supervisors in 2021 and one-time bonuses of \$1,500 for newly hired DCWs. Starting in 2022, Maine's state budget also provided permanent funding to sustain HCBS worker wages at 125 percent of the state's minimum wage (Manz 2022). Iowa gave one-time recruitment and retention bonuses to direct support professionals, including supervisors (IA DHS 2021). Iowa also used its ARPA funds to contract with a statewide crisis provider to assist DCWs serving individuals with co-occurring ID/DD and behavioral health conditions. The crisis provider operates a 24/7 helpline for workers to call if they need assistance deescalating a situation or advice on administering care. The state also offers mobile response specifically for this population (Matney 2023).

Some states are addressing gaps in the HCBS workforce by supporting natural caregivers, such as family members. For example, Washington established the Medicaid Alternative Care program and the Tailored Supports for Older Adults program, which support unpaid family caregivers. These programs are intended to address the health and wellness of the caregiver. Research has indicated that the stress and burden associated with caregiving can put the caregiver and the person receiving care at risk (WA DSHS 2018). The COVID-19 pandemic has further demonstrated the critical value of informal caregivers for beneficiaries requiring LTSS. During the COVID-19 public health emergency (PHE), more than half of states allowed family members to be paid providers (CMS 2023). The Administration for Community Living's report 2022 *National Strategy to Support Family Caregivers* emphasized the role of family caregivers in supporting individuals with disabilities and those age 65 and older (ACL 2022).

**Appendix K flexibilities.** In an emergency, Section 1915(c) waivers can be modified with the submission of an Appendix K. In light of the COVID-19 PHE, CMS created a prepopulated template to modify Appendix K, referred to as the “Appendix K COVID Addendum,” that highlighted the most common flexibilities requested by states (CMS 2020). During the PHE, states used the flexibilities available through Appendix K to bolster HCBS delivery and reimbursement. Some of these flexibilities include modifying services, payment rates, and eligibility criteria. CMS also permitted states to use virtual LOC determinations, pay for HCBS in institutional settings, and allow family caregivers to be reimbursed for care provided to an HCBS user (CMS 2023). Appendix K flexibilities may also be used to expand provider qualifications or the pool of providers who can deliver services. During the PHE, 29 states used the Appendix K COVID Addendum to request flexibility to allow spouses and parents of minor children to be paid providers, and 25 states requested to allow family members to be paid providers. CMS has indicated that continuing allowance of payment for family caregivers to render services may be approved in standard Section 1915(c) applications but not under Section 1905(a)(24) state plan personal care benefit, in which legally responsible individuals may not be reimbursed (CMS 2023, Teshale et al. 2021).

Every state with a Section 1915(c) HCBS waiver program submitted an Appendix K requesting flexibilities in HCBS delivery and services. Although Appendix K flexibilities are set to expire six months after the end of the PHE, states have the option to make some flexibilities permanent through their Section 1915(c) waivers, such as flexibilities around the use of telehealth in HCBS delivery (CMS 2023).

## Use of services

This domain of the access framework measures realized access by examining use of services and, in some cases, use of specific providers or settings. Existing measures typically focus on medical care; relatively few standardized measures are available for other types of services, particularly for LTSS. Monitoring unmet need and particular access goals for HCBS can be a challenge. Service gaps, such as delivery of fewer HCBS hours than recommended in the person-centered service plan, are difficult to

capture in administrative data, as authorized hours are not reported on claims. Furthermore, some beneficiaries in need of HCBS may not be receiving services because they are on a waiver waiting list. Administrative data also cannot capture information on the key goals of HCBS, such as an individual’s ability to live independently, visit with family and friends, and participate in community activities.

**Enrollment caps and waiting lists.** States are allowed to set caps on the number of people served under a Section 1915(c) waiver and to establish waiting lists when demand exceeds the waiver’s approved capacity. Some Section 1115 demonstrations also allow waiting lists for HCBS. In general, waiting lists are indicative of an unmet need for HCBS waiver services; however, they are an imperfect measure of access. For example, eligibility screening for waiver services happens at different times in different states, making it difficult to compare waiting lists across states.<sup>13</sup>

Although waiting lists allow states to manage costs, interviews with federal officials, national experts, and beneficiary advocates noted that they also restrict access to HCBS for some individuals who need them. In our previous work on waiting lists, state funding was cited as the most important factor in many states for increasing waiver capacity, such as the number of waiver slots. In some states, explicit support from the governor or the state legislature led to funding increases that helped reduce waiting lists (MACPAC 2020a).

Interviewees told us that some individuals with LTSS needs may apply to several waiver programs at once in an effort to gain access to HCBS, even when one waiver program would best suit their needs. Another waiver may not have a waiting list or may have a shorter wait time, and thus, individuals might apply to begin receiving some services while waiting for a slot in a different HCBS waiver with services that more appropriately meet their needs. Most states with waiting lists allow individuals to be on more than one waiting list at a time (O’Malley Watts et al. 2022b).

Long wait times for waiver services can also result in some people finding other ways to meet their LTSS needs. One study found that among all populations, in 2020, the average wait time for waiver services was 44 months, but substantial variation existed among

populations, with a range of 1 month for individuals with HIV/AIDS to 60 months for individuals with ID/DD (O'Malley Watts et al. 2022b). Among states that we interviewed in 2020, estimates of wait times ranged from less than 1 year to 14 years. Wait times also differed within states among their various waivers, often by differences of more than five years (MACPAC 2020a). As such, beneficiaries may get their LTSS needs met through state plan services or support from family caregivers while they wait for an HCBS waiver slot to become available. It is difficult to assess how many people on waiting lists are actually going without any HCBS because states do not track how individuals meet their care needs while waiting for waiver services (MACPAC 2020a).

States are using ARPA funding to expand beneficiary services, including efforts to reduce waiting lists. Six states—Alabama, California, New Mexico, North Carolina, Tennessee, and Texas—are proposing to eliminate or reduce waiting lists by adding more than 17,000 waiver slots (CMS 2021). For example, Texas is adding an additional 1,549 waiver slots distributed among 6 different waivers. The state is also proposing to update its waiting list management policies. In Texas, individuals are placed on waiting lists on a first-come, first-served basis but are not screened for eligibility for a waiver until a slot becomes available. The state proposed spending \$13 million (including \$6.5 million of federal ARPA funds and \$6.5 million of state general revenue) to use a contractor to screen individuals on the waiting list for eligibility as well as make referrals to available services until a waiver slot opens up. The contractor is also tasked with creating an online portal for waiting list participants to see their place on the list, update their contact information, and update their needs assessment (TX HHS 2022).

**Disparities in access.** Disparities in access to HCBS for LTSS subpopulations may exist across a range of factors, including by race and ethnicity, by geographic location, and by age. However, several interviewees shared the challenge of identifying the extent to which these disparities occur given the lack of available data, particularly related to race and ethnicity. One study found that Medicaid HCBS spending is lowest for dually eligible Black males with multiple sclerosis as compared to white males with multiple sclerosis who had the highest HCBS spending (Fabius et al. 2018).

Other evidence points to disparities: among people with Alzheimer's disease and related dementias, higher HCBS expenditure was linked to a lower probability of institutional care for white individuals and not for Black individuals (Yan et al. 2021). Interviewees also noted geographic disparities in rural areas where it can be more difficult to find HCBS workers. In these cases, self-direction may be a useful tool for getting assistance to beneficiaries. Every state makes self-direction available as an option in at least one HCBS program in the state (O'Malley Watts et al. 2022c). Finally, interviewees told us that age can be a barrier to accessing HCBS. One interviewee shared that individuals supporting care plan development, such as social workers, may not engage in person-centered planning for older adults by asking beneficiaries about their preferences and instead may assume knowledge of their needs, which could affect access to services.

