# Executive Summary: June 2024 Report to Congress on Medicaid and CHIP

MACPAC’s June 2024 *Report to Congress on Medicaid and CHIP* contains four chapters of interest to Congress: (1) improving the transparency of financing in Medicaid and the State Children’s Health Insurance Program (CHIP), (2) optimizing state Medicaid agency contracts (SMACs), (3) analyzing enrollment trends in Medicare Savings Programs (MSPs), and (4) improving demographic data collection in Medicaid.

## CHAPTER 1: Improving the Transparency of Medicaid and CHIP Financing

Chapter 1 makes recommendations to Congress on improving the transparency of financing the non-federal share of Medicaid and CHIP. In the Commission’s view, the primary goal of improving transparency of Medicaid and CHIP financing is to better understand how much providers are paid today under currently permissible financing mechanisms. Identifying payment amounts is the first component of MACPAC’s provider payment framework for assessing whether payments are consistent with the statutory goals of efficiency, economy, quality, and access.

Financing of Medicaid and CHIP is a shared responsibility between states and the federal government. The federal government matches allowable state expenditures according to the federal matching assistance percentage. The statute permits states to raise the non-federal share of Medicaid and CHIP expenditures through multiple sources. The extent to which states rely on funding sources other than state general revenue varies considerably by state and type of service.

MACPAC has previously recommended that the Centers for Medicare & Medicaid Services (CMS) collect data on provider costs of contributing to the non-federal share so that we can account for these costs when assessing net payments to hospitals and nursing facilities. This work expands on earlier research by including all providers, not just hospitals and nursing facilities, including all financing methods, not just provider contributions, and including both state and provider-level financing amounts.

In this chapter, we make the following recommendations:

1. In order to improve transparency and enable analyses of net Medicaid payments, Congress should amend Section 1903(d)(6) of the Social Security Act to require states to submit an annual, comprehensive report on their Medicaid financing methods and the amounts of the non-federal share of Medicaid spending derived from specific providers. The report should include:

* a description of the methods used to finance the non-federal share of Medicaid payments, including the parameters of any health care-related taxes;
* a state-level summary of the amounts of Medicaid spending derived from each source of non-federal share, including state general funds, health care-related taxes, intergovernmental transfers, and certified public expenditures; and,
* a provider-level database of the costs of financing the non-federal share of Medicaid spending, including administrative fees and other costs that are not used to finance payments to the provider contributing the non-federal share.

This report should be made publicly available in a format that enables analysis.

1. In order to provide complete and consistent information on the financing of Medicaid and the State Children’s Health Insurance Program (CHIP), Congress should amend Section 2107(e) of the Social Security Act (the Act) to apply the Medicaid financing transparency requirements of Section 1903(d)(6) of the Act to CHIP.

The Commission will continue to examine Medicaid payment policies guided by MACPAC’s provider payment framework, as well as monitor larger trends in federal Medicaid spending, including the share of Medicaid spending financed by states, providers, and the federal government. The Commission has previously

examined alternative approaches to federal Medicaid financing that are intended to alter the trajectory of federal

spending, but cannot examine the full effects of these policies until more state and provider-level financing data are available.

## CHAPTER 2: Optimizing State Medicaid Agency Contracts

Chapter 2 focuses on steps toward better coordination of care for people who are dually eligible for Medicaid and Medicare. Dually eligible beneficiaries may experience fragmented care and poor health outcomes when their benefits are not coordinated. The most widely available tool for integrating Medicaid and Medicare benefits are Medicare Advantage (MA) dual eligible special needs plans (D-SNPs), which operated in 45 states and the District of Columbia in 2023. To operate, D-SNPs must sign a SMAC with the state Medicaid agency that details the federal minimum requirements describing how the D-SNP must coordinate Medicaid services for beneficiaries, as well as additional requirements the state chooses to include.

In the Commission’s previous reports to Congress, we highlighted the benefits of integrated care, the barriers that states face in developing these models, and described the strategies available to states to integrate care through their contracts with D-SNPs. Building on that work, we set out to better understand the degree to which states use their contracting authority to provide care coordination and integrate care for their dually eligible beneficiaries, as well as to understand how states consider, oversee, and enforce their contracts.