More data are necessary to identify potential disparities in HCBS access. The federal government and the states are working on obtaining better data; however, data limitations related to race and ethnicity continue to be an area the Commission has highlighted as a challenge given that some states have high rates of missing data (MACPAC 2022e). The Commission recently voted on several recommendations related to the collection of race and ethnicity data in Medicaid applications (MACPAC 2023). Other sources may also exist to supplement government data. For example, one state official pointed out that although the state does not stratify HCBS data on use and outcomes by race and ethnicity, the managed care organizations operating in the state regularly collect such data.

We also heard concerns about a lack of coordination on quality metrics across HCBS programs. CMS recently released a set of national standardized HCBS quality metrics that is intended to streamline state reporting on data for HCBS users. In a July 2022 letter to state Medicaid directors, CMS published the HCBS Quality Measure Set and strongly recommended that states stratify their data by race and ethnicity, sex, age, rural or urban location, disability, and language (CMS 2022b). Stratified data allow states to determine existing health disparities encountered by HCBS beneficiaries to inform targeted initiatives intended to address such differences. CMS notes that the goal of this effort is to encourage increased

use of standardized metrics within and across states for HCBS programs. This policy change may lead to more comparative quality data on HCBS programs that both states and CMS can use to enhance quality of care (CMS 2022b). Policymakers may be better able to monitor whether different LTSS populations are receiving the services they need if states collect HCBS data in a standardized manner and the data are stratified by subgroups.

## Beneficiary perceptions and experiences

The third domain in MACPAC's access framework, beneficiary perceptions and experiences, is focused on barriers to accessing care, experiences with care, and beneficiaries' knowledge and understanding of available benefits. This includes their connection to the health care system, timeliness of care, unmet needs, and culturally competent care (MACPAC 2022d, Kenney et al. 2016). Our key interview finding in this domain centers on the barriers that largely relate to a lack of clarity and understanding of the available options and how to access them among individuals interested in accessing HCBS.

**Beneficiary knowledge gaps.** Medicaid waivers have complex requirements, which can create challenges for beneficiaries and for states. Interviewees explained that the range of waivers that cover HCBS, each with unique eligibility pathways and often managed by separate state agencies, can result in confusion among beneficiaries about which they qualify for. Given multiple waiver options, beneficiaries may apply for multiple waivers to increase their chance of being determined eligible and obtaining coverage.

Overall, consumers face knowledge gaps regarding available HCBS supports in their communities. Several interviewees noted that people who are eligible for HCBS can encounter confusing information about HCBS options and how to access them. Interviewees told us that information on state websites varies in terms of the level of detail, and the websites can be difficult to navigate.

One source of information for beneficiaries is information and referral/assistance (I&R/A) networks, which include a range of entities responsible for making available and coordinating services for persons with a disability, older adults, and caretakers (ADvancing States 2022). Some of the primary functions for I&R/A specialists include identification and referral to available services in the community and information sharing. Entities involved in these state-established networks vary; they include but are not limited to area agencies on aging (AAA), 211 call centers, aging and disability resource centers, and centers for independent living. Each entity also offers different services, ranging from providing a referral to essential supports (e.g., assistance with utilities) to options counseling. One key issue is a lack of training for and high turnover rates among information counselors, which are partly driven by low wages similar to the HCBS workforce challenges. For example, one state noted that it is experiencing a high turnover rate among its AAA counselors, which it depends on to serve as an HCBS resource for residents. These challenges are not unique to this particular state or to AAAs. Interviewees noted that states could also turn their attention to other areas that may create access barriers to seeking information; states can examine if information is accessible for those with limited English proficiency or for individuals who are visually impaired.

Services provided through I&R/A entities may also be operated through a no wrong door (NWD) system, in which state and local agencies coordinate to create a simplified process for people to access information, determine their eligibility, and provide one-on-one counseling on LTSS options (ADvancing States 2022, NCD 2022). The NWD system was initiated as part of a joint effort by the Administration for Community Living, CMS, and the Veterans Health Administration (NCD 2022). NWD initiatives have multiple funding streams, including federal, state, and local funding; however, the funding available to states to implement NWD systems is limited and has hindered their ability to implement NWD systems to their full capacity (NCD 2022, NCOA 2022). Some states have used ARPA funding to improve the availability of HCBS information



for individuals by allocating funding specifically to the state's NWD system.

Despite state efforts to establish NWD systems, we heard from several national experts that these systems are not widely available. Some states are working to improve their NWD systems. For example, Iowa is further developing its warm handoff and referral system, which enables individuals to access the information they need regardless of which entity they seek information from. California, through ARPA funding, is investing \$5 million in its NWD system to improve communication between entities in the system. This investment is intended to facilitate access to information for beneficiaries on the availability of HCBS in the state, irrespective of what “door” an individual uses (Kashen and Knackstedt 2022). Advance education and knowledge for beneficiaries is critical before the need for HCBS presents itself. Some individuals wait to access HCBS until they are experiencing an immediate need for services. NWD systems can make information more widely available.

## Administrative complexity

The final domain in MACPAC's HCBS access framework, administrative complexity, examines the following: state burden in administering multiple HCBS programs often under different federal authorities, constraints on state capacity and resources, the implications of system complexity for beneficiaries, and the concept of establishing a core set of services. Our interviews revealed themes consistent with this domain, including administrative complexity for beneficiaries involved in navigating the Medicaid statutory authorities for providing HCBS as well as challenges for states, including budgetary constraints, a lack of staff with knowledge of HCBS, and limited state systems capacity, all of which reduce a state's ability to expand access to HCBS.

**State administration of HCBS.** Interviewees shared that states can experience challenges providing access to HCBS given the complexity associated with administering HCBS waiver programs as well as state capacity challenges. States may cover HCBS via different waiver and state plan authorities. States' decisions regarding their administrative approach

can be driven by varying reporting and renewal requirements, which can consume state resources.

HCBS waiver reporting requirements are more prescriptive than those for state plan options, but the use of a waiver may provide additional programmatic flexibility for states. States with a Section 1915(i) state plan option must make the estimated number of persons to be enrolled and the count of enrollees from the prior year available to CMS annually (42 CFR 441.745(a)(1)(i)). For Section 1915(c) waivers and per federal regulation, states are required to submit an annual form CMS-372(S) for each approved waiver (42 CFR 441.302(h)). This reporting requirement includes data on expenditures and service utilization of individuals participating in the waiver as well as information about the effect of the waiver on the “health and welfare” of HCBS users (CMS 2019). Several state officials and national experts considered the waiver reporting requirements excessive and unnecessary to determine the effectiveness of a program. They suggested reducing the number of requirements as a way to support states and their ability to effectively administer HCBS programs. One state official suggested that the waiver renewal process could be better aligned with the state plan renewal process to remove the additional work involved with waiver renewals, which require different and more information than the state plan renewal process. However, compared with HCBS state plan options, waivers give states enhanced flexibilities, such as waiving the statewideness requirement, that may justify additional reporting requirements.

Through interviews with stakeholders and panels of experts, we identified various suggestions to streamline HCBS administration. They include consolidating HCBS authorities, aligning reporting requirements and renewal processes for waivers with those required for state plan amendments to decrease administrative requirements, rethinking the design of HCBS programs to better align with beneficiary needs, and encouraging the use of managed care to provide HCBS. We have provided some state examples that reflect innovative approaches to restructuring administration of HCBS (Box 4-1).