The chapter describes findings from this work, in addition to highlighting how states face barriers to overseeing their SMACs. The Commission makes two recommendations, one to states and one to CMS, that are intended to support states by providing a starting point for optimizing and overseeing SMACs and to explain how integrated care may benefit beneficiaries residing in their states.

In this chapter, we make the following recommendations:

1. State Medicaid agencies should use their contracting authority at 42CFR 422.107 to require that Medicare Advantage dual eligible special needs plans (D-SNPs) operating in their state regularly submit data on care coordination and Medicare Advantage encounters to the state for purposes of monitoring, oversight, and assurance that plans are coordinating care according to state requirements. If states were required by Congress (as previously recommended by the Commission) to develop a strategy to integrate Medicaid and Medicare coverage for their dually eligible beneficiaries, states that include D-SNPs in their integration approach should describe how they will incorporate care coordination and utilization data and how these elements can advance state goals.
2. The Centers for Medicare & Medicaid Services should issue guidance that supports states in their development of a strategy to integrate care that is tailored to each state’s health coverage landscape. The guidance should also emphasize how states that contract with Medicare Advantage dual eligible special needs plans can use their state Medicaid agency contracts to advance state policy goals.

## CHAPTER 3: Medicare Savings Programs: Enrollment Trends

Chapter 3 examines MSPs, which the Commission has had a longstanding interest in because of the potential to improve access to care for low-income Medicare beneficiaries. People who are eligible for both Medicare and Medicaid may be eligible to receive Medicaid assistance with their Medicare premiums and cost sharing through MSPs.

The chapter describes MSPs and their role in providing Medicaid assistance with Medicare premiums and cost sharing to individuals who are dually eligible for Medicaid and Medicare. It begins by providing an overview of the MSPs, and then discusses MACPAC’s prior work analyzing participation rates in the programs, including prior Commission recommendations aimed at improving participation in the MSPs. The chapter concludes with our new analysis of enrollment trends, including comparisons across MSPs and comparisons of enrollment trends by demographic characteristics including age, sex, and urban or rural residence.

We found that MSP enrollment trends increased from 2010 to 2021 across all MSPs categories of dual eligibility, with the majority of dually eligible beneficiaries enrolled in an MSP. In 2021, around 80 percent of dually eligible beneficiaries, or about 10 million people, were enrolled in an MSP. These findings indicate that state and federal efforts over the last decade to increase awareness of the MSPs among eligible low-income Medicare beneficiaries may have achieved their intended goals have made substantial progress.

## CHAPTER 4: Medicaid Demographic Data Collection

The final chapter of the June report looks at the collection of demographic data in Medicaid. Medicaid plays an important role in providing health insurance coverage to historically marginalized populations, and disparities in health care access and outcomes persist among these populations. However, gaps in demographic data collection can impede efforts to measure and address these health disparities.

MACPAC’s June 2022 Report to Congress highlights how Medicaid can take an active role in advancing health equity. In the March 2023 report, the Commission recommended updating the race and ethnicity questions on the model application and developing training materials to encourage responses and improve the usability of data. As a continuation of this work, we evaluated the availability of primary language, limited English proficiency, sexual orientation and gender identity (SOGI), and disability data to help measure and address health disparities among the Medicaid population.

Chapter 4 describes the importance of collecting demographic data and federal and state priorities for collecting and using these data. These data are important in supporting independent research and state monitoring efforts, informing policy decisions, civil rights enforcement, and improving stakeholder knowledge about the health service needs of the many populations covered by Medicaid. We conclude with key considerations for collecting these data and factors affecting data quality.

Although our findings demonstrate that there is a need to improve existing data, they also illustrate that language, SOGI, and disability data are already available from a number of data sources. MACPAC will continue to capitalize on existing Medicaid demographic data to measure health disparities in access to care and health outcomes and encourages CMS, states, researchers, and other stakeholders to do the same.