## BOX 4-1. Innovative State Approaches to Restructuring Administration of Home- and Community-Based Services

**Florida.** Florida operates the iBudget waiver program to provide home- and community-based services (HCBS) to individuals with intellectual disabilities or developmental disabilities (ID/DD). Previously, Florida used a prior authorization system. A support coordinator was responsible for creating a list of services with input from the individual or family, and services were reviewed by an authorizing agent. However, challenges related to the prior-authorization system and the costs associated with it led the state to transition to a budget-based program. Together with stakeholders, the Florida Agency for Persons with Disabilities established the iBudget program as a cost control mechanism for the state while simultaneously allowing persons with ID/DD and their families autonomy and flexibility to choose the services they need to reside in the community. The individualized budget is based on an algorithm, and participants, with the support of a coordinator, have budget and employer authority to allocate funds to services and direct who furnishes their care (AHCA 2021). In its recent American Rescue Plan Act (ARPA, P.L. 117-2) spending plan, Florida included funding to expand the iBudget waiver slots to move individuals off the waiting list.

**Minnesota.** Minnesota used ARPA funds to launch a Waiver Reimagine Advisory Committee that is supporting the second phase of the state's efforts to consolidate its four disability waiver programs, each associated with varying diagnoses and populations served, into two waivers based on an individual's level of need and one set of eligibility requirements (MN DHS 2023). The advisory committee solicits insights from individuals with disabilities and their families to inform the development of the two waivers. During the first phase of the initiative that ended in 2021, the state worked to align services across waivers to enable a seamless transition from four waivers to two in the second phase of the project, which was authorized to begin in 2021 at the conclusion of Phase 1 (MN DHS 2023).

**Tennessee.** Tennessee operates a Section 1115 demonstration program, which offers Medicaid managed care for the majority of the Medicaid population in the state. Tennessee had numerous Section 1915(c) waivers that it consolidated into a single Section 1115 demonstration program by offering the CHOICES program. CHOICES provides HCBS through managed care for older adults and individuals with physical disabilities based on their eligibility for one of three population groups, as defined by certain medical and functional criteria, and their TennCare eligibility group. Tennessee also has the Employment and Community First CHOICES program, which provides employment supports for individuals with ID/DD based on their eligibility for one of five population groups. The state is using ARPA funding to increase access to HCBS by serving additional individuals with ID/DD in the Employment and Community First CHOICES program.

Interviewees also provided feedback on the use of tiered waivers. Some states use a tiered waiver structure in which multiple waivers serve the same populations but offer varying types and intensities of services. A state may have multiple waivers targeting individuals with ID/DD, but they may not all cover personal care services. Louisiana has a tiered benefit

system for individuals with ID/DD through use of several Section 1915(c) waivers (Box 4-2). One state official suggested allowing for tiered benefit packages within one Section 1915(c) waiver program rather than having a separate waiver for each tier (i.e., redesign within existing authorities).



## BOX 4-2. Louisiana's Tiered Home- and Community-Based Services Waiver System

In 2018, Louisiana's Office for Citizens with Developmental Disabilities (OCDD), with help from stakeholders, launched its Tiered Waiver program. With this new program, the state moved away from operating on a first-come, first-served basis to meet the home- and community-based services needs of more than 10,000 persons with intellectual disabilities or developmental disabilities (ID/DD) on a waiting list (LDH 2018). The goal was to consolidate the waiting lists associated with its four existing Section 1915(c) waivers. Individuals were screened and stratified into five groups based on level of need, with a goal to set priorities for access to the next available OCDD waiver slot for persons most at risk of institutionalization (LDH 2022). This screening process continues at the time of publication. The state uses a person-centered planning process, in which the Louisiana Plus assessment tool is used to identify the type of ID/DD waiver best suited to the person's needs and for which they are eligible.

**State capacity.** States are operating with limited capacity and resources amid competing priorities and tight budget constraints. State administrative capacity limitations can restrict states' ability to fulfill program requirements, such as timely eligibility determinations, as well as to carry out initiatives that improve quality and outcomes (MACPAC 2014). Further, state administrative staffing shortages may hinder efforts to establish more robust HCBS systems. Interviewees noted that some states with multiple HCBS waivers are managed by different state agencies. Interviewees also shared that the technological investments that states must implement to comply with new CMS requirements create challenges. States used ARPA funds to enhance state platforms responsible for billing, reporting, and tracking data; improve administration of HCBS programs; and invest in systems that promote cross-sector integration, such as between Medicare and Medicaid HCBS (Kashen and Knackstedt 2022, Sullivan 2021).

Many interviewees pointed to budgetary constraints as limiting state ability to expand access to HCBS. They indicated that states may cut services to meet budgetary demands when they arise. States have leveraged one-time ARPA funding to mitigate budget constraints and increase access to HCBS. In Illinois, ARPA funding is being directed to assistive technology as well as vehicle and home modifications that support community living. Other initiatives targeted expanding access to specific HCBS populations, such as persons

with behavioral health needs and the workers who support this population (Kashen and Knackstedt 2022).

**Complex requirements.** National experts and federal officials said that the complexity of income and resource eligibility criteria may deter some individuals from applying for HCBS. In particular, we heard this feedback about the medically needy pathway. This pathway provides coverage to people with modestly higher incomes than the Medicaid limit in the state with an opportunity to become Medicaid eligible, if they meet spend-down requirements. Specifically, states establish a medically needy income level (MNIL) to which a beneficiary must spend down within a certain time frame, referred to as a "budget period," which varies from one to six months. This spend down typically occurs when beneficiaries incur medical expenses and pay for them out of pocket. Once individuals spend down their income to their states' MNIL, they are eligible for Medicaid.

A proposed rule in 2022 looked to address differential treatment in current Medicaid regulations by making the medically needy pathway more accessible to individuals applying for Medicaid and in need of HCBS by accounting for the projected expenses of individuals who are not institutionalized and are receiving HCBS when determining Medicaid eligibility for a given budget period (CMS 2022c).<sup>14</sup> The proposed rule is intended to do the following: (1) decrease Medicaid churn among noninstitutionalized individuals whose

Medicaid eligibility often begins after a new budget period is initiated, resulting in coverage gaps; (2) decrease states' administrative costs because of an expected decline in Medicaid churn; and (3) improve outcomes with continuity of care.

Medicaid-eligible individuals enrolling through the medically needy pathway must spend down their income to their state's MNIL. In 2020, the median MNIL across the 32 states and the District of Columbia with this pathway was \$478.50 per month or 45 percent of the FPL for an individual. Asset limits for this pathway generally align with SSI levels, which are \$2,000 for an individual and \$3,000 for a couple (MACPAC 2021).<sup>15</sup> Given the income limit they would have to spend down to, eligible individuals may be hesitant to apply for HCBS out of a concern that they would have insufficient income to maintain their community living expenses.

The process of being determined eligible for Medicaid HCBS is complex and can take considerable time. State and federal officials raised concerns about the lengthy process and noted that individuals have to navigate both functional and financial assessment processes. For example, one state official said that waiver applicants with ID/DD have to be determined medically eligible twice through a state developmental disability system determination and an HCBS medical eligibility determination. Interviewees suggested it would be helpful to streamline eligibility and enrollment processes—for example, by allowing for medical and financial eligibility determination processes to occur concurrently. Florida, along with several other states, has web-based and automated eligibility systems that link the medical and financial eligibility processes, resulting in simultaneous eligibility determinations. Another mechanism to streamline eligibility is to use more refined and consolidated assessment tools. A number of states have looked to ARPA funding to reexamine their assessment tools. For example, Rhode Island is working to move from six functional assessment tools to one tool for all HCBS programs in the state (RI EOHHS 2021).

**Core benefit.** MACPAC convened a roundtable in December 2021 to discuss ways to streamline and increase access to HCBS. The roundtable discussed the idea of establishing a core set of services across all HCBS programs, referred to as a “core benefit.” A core benefit could provide a basic set of HCBS

designed to increase access to care while recognizing that some beneficiaries may need additional services or a higher level of services to meaningfully live in the community. To flesh out the roundtable discussion, we included this idea in the interviews that CHCS conducted for us in 2022. We asked interviewees for feedback at a conceptual level on the idea of a core benefit, including a range of design considerations and implications for the current HCBS delivery system. For example, interviewees explored several design considerations related to standardizing a core benefit or allowing state flexibility in the design. Other considerations included having one basic core benefit as opposed to multiple population-based core benefits and whether services should be offered in a tiered approach from least intensive to most intensive or should be allocated based on costs.

Overall, interviewee responses were mixed on the idea of establishing a core benefit and its potential to streamline and increase access to HCBS. Interviewees cautioned that the potential success of a core benefit as a way to increase access to services would depend on how the benefit is designed and implemented. They also noted that increases in access would likely vary across states because of the differences that exist in state policies and systems for determining HCBS eligibility and enrolling eligible beneficiaries and for the benefits covered. One state official predicted changes to provider payment rate structures to bolster provider networks in the event of implementing a core benefit. The state official also expressed apprehensions related to state staff capacity to implement a new benefit. Some individuals raised concerns related to design and implementation, questioning if such a benefit would add more complexity to the system. Almost all interviewees agreed that for a core benefit to streamline and increase access to HCBS, it would need to be a mandatory Medicaid benefit.

Interviewees raised several concerns around implementing a core benefit. Potential issues included limited workforce availability, the need for increased federal financial support, constraints on state capacity to enhance current infrastructure to accommodate new enrollees, the time it would take to initiate the benefit, and supports that beneficiaries would need to prevent disparities in access to the new core benefit. The primary concerns expressed by states we interviewed were the ongoing workforce shortages

and limited state staff capacity to implement a new benefit. Many interviewees also noted that states would need additional federal financial support to implement a new core benefit, particularly if it was mandatory. Some interviewees noted that low state take-up of the optional Section 1915(k) program, which includes an enhanced 6 percent federal match, might suggest that states would require greater support. One state official noted that states could struggle with the investments in infrastructure that would likely be needed to support implementation of a new benefit, such as updating state information technology systems and developing more user-friendly systems to process and track applications.

Several interviewees mentioned that states would require substantial time to implement a core benefit—for example, to engage stakeholders in the process and secure funding from the state legislature. Interviewees also noted that implementation of the core benefit should include beneficiary supports such as options counseling to help individuals make informed choices about their coverage. Interviewees told us that although the core benefit could allow individuals to more easily access services, it could also exacerbate disparities in access if it does not account for the varying levels of support that different beneficiaries might need, such as information in a language other than English.

Given the challenges that states are facing with the unwinding of the continuous coverage requirement established for Medicaid under the PHE and with implementation of ARPA-funded initiatives, introducing a core benefit, whether optional or mandatory, would be a substantial change to the HCBS system. The impact of such a change on access is unknown, particularly with the limited availability of workers to provide services, but may warrant further study in the future as the landscape changes.

## Next Steps

States have been investing in HCBS as evidenced by the growth of HCBS expenditures relative to institutional care in recent decades. However, our summary of existing HCBS authorities and flexibilities, analysis of state coverage of HCBS by taxonomy categories, and extensive interviews indicate that access to and management of HCBS programs are complex and challenging to navigate for beneficiaries and states. HCBS worker shortages and limited state

staff capacity further exacerbate these challenges. For beneficiaries, lack of familiarity with available options, complex and lengthy eligibility processes, and state use of enrollment caps and waiting lists for some waivers can mean delays in access to services. States also face challenges; they are administering multiple HCBS programs with limited resources and competing priorities for staff already juggling multiple responsibilities. Our findings show that policy and operational challenges persist.

The Commission is committed to exploring ways to expand access to HCBS within each domain of our HCBS access framework, taking into account state needs. In the coming year, we will work to identify policies that drive toward a more streamlined HCBS delivery system with increased access for beneficiaries and reduced administrative burden for states. The findings summarized in this chapter serve as the basis for upcoming Commission work, including projects that will examine HCBS spending and use, HCBS payment rates, and administrative requirements for HCBS programs.

## Endnotes

<sup>1</sup> Most Medicaid-covered services are described in the Medicaid state plan, which is an agreement between states and the federal government about how the state will administer its Medicaid program. Services provided under the Medicaid state plan are statutorily required to be available statewide to all Medicaid-eligible beneficiaries.

<sup>2</sup> CHCS and RTI International conducted interviews with representatives from the Administration for Community Living, Centers for Medicare & Medicaid Services (CMS), Wisconsin, Florida, Tennessee, Washington, Louisiana, New York, Justice in Aging, The Council on Quality and Leadership, Autistic Self-Advocacy Network, National Association of State Mental Health Program Directors, Brain Injury Association of America, AIDS United, Family Voices, Topeka Independent, Community Living Policy Center, and ADvancing States.

<sup>3</sup> *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).

<sup>4</sup> Section 1115 demonstrations also provide states with the authority to pay for services that cannot otherwise be covered under the state plan as long as spending on the demonstration is projected to be budget neutral to the federal government.

<sup>5</sup> MACPAC staff searched the CMS database of state waivers between May and July 2022 to identify current, approved Section 1915(c) and Section 1115 demonstrations. The U.S. territories were not included in this review. Pending, expired, and terminated waivers also were not included. Additionally, only Section 1115 demonstrations that cover HCBS were reviewed and included. Staff also searched CMS's database of Medicaid state plan amendments and state Medicaid websites for Section 1915(i) and 1915(k) state plan authorities. In the Section 1915(c) waiver application, states can identify the HCBS taxonomy category for each service they choose to cover, but not all states filled this out. For states that did fill this out, we relied on those classifications. For the states that did not, we read the service descriptions and relied on CMS guidance to assist us in choosing the most appropriate category (CMS 2014). We were able to map each service to a taxonomy category; therefore, we did not include the "unknown" HCBS taxonomy category in our results. Additionally, Section 1115 demonstrations and state plan documents do not identify the HCBS taxonomy categories the state is using, so we assigned categories for services listed in those documents. Another limitation of our review is the inability to summarize our findings for specific age groups. For example, in Section 1915(c) waivers, states can choose to limit services to a certain age range (e.g., age 0 to 21 or age 18 and older), but other waivers cover both children and adults, so it is not possible to catalog services by age.

<sup>6</sup> We excluded state plan authorities under Section 1905(a) (24) and Section 1915(j) from our review. Section 1905(a) (24) allows states to cover personal care services under the state plan but does not give beneficiaries the authority to manage a personal budget. These services are also not directed to one particular population and are made available to any eligible beneficiary in a state with this benefit. Section 1915(j) provides authority for self-directed personal assistance services (PAS), giving beneficiaries the ability to hire and direct their own PAS attendant. States may also give beneficiaries the authority to manage their own individual service budget. Often, self-direction is offered through other Medicaid authorities, and the Section 1915(j) option is not frequently implemented by states. Furthermore, Section 1915(j) authority may not target a particular population, unless combined with a 1915(c) waiver (Randi et al. 2021). This authority can also allow for self-directed services via the state plan optional personal care services.

<sup>7</sup> The 12 HCBS target groups included in Section 1915(c) waivers include: (1) aged, (2) disabled (physical), (3) disabled (other), (4) brain injury, (5) HIV/AIDS, (6) medically fragile, (7) technology dependent, (8) autism, (9) developmental

disability, (10) intellectual disability, (11) mental illness, and (12) serious emotional disturbance (CMS 2022a).

<sup>8</sup> Rebalancing ratio refers to the share of total LTSS spending devoted to HCBS, expressed as a percentage (Murray et al. 2021a).

<sup>9</sup> In FY 2019, 25 states had MLTSS programs, but the total expenditures include data from only 20 states.

<sup>10</sup> DCWs include personal care aides, home health aides, and certified nursing assistants. Direct support professionals assist individuals with ID/DD, providing a broader range of services than personal care aides, such as employment support (PHI 2022). Independent providers are those who are employed directly by beneficiaries through consumer direction.

<sup>11</sup> There are additional types of HCBS providers, such as those that provide adult day services.

<sup>12</sup> ARPA increased the FMAP by 10 percent for the one-year period of April 1, 2021, through March 31, 2022. States had to submit spending plans to CMS on how they would spend this new money. All 50 states and the District of Columbia have received approval from CMS, and, at the time of publication, are implementing the initiatives included in their plans. States have until March 31, 2025 to spend the increased FMAP earned during the one-year period.

<sup>13</sup> Seven states do not screen for eligibility before placing people on waiting lists; individuals on waiting lists in these states account for 59 percent of the national total waiting list population in FY 2020 (O'Malley Watts et al. 2022b).

<sup>14</sup> The medically needy income eligibility determination process under current regulation (§ 435.831(g)(1)) only permits deduction of projected medical expenses from the income of individuals in institutions, which serves as part of their spend down for a designated budget period for purposes of determining Medicaid eligibility. Other expenses, such as those incurred by the individual's family members, may also be included in deductions from the countable income.

<sup>15</sup> The medically needy pathway allows states to cover individuals with high medical expenses relative to their income once they have spent down to a state's MNIL. The income threshold and the budget period used in medically needy eligibility determinations are state specific. States may offer full Medicaid services or a more limited set of state-specified benefits to this group. They may also provide institutional LTSS and HCBS waiver benefits to those meeting level of care criteria.



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# APPENDIX 4A: Environmental Scan of Home- and Community-Based Services Authorities

To address state variation in names of services and to make it easier to report on home- and community-based services (HCBS) use and spending, researchers developed the HCBS taxonomy—a uniform classification system that includes 18 categories, each associated with a set of subcategories (Table 4A-1) (Peebles et al. 2017). The HCBS taxonomy is used in Section 1915(c) waivers, in which there are designated fields for states to select an HCBS taxonomy category and subcategory for each service covered in the waiver.

**TABLE 4A-1. HCBS Taxonomy Categories**

HCBS taxonomy category	Examples of HCBS taxonomy services
Case management	Case management
Round-the-clock services	Group living, shared living, in-home habilitation, and in-home round-the-clock services
Supported employment	Job development, ongoing supported employment (individual or group), and career planning
Day services	Prevocational services, day habilitation, education services, day treatment or partial hospitalization, adult day health, adult day services, community integration, medical day care for children
Nursing	Private duty nursing and skilled nursing
Home-delivered meals	Home-delivered meals
Rent and food expenses for live-in caregivers	Rent and food expenses for live-in caregivers
Home-based services	Home-based habilitation, home health aide, personal care, companion, homemaker, chore
Caregiver support	Respite (in home and out of home) and caregiver counseling or training
Other mental health and behavioral services	Mental health assessment, assertive community treatment, crisis intervention, behavior support, peer specialist, counseling, psychosocial rehabilitation, clinic services
Other health and therapeutic services	Health monitoring; health assessment; medication assessment and/or management; nutrition consultation; physician services; prescription drugs; dental services; occupational therapy; physical therapy; speech, hearing, and language therapy; respiratory therapy; cognitive rehabilitative therapy; other therapies
Services supporting participant direction	Financial management services in support of participant direction and information and assistance in support of participant direction
Participant training	Participant training
Equipment, technology, and modifications	Personal emergency response system, home and/or vehicle accessibility adaptations, equipment and technology, supplies
Non-medical transportation	Non-medical transportation
Community transition services	Community transition services
Other services	Goods and services, interpreter, housing consultation, other
Unknown	Unknown

**Note:** HCBS is home- and community-based services.

**Sources:** CMS 2014, Peebles and Bohl 2013.

MACPAC conducted an environmental scan in 2022, in which we reviewed Section 1915(c) waivers and Section 1115 demonstrations and Section 1915(i) state plan authority, to determine which categories of services states are covering for each target population (Table 4A-2). We also illustrate the number of states that cover any HCBS by target population as well as the number of states covering each HCBS taxonomy category.

**TABLE 4A-2.** State Coverage of HCBS Under Sections 1915(c), 1915(i), and 1115 by Target Population, July 2022

HCBS taxonomy categories	Count of Medicaid HCBS authorities and states offering HCBS, by target population						
	Intellectual disabilities and developmental disabilities <sup>1</sup>	Physical and other disabilities	Aged	Brain injury	Mental illness and serious emotional disturbance	Medically fragile and technology dependent	HIV/AIDS
<b>Total number of waivers and authorities in use</b>	<b>129</b>	<b>86</b>	<b>76</b>	<b>33</b>	<b>28</b>	<b>27</b>	<b>10</b>
<b>Total number of states</b>	<b>51</b>	<b>49</b>	<b>51</b>	<b>26</b>	<b>23</b>	<b>23</b>	<b>10</b>
Caregiver support	48	44	46	17	15	16	8
Case management	27	32	33	12	10	11	4
Community transition services	32	28	30	11	7	5	1
Day services	48	44	47	17	12	7	7
Equipment, technology, and modifications	48	45	46	20	12	15	7
Home-based services	46	48	48	22	14	15	9
Home-delivered meals	14	38	39	6	8	4	6
Non-medical transportation	40	32	32	15	10	7	4
Nursing	33	29	27	6	7	13	6
Other health and therapeutic services	43	30	29	19	11	10	5
Other mental health and behavioral services	42	18	17	15	18	5	5
Other services	37	26	24	10	14	8	3
Participant training	25	13	13	10	12	2	2
Rent and food expenses for live-in caregivers	7	0	0	0	1	0	0
Round-the-clock services	44	32	34	13	10	3	2
Services supporting participant direction	23	20	21	6	6	6	3
Supported employment	48	21	13	18	15	6	4

**Notes:** HCBS is home- and community-based services. The number of states includes all 50 states and the District of Columbia for a total of 51. We were able to map each service to a taxonomy category; therefore, we did not include the “unknown” HCBS taxonomy category in our results.

<sup>1</sup> The intellectual disabilities and developmental disabilities category also includes autism.

**Source:** MACPAC analysis of approved Section 1915(c) waivers and Section 1115 demonstration authority and Section 1915(i) state plan authority, July 2022.



The most commonly covered HCBS among all states by target population are reported in Table 4A-3.

**TABLE 4A-3.** Top Five Most Common HCBS by Target Population, July 2022

Target population	HCBS taxonomy categories
Aged	<ul style="list-style-type: none"> <li>• Home-based services</li> <li>• Day services</li> <li>• Caregiver support</li> <li>• Equipment, technology, and modifications</li> <li>• Home-delivered meals</li> </ul>
Intellectual disabilities and developmental disabilities <sup>1</sup>	<ul style="list-style-type: none"> <li>• Caregiver support</li> <li>• Day services</li> <li>• Equipment, technology, and modifications</li> <li>• Supported employment</li> <li>• Home-based services</li> </ul>
Brain injury	<ul style="list-style-type: none"> <li>• Home-based services</li> <li>• Equipment, technology, and modifications</li> <li>• Other health and therapeutic services</li> <li>• Supported employment</li> <li>• Caregiver support</li> <li>• Day services</li> </ul>
Physical and other disabilities	<ul style="list-style-type: none"> <li>• Home-based services</li> <li>• Equipment, technology, and modifications</li> <li>• Caregiver support</li> <li>• Day services</li> <li>• Home-delivered meals</li> </ul>
Mental illness and serious emotional disturbance	<ul style="list-style-type: none"> <li>• Other mental health and behavioral services</li> <li>• Caregiver support</li> <li>• Home-based services</li> <li>• Supported employment</li> <li>• Other services</li> </ul>
HIV/AIDS	<ul style="list-style-type: none"> <li>• Home-based services</li> <li>• Caregiver support</li> <li>• Day services</li> <li>• Equipment, technology, and modifications</li> <li>• Home-delivered meals</li> <li>• Nursing</li> </ul>
Medically fragile and technology dependent	<ul style="list-style-type: none"> <li>• Caregiver support</li> <li>• Equipment, technology, and modifications</li> <li>• Home-based services</li> <li>• Nursing</li> <li>• Case management</li> </ul>

**Notes:** HCBS is home- and community-based services. For some populations, we included six services instead of five due to a tie in the number of states covering one or more services.

<sup>1</sup> The intellectual disabilities and developmental disabilities category also includes autism.

**Source:** MACPAC analysis of approved Section 1915(c) waivers and Section 1115 demonstration authority and Section 1915(i) state plan authority, July 2022.

At the time of our environmental scan, nine states covered HCBS via Section 1915(k) state plan authority. Table 4A-4 presents the range of HCBS made available to all eligible beneficiaries by tallying the number of states that cover each service.

**TABLE 4A-4.** HCBS Covered under Section 1915(k) State Plan Authority, July 2022

HCBS taxonomy categories	Number of states covering service
Caregiver support	0
Case management	3
Community transition services	3
Day services	1
Equipment, technology, and modifications	7
Home-based services	9
Home-delivered meals	4
Non-medical transportation	1
Nursing	2
Other health and therapeutic services	1
Other mental health and behavioral services	0
Other services	0
Participant training	7
Rent and food expenses for live-in caregivers	0
Round-the-clock services	0
Services supporting participant direction	4
Supported employment	0

**Notes:** HCBS is home- and community-based services. Section 1915(k) is also known as the Community First Choice option. We were able to map each service to a taxonomy category; therefore, we did not include the “unknown” HCBS taxonomy category in our results.

**Source:** MACPAC analysis of Section 1915(k) state plan authority, July 2022.



# 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 quaternary 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.

**Robert Duncan, MBA, (Vice Chair)**, is chief operating officer of Connecticut Children's—Hartford. Before this, he served as executive vice president of Children's Wisconsin, where he oversaw the strategic contracting for systems of care, population health, and the development of value-based contracts. He was also the president of Children's Community Health Plan, which insures individuals with BadgerCare Plus coverage and those on the individual marketplace, and Children's Service Society of Wisconsin. He has served as both the director of the Tennessee Governor's Office of Children's Care Coordination and the director of the Tennessee Children's Health Insurance Program, overseeing the state's efforts to improve the health and welfare of children across Tennessee. Earlier, he held various positions with Methodist Le Bonheur Healthcare. Mr. Duncan received his master of business administration from the University of Tennessee at Martin.

**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.

**Tricia Brooks, MBA**, is a research professor at the McCourt School of Public Policy at Georgetown University and a senior fellow at the Georgetown University Center for Children and Families (CCF), an independent, non-partisan policy and research center whose mission is to expand and improve health coverage for children and families. At CCF, Ms. Brooks focuses on issues relating to policy, program administration, and quality of Medicaid and CHIP coverage for children and families. Before joining CCF, she served as the founding CEO of New Hampshire Healthy Kids, a legislatively created non-profit corporation that administered CHIP in the state, and served as the Medicaid and CHIP consumer assistance coordinator. Ms. Brooks holds a master of business administration from Suffolk University.

**Jennifer L. Gerstorff, FSA, MAAA**, is a principal and consulting actuary with Milliman's Seattle office. Since joining the firm in 2006, she has served as lead actuary for several state Medicaid agencies. In addition to supporting state agencies through her consulting work, Ms. Gerstorff actively volunteers with the Society of Actuaries and American Academy of Actuaries work groups, participating in research efforts, developing content for continuing education opportunities, and facilitating monthly public interest group discussions with Medicaid actuaries and other industry experts. She received her bachelor's in applied mathematics from Columbus State University.



**Angelo P. Giardino, MD, PhD, MPH**, is the Wilma T. Gibson Presidential Professor and chair of the Department of Pediatrics at the University of Utah's Spencer Fox Eccles School of Medicine and chief medical officer at Intermountain Primary Children's Hospital in Salt Lake City, Utah. Before this, Dr. Giardino worked at Texas Children's Health Plan and Texas Children's Hospital from 2005 to 2018. He received his medical degree and doctorate in education from the University of Pennsylvania, completed his residency and fellowship training at the Children's Hospital of Philadelphia, and earned a master of public health from the University of Massachusetts. He also holds a master in theology from Catholic Distance University and a master in public administration from the University of Texas Rio Grande Valley.

**Dennis Heaphy, MPH, MEd, MDiv**, is a health justice advocate and researcher at the Massachusetts Disability Policy Consortium, a Massachusetts-based disability rights advocacy organization. He is also a dually eligible Medicaid and Medicare beneficiary enrolled in One Care, a plan operating in Massachusetts under the CMS Financial Alignment Initiative. Mr. Heaphy is engaged in activities that advance equitable whole person-centered care for beneficiaries in Massachusetts and nationally. He is cofounder of Disability Advocates Advancing Our Healthcare Rights (DAAHR), a statewide coalition in Massachusetts. DAAHR was instrumental in advancing measurable innovations that give consumers voice in One Care. Examples include creating a consumer-led implementation council that guides the ongoing development and implementation of One Care, an independent living long-term services and supports coordinator role on care teams, and an independent One Care ombudsman. Previously, he worked as project coordinator for the Americans with Disabilities Act for the Massachusetts Department of Public Health (MDPH) and remains active on various MDPH committees that advance health equity. In addition to policy work in Massachusetts, Mr. Heaphy is on the advisory committee of the National Center for Complex Health & Social Needs and the Founders Council of the United States of Care. He is a board member of Health Law Advocates, a Massachusetts-based nonprofit legal group representing low-income individuals. He received his master of public health and master of divinity from Boston University and master of education from Harvard University.

**Timothy Hill, MPA**, is vice president for client engagement at the American Institutes for Research (AIR), where he provides leadership and strategic direction across a variety of health-related projects. Before joining AIR, Mr. Hill held several executive positions within CMS, including deputy director of the Center for Medicaid and CHIP Services, the Center for Consumer Information and Insurance Oversight, and the Center for Medicare. Mr. Hill earned his bachelor's degree from Northeastern University and his master's degree from the University of Connecticut.

**Carolyn Ingram, MBA**, is an executive vice president of Molina Healthcare, Inc., which provides managed health care services under the Medicaid and Medicare programs as well as through state insurance marketplaces. Ms. Ingram is also the plan president for Molina Healthcare of New Mexico and the executive director of the Molina Healthcare Charitable Foundation. Previously, Ms. Ingram served as the director of the New Mexico Medicaid program, where she launched the state's first managed long-term services and supports program. She also held prior leadership roles, including vice chair of the National Association of Medicaid Directors and chair of the New Mexico Medical Insurance Pool. Ms. Ingram earned her bachelor's degree from the University of Puget Sound and her master of business administration from New Mexico State University.

**Verlon Johnson, MPA**, is executive vice president and chief strategy officer at CNSI, a Virginia-based health information technology firm that works with state and federal agencies to design technology-driven products and solutions that improve health outcomes and reduce health care costs. Ms. Johnson previously served as an associate partner and vice president at IBM Watson Health. Before entering private industry, she was a public servant for more than 20 years, holding numerous leadership positions, including associate consortium administrator for Medicaid and CHIP at CMS, acting regional director for the U.S. Department of Health and Human Services, acting CMS deputy director for the Center for Medicaid and CHIP Services (CMCS), interim CMCS Intergovernmental and External Affairs group director, and associate regional administrator for both Medicaid and Medicare. Ms. Johnson earned a master of public administration with an emphasis on health care policy and administration from Texas Tech University.

**Patti Killingsworth** is the senior vice president of long-term services and supports strategy at CareBridge, a value-based health care company dedicated to supporting Medicaid and dually eligible beneficiaries receiving home- and community-based services. Ms. Killingsworth is a former Medicaid beneficiary and lifelong family caregiver with 25 years of Medicaid public service experience, most recently as the longstanding assistant commissioner and chief of long-term services and supports for TennCare, the Medicaid agency in Tennessee. Ms. Killingsworth received her bachelor's degree from Missouri State University.

**John B. McCarthy, MPA**, is a founding partner at Speire Healthcare Strategies, which helps public and private sector entities navigate the health care landscape through the development of state and federal health policy. Previously, he served as the Medicaid director for both the District of Columbia and Ohio, where he implemented a series of innovative policy initiatives that modernized both programs. He has also played a significant role nationally, serving as vice president of the National Association of Medicaid Directors. Mr. McCarthy holds a master in public affairs from Indiana University's Paul H. O'Neill School of Public and Environmental Affairs.

**Adrienne McFadden, MD, JD**, is the chief medical officer of Medicaid at Elevance Health, where she serves as the strategic clinical thought leader for the Medicaid line of business. Previously, Dr. McFadden was the chief medical officer at Buoy Health, a virtual health service created to support patient decision making. After beginning her career in emergency medicine, Dr. McFadden has held multiple executive and senior leadership roles, including vice president for Medicaid at Humana, Inc.; director of the Office of Health Equity at the Virginia Department of Health; and inaugural medical director of the South University Richmond Physician Assistant Program. Dr. McFadden received her medical and law degrees from Duke University.

**Rhonda M. Medows, MD**, is a nationally recognized expert in population health and health equity. As president of Providence Population Health Management, Dr. Medows uses her platform to change the way health care organizations approach large-scale issues, such as improving equity in the Medicare and Medicaid programs. Before joining Providence, she was an executive vice president and

chief medical officer at UnitedHealth. In the public sector, she served as commissioner for the Georgia Department of Community Health, secretary of the Florida Agency for Health Care Administration, and chief medical officer for the CMS Southeast Region. Dr. Medows holds a bachelor's degree from Cornell University and earned her medical degree from Morehouse School of Medicine in Atlanta, Georgia. She practiced medicine at the Mayo Clinic and is board certified in family medicine. She is also a fellow of the American Academy of Family Physicians.

**Jami Snyder, MA**, is the president and chief executive officer of JSN Strategies, LLC, where she provides health care-related consulting services to a range of public and private sector clients. Previously, she was the Arizona cabinet member charged with overseeing the state's Medicaid program. During her tenure, Ms. Snyder spearheaded efforts to stabilize the state's health care delivery system during the COVID-19 public health emergency and advance the agency's Whole Person Care Initiative. Ms. Snyder also served as the Medicaid director in Texas and as the president of the National Association of Medicaid Directors. Ms. Snyder holds a master in political science from Arizona State University.

**Katherine Weno, DDS, JD**, is an independent public health consultant. Previously, she held positions at the Centers for Disease Control and Prevention, including senior adviser for the National Center for Chronic Disease Prevention and Health Promotion and director of the Division of Oral Health. Dr. Weno also served as the director of the Bureau of Oral Health in the Kansas Department of Health and Environment. Previously, she was the CHIP advocacy project director at Legal Aid of Western Missouri and was an associate attorney at Brown, Winick, Graves, Gross, Baskerville, and Schoenebaum in Des Moines, Iowa. Dr. Weno started her career as a dentist in Iowa and Wisconsin. She earned degrees in dentistry and law from the University of Iowa.

## Biographies of Staff

**Asmaa Albaroudi, MSG**, is a senior analyst. Before joining MACPAC, she was a Health and Aging Policy Fellow with the House Energy and Commerce Committee's Subcommittee on Health. Ms. Albaroudi also worked as the manager of quality and policy initiatives at the National PACE Association, where she provided research and analysis on federal and state regulations. She is currently a doctoral candidate at the University of Maryland, College Park, School of Public Health, where her research centers on long-term care. Ms. Albaroudi holds a master of science in gerontology and a bachelor of science in human development and aging from the University of Southern California.

**Annie Andrianasolo, MBA**, is the chief administrative officer. Most recently, she managed the CEO's office at the Pharmaceutical Research and Manufacturers of America. She previously worked for various nonprofit organizations, including the Public Health Institute, the Minneapolis Foundation, and the World Bank. Ms. Andrianasolo holds a bachelor of arts in economics from the University of the District of Columbia and a master of business administration from Johns Hopkins University.

**Gabby Ballweg** is a research assistant. Before joining MACPAC, Ms. Ballweg worked as the project coordinator for the Wisconsin Community Health Empowerment Fund and interned at Action on Smoking and Health. Ms. Ballweg graduated from the University of Wisconsin, Madison, with a bachelor of science in biology and political science.

**Lesley Baseman, MPH**, is a senior policy analyst. Before joining MACPAC, she was a public health fellow for Massachusetts state senator Jo Comerford, where she worked on the Joint Committee on COVID-19 and the Joint Committee on Public Health. Ms. Baseman also worked as a data scientist and programmer at the RAND Corporation, where she focused on policy research pertaining to access to care for the uninsured and underinsured and quality of care in the Medicare program. She holds a master of public health in health policy from the Harvard T.H. Chan School of Public Health and a bachelor of arts in economics from Carleton College.

**Kirstin Blom, MIPA**, is a policy director. 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.

**Caroline Broder** is the director of communications. Before joining MACPAC, she led strategic communications for a variety of health policy organizations and foundations, where she developed and implemented communications strategies to reach both the public and policymakers. She has extensive experience working with researchers across multiple disciplines to translate and communicate information for the public. She began her career as a reporter covering health and technology issues. Ms. Broder holds a bachelor of science in journalism from Ohio University.

**Moir Forbes, MBA**, is the principal policy director focusing on payment and financing, program administration, and managed care. Previously, she served as director of the division of health and social service programs in the Office of Executive Program Information at the U.S. Department of Health and Human Services (HHS) and as a vice president in the Medicaid practice at The Lewin Group. She has extensive experience with federal and state policy analysis, Medicaid program operations, and delivery system design. Ms. Forbes was elected to the National Academy of Social Insurance in 2019. She has a master of business administration from The George Washington University and a bachelor of arts from Bryn Mawr College.

**Drew Gerber, MPH**, is an analyst. Before joining MACPAC, he consulted with the Minnesota Department of Human Services on long-term services and supports financing options, and he served as project manager for the University of Minnesota's COVID-19 modeling effort. Mr. Gerber holds a master of public health in health policy from the University of

Minnesota and a bachelor of science in journalism and global health from Northwestern University.

**Martha Heberlein, MA**, is the research advisor and a principal analyst. Before joining MACPAC, she was the research manager at the Georgetown University Center for Children and Families, where she oversaw a national survey on Medicaid and State Children's Health Insurance Program (CHIP) eligibility, enrollment, and renewal procedures. Ms. Heberlein holds a master of arts in public policy with a concentration in philosophy and social policy from The George Washington University and a bachelor of science in psychology from James Madison University.

**Tamara Huson, MSPH**, is an analyst. Before joining MACPAC, she worked as a research assistant in the Department of Health Policy and Management at The University of North Carolina. She also worked for the American Cancer Society and completed internships with the North Carolina General Assembly and the Foundation for Health Leadership and Innovation. Ms. Huson holds a master of science in public health from The University of North Carolina at Chapel Hill and a bachelor of arts in biology and global studies from Lehigh University.

**Joanne Jee, MPH**, is a policy director and the congressional liaison focusing on CHIP and children's coverage. Before joining MACPAC, she was a program director at the National Academy for State Health Policy, where she focused on children's coverage issues. Ms. Jee also has been a senior analyst at GAO, a program manager at The Lewin Group, and a legislative analyst in the HHS Office of Legislation. Ms. Jee has a master of public health from the University of California, Los Angeles, and a bachelor of science in human development from the University of California, Davis.

**Linn Jennings, MS**, is a senior analyst. Before joining MACPAC, they worked as a senior data and reporting analyst at Texas Health and Human Services in the Women, Infants, and Children program and as a budget and policy analyst at the Wisconsin Department of Health in the Division of Medicaid. They hold a master of science in population health sciences with a concentration in health services research from the University of Wisconsin, Madison, and a bachelor of arts in environmental studies from Mount Holyoke College.

**Carolyn Kaneko** is the graphic designer. Before joining MACPAC, she was design lead at the Artist Group, handling a wide variety of marketing projects. Her experience includes managing publication projects at all stages of design production and collaborating in the development of marketing strategies. Ms. Kaneko began her career as an in-house designer for an offset print shop. She holds a bachelor of arts in art from Salisbury University with a concentration in graphic design.

**Kate Massey, MPA**, is the executive director. Before joining MACPAC, she was senior deputy director for the Behavioral and Physical Health and Aging Services Administration with the Michigan Department of Health and Human Services. Massey has nearly 20 years of operational and policy expertise in Medicaid, Medicare, CHIP, and private market health insurance. She previously served as chief executive officer for Magellan Complete Care of Virginia. Before that, she served as vice president for Medicaid and Medicare and government relations for Kaiser Permanente of the Mid-Atlantic States, overseeing the launch of two Medicaid managed care organizations in Virginia and Maryland. She also has worked for Amerigroup, where she established its Public Policy Institute and served as executive director. Earlier positions include working for the Office of Management and Budget, where she led a team focused on Medicaid, CHIP, and private health insurance market programs. She also served as unit chief of the Low-Income Health Programs and Prescription Drugs Unit in the Congressional Budget Office. Ms. Massey has a master of public affairs from the Lyndon B. Johnson College of Public Policy at the University of Texas at Austin and a bachelor of arts from Bard College in New York.

**Jerry Mi** is a research assistant. Before joining MACPAC, Mr. Mi interned for the U.S. House of Representatives Committee on Energy and Commerce, the Health Resources and Services Administration, the Food and Drug Administration, and the National Institutes of Health. Mr. Mi graduated from the University of Maryland with a bachelor of science in biological sciences.

**Robert Nelb, MPH**, is a principal analyst focusing on issues related to Medicaid payment and delivery system reform. Before joining MACPAC, he served as a health insurance specialist at the



Centers for Medicare & Medicaid Services, leading projects related to CHIP and Medicaid Section 1115 demonstrations. Mr. Nelb has a master of public health and a bachelor of arts in ethics, politics, and economics from Yale University.

**Nick Ngo** is the chief information officer. Before joining MACPAC, Mr. Ngo was deputy director of information resources management for the Merit Systems Protection Board, where he spent 30 years. He began his career in the federal government as a computer programmer with the U.S. Department of the Interior. Mr. Ngo graduated from George Mason University with a bachelor of science in computer science.

**Audrey Nuamah, MPH**, is a senior analyst focusing on health equity–related projects. Before joining MACPAC, Ms. Nuamah worked as a program officer at the Center for Health Care Strategies, where she worked with state agencies and provider organizations to focus on cross-agency partnerships, advance health equity, and engage complex populations. Before that, Ms. Nuamah worked for the commissioner of health at the New York State Department of Health. Ms. Nuamah holds a master of public health with a concentration in health policy and management from Columbia University Mailman School of Public Health and a bachelor of arts in health and societies from the University of Pennsylvania.

**Kevin Ochieng** is the senior IT specialist. Before joining MACPAC, Mr. Ochieng was a systems analyst and desk-side support specialist at American Institutes for Research, and before that, an IT consultant at Robert Half Technology, where he focused on IT system administration, user support, network support, and PC deployment. Previously, he served as an academic program specialist at the University of Maryland University College. Mr. Ochieng has a bachelor of science in computer science and mathematics from Washington Adventist University.

**Chris Park, MS**, is the data analytics advisor and a principal analyst. He focuses on issues related to managed care payment and Medicaid drug policy and has lead responsibility for MACStats. Before joining MACPAC, he was a senior consultant at The Lewin Group, where he provided quantitative analysis and technical assistance on Medicaid policy issues, including managed care capitation rate setting, pharmacy reimbursement, and cost-containment

initiatives. Mr. Park holds a master of science in health policy and management from the Harvard T.H. Chan School of Public Health and a bachelor of science in chemistry from the University of Virginia.

**Steve Pereyra** is the financial analyst. Before joining MACPAC, he worked as a finance associate for the nonprofit OAR, where he handled various accounting responsibilities and administered the donations database. He graduated from Old Dominion University with a bachelor of science in business administration.

**Aaron Pervin, MPH**, is the contracting officer and a principal analyst focusing on disproportionate share hospital payment policies and financing of health information technology. Before joining MACPAC, Mr. Pervin worked for the Commonwealth of Massachusetts at the Health Policy Commission, where his work focused on increasing the prevalence of alternative payment arrangements and delivery system reform at the state level. Mr. Pervin holds a master of public health from Harvard University and a bachelor of arts in political science from Reed College.

**Ken Pezzella, CGFM**, is the chief financial officer. He has more than 20 years of federal financial management and accounting experience in both the public and private sectors. Mr. Pezzella also has broad operations and business experience and is a proud veteran of the U.S. Coast Guard. He holds a bachelor of science in accounting from Strayer University and is a certified government financial manager.

**Melanie Raible** is the communications specialist. Before joining MACPAC, she worked as a crisis specialist at Life Crisis Center in Salisbury, Maryland, where she helped women and children in domestic violence situations find shelter and resources. Ms. Raible graduated from Salisbury University with a bachelor of arts in communications and public relations and a minor in gender studies.

**Melinda Becker Roach, MS**, is a senior analyst. Before joining MACPAC, Ms. Roach was a program director at the National Governors Association (NGA) Center for Best Practices, as well as NGA's legislative director for health and human services. Ms. Roach previously served as a legislative advisor on personal staff in the U.S. House of Representatives. She holds a master of science in health policy and management from the Harvard T.H. Chan School of Public Health and a bachelor of arts in history from Duke University.

**Ava Williams** is a research assistant. Ms. Williams graduated from Nova Southeastern University in Florida, where she worked as a research assistant focusing on suicide demographics in Miami-Dade County. She has a bachelor of science in psychology.

**Erica Williams** is the human resources specialist. Before joining MACPAC, Ms. Williams was the human resources information system coordinator and licensure coordinator of a regional health system. Before this, she worked for a nonprofit organization as a human resource generalist. She graduated from Delaware State University with a bachelor of arts in special education and psychology.

**Kiswana Williams** is the executive assistant. Before joining MACPAC, she had extensive experience in providing administrative assistance to a variety of organizations in government contracting, law, and real estate. She also has experience coordinating large meetings with executive leadership. Ms. Williams holds a bachelor of science in business administration from the University of Maryland, College Park.

**Amy Zettle, MPP**, is a principal analyst. Before joining MACPAC, she served as the legislative director for the Health and Human Services Committee at the NGA. Ms. Zettle has been a federal affairs director at Cigna and a health care analyst at the Potomac Research Group. Ms. Zettle holds a master of public policy from the University of Maryland and a bachelor of arts in economics from John Carroll University.







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Advising Congress on  
Medicaid and CHIP Policy

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